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State/Territory Name: Texas

State Plan Amendment (SPA) #: TX-19-0045

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

April 9, 2024

Emily Zalkovsky
Medicaid Director, Medicaid/CHIP Division
Medical and Social Services
State of Texas, Health and Human Services Commission
4900 Lamar Boulevard
Austin, TX 78751

Dear Director Zalkovsky:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA), TX-19-0045, submitted June 30, 2019, with additional information submitted on March 18, 2024 has been approved. This SPA has an effective date of July 1, 2018.

Through this SPA, Texas has provided the necessary assurances indicating that the state complies with the managed care requirements in the delivery of CHIP services and benefits covered under the state's separate child health plan as of July 1, 2018 consistent with the regulations at 42 CFR 457 Subpart L. Additionally, through this SPA the state is updating its process for conducting reviews of health services matters.

This SPA approval does not substitute for CMS review of any contracts between the state and managed care entities that serve the state's CHIP populations. All managed care contracts for CHIP populations in effect as of the state fiscal year beginning on or after July 1, 2018 must comply with the CHIP managed care regulations and be submitted for CMS review.

Your title XXI project officer is Abbie Walsh. She is available to answer questions concerning this amendment and other CHlP-related issues. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850
Telephone: (667) 290-8863
E-mail: abagail.walsh@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Division Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,
/Signed by Sarah deLone/

Sarah deLone
Director

OMB #: 0938-0707
Exp. Date:

MODEL APPLICATION TEMPLATE FOR

STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (CHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements, as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

Form CMS-R-211

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: Texas
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

Cecile Young
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name: ~~Stephanie Stephens~~Emily Zalkovsky	Position/Title: Chief Medicaid and CHIP Services Officer
Name: Trey Wood	Position/Title: Deputy Executive Commissioner of Financial Services
Name:	Position/Title:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, Baltimore, Maryland 21244.

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) **(42 CFR 457.70)**:

1.1.1. ☒ Obtaining coverage that meets the requirements for a separate child health program **(Section 2103)**; **OR**

1.1.2. ☐ Providing expanded benefits under the state's Medicaid plan **(Title XIX)**; **OR**

1.1.3. ☐ A combination of both of the above.*

* Phase I children (Medicaid "Phase-In" children) covered under the original Texas CHIP state plan have been completely phased in to Medicaid as an eligibility group. However, the state would reserve the right to continue to claim FMAP for any outstanding and unpaid Medicaid claims for that group for dates of service prior to their conversion to a regular Medicaid FMAP group.

1.2 ☒ Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. **(42 CFR 457.40(d))**

1.3 ☒ Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. **(42CFR 457.130)**

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment **(42 CFR 457.65)**:

Effective dates: See below.*

Implementation date: May 1, 2000 (CHIP Phase II)

* The Compliance SPA amendment, approved May 5, 2003, reformatted Texas' previous CHIP state plan covering Phase I and Phase II children. In general, the effective date(s) are the same as the original CMS-approved effective dates for Phase I (Medicaid coverage for phase-in children) and Phase II (separate, state-designed CHIP coverage up to 200 percent FPL).

Subsequent amendments to the original CHIP state plan (related to the Phase II program) were incorporated into the new state plan template, and are effective per their CMS-approved effective dates. The amendments to date are listed below:

- CHIP Method of Finance Change – Approved December 13, 2001, Effective September 1, 2001.
- CHIP Cost-sharing Changes- Approved May 1, 2002, Effective March 1, 2002.
- CHIP Car Seat Initiative- Approved November 25, 2002, Effective June 15, 2002.
- CHIP Community Health Worker Initiative – Approved May 5, 2003, Effective May 5, 2003.
- CHIP Program Changes related to actions of the 78th Texas Legislature – Approved July 25, 2003, Effective September 1, 2003.
- CHIP Program Changes related to Community Health Worker Initiative – Approved November 18, 2004, Effective August 1, 2004.
- CHIP Restoration of Medical Benefits – Approved May 26, 2006, Effective September 1, 2005.
- CHIP Cost-sharing Changes – Approved May 10, 2006, Effective January 1, 2006.
- CHIP Restoration of Dental Benefits – Approved December 23, 2005, Effective April 1, 2006.
- CHIP Program changes related to the time period for payment of cost-sharing obligations – Approved January 18, 2007, Effective August 1, 2006.
- CHIP Program changes related to the CHIP Perinatal Program – Approved June 2, 2006, Effective September 1, 2006.
- CHIP Program changes related to Applicant and Enrollee Protections – Approved September 24, 2007, Effective May 1, 2007.
- CHIP Program changes related to HB 109, 80th Legislature, Regular Session, 2007 – Approved December 28, 2007, Effective September 1, 2007.
- CHIP Program changes related to dental benefits – Approved November 8, 2007, Effective September 1, 2007.
- CHIP extension for enrollment fee payments for Hurricane Ike – Approved October 30, 2008, Effective September 7, 2008.
- CHIP income exemption for temporary census employees – Approved October 30, 2008, Effective October 1, 2008.
- CHIP Program changes applying payment requirements consistent with the Medicaid prospective payment system for federally qualified health centers and rural health clinics, Approved October 25, 2010, Effective October 1, 2009.
- CHIP eligibility expansion for qualified aliens under age 19, Approved February 11, 2011, Effective May 1, 2010.

- ❑ CHIP Program change related to hospice care, Approved October 25, 2010, Effective August 1, 2010.
- ❑ CHIP Perinatal Program changes allowing eligible unborn children to receive coverage for 12 continuous months, except when labor with delivery is paid for by Medicaid and the newborn is deemed eligible for Medicaid, Approved October 25, 2010, Effective September 1, 2010.
- ❑ CHIP method of finance change to provide federal matching funds for public school employee children, Approved February 11, 2011, Effective September 1, 2010.
- ❑ CHIP changes for behavioral health benefits and cost-sharing, Approved October 25, 2010, Effective March 1, 2011.
- ❑ CHIP change to provide federal matching funds for public employee children, Approved July 27, 2011, Effective September 1, 2011.
- ❑ CHIP Program change related to the dental program and cost-sharing, Approved August 5, 2011, Effective March 1, 2012.
- ❑ CHIP update to the electronic system processes used to determine CHIP eligibility, Effective September 1, 2013.
- ❑ CHIP change incorporating approved Modified Adjusted Gross Income (MAGI) Conversion Plan to cost-sharing bands, Effective January 1, 2014.
- ❑ CHIP changes incorporating Affordable Care Act state plan templates and deleting pages superseded by templates, and eliminating resources, Effective September 1, 2016.
- ❑ CHIP updates to the enrollment process for continuity of care, Effective October 1, 2016
- ❑ CHIP updates to provisions for implementing temporary adjustments to eligibility and enrollment policies for application and redetermination, and cost-sharing requirements for children in families living in in Federal Emergency Management Agency (FEMA) or Governor declared disaster areas at the time of the disaster event: In the event of a disaster, the State will notify CMS of the intent to provide temporary adjustments to its eligibility and enrollment policies for application and redetermination policies and cost-sharing requirements, the effective dates of such adjustments, and the counties/areas impacted by the disaster, Approved August 31, 2017, Effective August 25, 2017.
- ❑ CHIP updates to the payment methodology for Federally-Qualified Health Centers and Rural Health Centers. Approved March 20, 2020, Effective April 1, 2018.

□ CHIP update to managed care template (Section 3 only), effective July 1, 2018

□ CHIP update to external review process, effective July 1, 2018 (Texas Department of Insurance ceases to receive external review requests. After June 30, 2018, the HHS-administered process is to receive all external review requests).

1.4-TC Tribal Consultation (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

Notification was provided to the Indians Health Programs in Texas and the Urban Inter-Tribal Center of Texas to demonstrate compliance with the Medicaid managed

care final rule and the Affordable Care Act on June 20, 2019.
TN: 19-0045, Approval Date: April 9, 2024, Effective Date: July 1, 2018

- ☐ CHIP Cost-sharing Changes related to SB 827, 87th Legislature, Regular Session, 2021 – Approved December 23, 2022 , Effective January 1, 2023.

1.4-TC Tribal Consultation (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

Tribal consultation was not required for this CHIP State Plan Amendment.
TN: 22-0001, Approval Date: December 23, 2022, Effective Date: January 1, 2023

- ☐ CHIP Coverage Required by the American Rescue Plan Act– Approved December 5, 2022, Effective March 11, 2021.

1.4-TC Tribal Consultation (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

Notification was provided to the Indians Health Programs in Texas and the Urban Inter-Tribal Center of Texas for implementing the American Rescue Plan Act of 2021 on July 29, 2022.
TN: 22-0031, Approval Date: December 5, 2022, Effective Date: March 11, 2021.

Superseding Pages of MAGI CHIP State Plan Material

Transmittal Number	SPA Group	PDF	Description	Superseded Plan
TX-14-0032 Effective/Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7	Eligibility- Targeted Low Income Children	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3
		CS9	Eligibility-Coverage from Conception to Birth	Supersedes the current section Age 4.1.1; 4.1.2.1; and 4.1.3
		CS10	Eligibility-Children who have access to Public Employee Coverage Hardship Exception	Supersedes the current section 4.4; 4.4.1; 4.4.2; and 4.4.3 Appendix: Supersedes current documentation
		CS15	MAGI-Based Income Methodologies	Incorporate within a separate subsection under section 4.3
TX-14-0033 Effective/Implementation Date: January I, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
TX-14-0034 Effective/Implementation Date: January 1, 2014	Establish 2101(t) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of lncome Disregards	Incorporate within a separate subsection under section 4.1
TX-14-0038 Effective/Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4
TX-14-0036 Effective/Implementation Date: January 1, 2014	Non-Financial Eligibility	CS17	Non-Financial- Citizenship	Supersedes the current section 4.1.5
		CS18	Non-Financial Eligibility-Residency	Supersedes the current sections 4.1.; 4.1.10.
		CS19	Non-Financial- Social Security Number	Supersedes the current section 4.1.9.
		CS20	Substitution of Coverage	Supersedes the current section 4.4.4
		CS21	Non-Financial Eligibility-Non-Payment ofPremiums	Supersedes the current section 8.7
		CS27	Continuous Eligibility	Supersedes the current section 4.1.8

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). **(42 CFR 457.80(a))**

The Texas State Data Center projects that in 2007 the population of children under age 19 in Texas will reach 6,731,000. The projected race/ethnic distribution is as follows: 2,613,000 (38.8 percent) Anglo; 822,000 (12.2 percent) African American; 3,054,000 (45.4 percent) Hispanic; and 242,000 (3.6 percent) for all other groups.

The March 2006 Current Population Survey (CPS) is the source for the most recent official estimates for poverty and health insurance coverage in Texas. The estimates are for calendar year 2005.

The survey indicates that in 2005 about 3.7 million (16.2 percent) of Texans had incomes below the federal poverty level (FPL). That total includes approximately 1.5 million children under age 19. The survey also indicates that in 2005 nearly 3.2 million (47.7 percent) of the 6.7 million children under age 19 were in families with incomes at or below 200 percent of FPL.

For 2005, the health insurance coverage status of Texas children under age 19 is estimated as follows*:

Health Insurance Coverage in 2005:
Texas Children Under Age 19

Insurance Type	Number of Children	Percent of Children
Medicaid/CHIP/Medicare	1,913,000	28.42%
Private	3,524,000	52.35%
Uninsured	1,294,000	19.22%
Total	6,731,000	100%

Medicaid is the public health insurance program generally available in Texas. There are several public-private partnerships in the State (see 2.2.2 below).

For 2005, the estimated number of uninsured Texas children under age 19 according to age group is as follows*

Uninsured Texas Children in 2005 by Age Group

Age Group	Number of Children	Number of Uninsured Children	Percent of Children Uninsured
0 – 5	2,206,000	411,000	18.63%
6 – 14	3,131,000	556,000	17.76%
15 – 18	1,394,000	327,000	23.46%
0 – 18	6,731,000	1,294,000	19.22%

For 2005, the estimated distribution of uninsured children under age 19 according to percent of poverty income category is as follows*:

Uninsured Texas Children Under 19 in 2005 by Percent of Poverty Income Category

Percent of Poverty Category	Number of Uninsured Children	Percent of Children Uninsured
0 – 100%	382,000	29.52%
101 – 150%	282,000	21.79%
151 – 200%	235,000	18.16%
Above 200%	395,000	30.53%
Total	1,294,000	100%

For 2005, the estimated distribution of uninsured children according to age group and percent of poverty income category is as follows*:

Uninsured Texas Children in 2005 by Age and Percent of Poverty Income Category

Age Category	0 – 100%	101 – 150%	151 – 200%	Above 200%	Total
0 – 5	134,000	69,000	64,000	144,000	411,000
6 – 14	163,000	133,000	106,000	154,000	556,000
15 – 18	85,000	80,000	66,000	97,000	327,000
0 – 18	382,000	282,000	235,000	395,000	1,294,000

* The sums across some categories may not add up exactly to the total due to rounding. The poverty and health insurance estimates apply to the segment of the population for whom poverty income status was determined. Poverty income status was determined based on the reported annual household/family income.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102)(a)(2) (42CFR 457.80(b))**

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

The Texas Health and Human Services Commission (HHSC), which has oversight responsibilities for the four other health and human services agencies, is responsible for the administration of certain programs, including the Texas Medicaid program and CHIP. Children are identified and enrolled in Medicaid or CHIP through a variety of mechanisms.

Enrollment
Applications are processed in local eligibility offices, hospitals, and clinics throughout the State, and by the administrative services contractor.

Families may apply online, by phone, or in person. For a paper application, families may access and print the application online or by calling a toll-free number to request that an application be mailed to them. They may then submit the completed application and supporting documentation by mail, fax, or in person.

HHSC processes all applications when families apply for children's health care benefits (Medicaid/CHIP) and other related programs (e.g., Medicaid for adults, Temporary Assistance for Needy Families (TANF)). Applications eligible for CHIP are electronically transmitted to the administrative services contractor to complete the enrollment process.

Identification
HHSC identifies children who are eligible to participate in Medicaid or CHIP through the following resources:

Out-stationed Eligibility Staff - HHSC outstations eligibility workers in clinics and hospitals. This staff perform eligibility functions as well as screening functions for potential Medicaid and CHIP eligible individuals. There are approximately 300 eligibility workers out-stationed in 190 facilities. The number of out-stationed eligibility staff in a facility is a function of the volume of eligibility determinations made at the facility. In some cases, disproportionate share hospitals (DSH) and Federally Qualified

Health Centers (FQHCs) fund the state share of salary and benefits costs associated with staff above and beyond those required by federal law. Facilities that are not DSH hospitals or FQHCs can contract with HHSC for eligibility specialists and appropriate support staff to be placed in the facility. Under these contracts, the facilities also reimburse HHSC for the state share of the employee's salary and benefits.

HHSC Office of the Ombudsman Texas Works Hotline (1-800-252-9330) - The Hotline primarily handles complaints concerning Food Stamps, Medicaid or temporary cash assistance (TANF). However, when a client calls and relays information about potential eligibility, or inquiries about programs for which they may be eligible, the client is referred to the correct local office or, if appropriate, to a designated regional contact.

HHSC Office of the Ombudsman (1-877-787-8999) - Clients and potential clients who call HHSC State Office are referred to the Office of the Ombudsman. Some of these calls may be from potential clients asking for instructions/assistance in applying for benefits. Callers are referred to local HHSC offices as appropriate.

Texas Medicaid Healthcare Partnership (TMHP) Client Hotline (1-800-335-8957 and 1-800-252-8263) - The hotline handles Medicaid client issues pertaining to the status of Medically Needy cases, billing questions, and Medicaid program benefits, as well as contact information for the Medical Transportation Program, Texas Health Steps (Texas' EPSDT program) services, and for HIPAA privacy violations.

Blue Pages Listings - Current information for local HHSC offices is contained in local telephone directories in the government blue pages section. This information is broken down by program and is updated as needed.

Worldwide Web Sites - HHS maintains an agency home page that contains information about what types of benefits are available throughout the agency. The YourTexasBenefits.com website provides a searchable listing of local offices and the services available at each of these offices.

Food Stamps – Individuals applying for food stamps are tested for eligibility for Medicaid during the same interview.

Newborns of Medicaid Eligible Mothers - Enrollment in Medicaid is automatic for the majority of newborns of Medicaid-eligible mothers. When the medical facility notifies HHSC about the birth of the child to a Medicaid-eligible mother, HHSC establishes eligibility for the child. An automated system then notifies the child's mother, designated providers, and the mother's caseworker about the child's eligibility. These newborn children are also included in the Texas Health Steps outreach (see below).

Title V - In the Texas Title V Children with Special Health Care Needs (CSHCN) program, most clients are required to apply to Medicaid or CHIP before they receive full CSHCN eligibility. Some are enrolled in Medicaid as a result. Those who reach a certain expenditure level for CSHCN services are required to apply again to Medicaid, with the emphasis on eligibility for the Medicaid Medically Needy Program, the spend down program under Title XIX.

The regional Title V CSHCN social work and eligibility staff and the CSHCN case management contractors help families with CSHCN to obtain Medicaid eligibility when appropriate.

In Title V Maternal/Child Health (MCH) contracts across the State, children who, after eligibility screening, appear to be eligible for Medicaid, are required to apply for Medicaid in order to continue to receive MCH services in the contractors' clinics. The contractors include many local health departments as well as hospital districts and other providers. An automated screening tool, the State of Texas Assistance and Referral System (STARS), is used by many of these providers to screen for possible eligibility for Medicaid, CSHCN, and other programs. The client must then go on to actual Medicaid eligibility determination if the STARS screen indicates they may be Medicaid eligible.

Supplemental Security Income (SSI) - SSI eligible persons are automatically enrolled in Medicaid in Texas. The Disability Determination Division makes disability determinations for SSI.

Foster Care - For children who are removed from their households by court order through the Texas Department of Family and Protective Services (DFPS), Medicaid is provided through foster care if the child was eligible for Medicaid prior to being removed from the household or if the child is determined to be Medicaid eligible by DFPS standards. Medicaid is also provided, under TANF limits, to children under 18 placed by a district court in the managing conservatorship of DFPS as a result of findings of abuse or neglect by DFPS.

Child Support - The Child Support Enforcement Office of the Attorney General seeks out the non-custodial parent for financial and/or medical support to supplement and/or replace state liability. This office also processes through the Third Party Reimbursement (TPR) system to seek premium reimbursement for cases where medical coverage is provided.

Local Mental Health Authorities (LMHAs) - Under the authority of the Department of State Health Services (DSHS), LMHAs are required to do

outreach to identify clients with serious mental illness and intellectual disabilities. The LMHAs vary in the amount and types of outreach conducted. Outreach activities may include: public announcements; distribution of brochures in targeted areas, such as doctors' offices, schools, and juvenile courts; public forums; or public festivals.

At intake, information, which may indicate Medicaid eligibility, is gathered by the LMHA. Individuals who appear to be Medicaid eligible are then referred for Medicaid eligibility determination. If the individual needs assistance with this referral, the LMHA will assist.

LMHAs may have out-stationed HHSC Medicaid eligibility workers on staff that do the Medicaid eligibility determinations on site.

Texas Health Steps (THSteps) - THSteps outreach efforts are aimed at encouraging the use of services (program participation) by enrolled THSteps clients. Texas Health Steps communicates with Medicaid-eligible families on the state level as well as on the regional and local level through a statewide system of HHSC staff and contractors using the following tools:

- over 435,000 informing letters per month;
- a variety of brochures and other handouts in English and Spanish for recipient and provider use;
- home visits, telephone calls, outreach at places where clients may be found, and efforts targeting specific groups such as migrant workers and newly enrolled Medicaid recipients;
- a single statewide toll-free number (1-877-THSTEPS) that is routed to the appropriate regional outreach location.
- regional provider newsletters which help to keep Health Steps providers informed of developments in the program;
- regional provider relations staff who help recruit and maintain Health Steps and Medicaid providers, supplementing the provider relations activities for which HHSC contracts with the Texas Medicaid and Healthcare Partnership (TMHP);
- the Medicaid Bulletin, which provides information to all Medicaid providers; and
- the Medicaid managed care enrollment broker, whose staff helps educate clients as they are enrolled in health plans.

In the course of promoting use of EPSDT service, THSteps staff and contractors inform interested families of the way to apply for Medicaid for other children.

Family Health Services Information & Referral Line - Toll-free hotline, funded by Title V, provides information and referrals for families who call in, including referrals to Medicaid and Title V MCH and CSHCN services.

Texas Information and Referral Network – The Texas Information and Referral Network (TIRN) at HHSC coordinates a statewide network of state and local contact points to provide information regarding health and human services in Texas, including Medicaid.

Effective May 1, 2010, Texas extends federally-matched CHIP coverage to qualified alien children who are otherwise eligible without a five-year delay. Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3, authorizes states to provide federally-matched Medicaid and CHIP coverage to qualified alien children.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

Texas has a variety of established programs and programs under development which involve private-public partnerships in providing health insurance coverage to uninsured children.

The Texas Health Insurance Risk Pool was funded by the Texas legislature in 1997 to provide the administrative structure for ensuring that health coverage is available to persons unable to otherwise obtain coverage because of their medical history or because they lose employer coverage. Coverage is automatic for uninsurable persons with certain diagnoses, such as metastatic cancer, leukemia, diabetes, epilepsy, and sickle cell anemia. The first Health Pool policies were effective February 1, 1998.

An extensive preferred provider network is utilized by the Pool. In addition, a prescription drug benefit is included with the policy. Participants can select a $500 deductible package, a $1,000 deductible package, a $2,500 deductible package or a $5,000 deductible package. Premium rates are based on deductible plan, age, sex, area of the State, and smoking status. Effective January 1, 2004, the Pool's rates were set at two times the Standard Rate. At present, premiums for children up to age 18 range from $121 per month to $549 per month. Benefits include inpatient and outpatient care and are limited to $1.5 million over a lifetime. Children are eligible for Pool coverage, either as eligible Pool applicants or as dependents of eligible Pool applicants.

The Community Access To Child Health (CATCH) Program is a program of the American Academy of Pediatrics (AAP) designed to improve access to health care by supporting pediatricians and communities that are involved in community-based efforts for children. The CATCH program provides pediatricians with training; technical assistance and resources; peer support and networking opportunities; and funding opportunities. A variety of funding opportunities are available, including implementation funds, planning funds, and resident funds. The Implementation Funds program supports pediatricians in the initial and/or pilot stage of developing and implementing a community-based child health initiative. Implementation funds are supported by Hasbro Children's Foundation, Ronald McDonald House of Charities, CVS Pharmacy, and AAP. The Planning Funds program offers grants to pediatricians to develop community-based initiatives that increase children's access to medical homes or to specific health services not otherwise available. The program is supported by a grant from Wyeth, with additional support provided by the AAP Friends of Children Fund, and the American Academy of Pediatric Dentistry Foundation. Resident funds are available for pediatric residents planning community-based child health initiatives, and are supported by grants from the Irving Harris Foundation and the AAP Friends of Children Fund, with additional support provided by the American Academy of Pediatric Dentistry Foundation. Projects have included providing health care services for children living in the colonias (rural developments along the Texas-Mexico border that frequently may not have basic amenities such as running water) and case management for very low birth weight babies.

The Healthy Tomorrows Partnership for Children Program is a collaborative grant of the federal Maternal and Child Health Bureau and the AAP for local entities, such as local health departments, county hospital districts, and community health centers that are supported in part with state funds to increase access to health services for mothers and children. Projects include providing direct health care, prevention of sexually transmitted disease among minority youth, and improving the health status of medically indigent, low birth weight infants.

Two public programs identify children who could benefit from a private-public partnership. The Texas Medicaid program, through the Health Insurance Premium Payment (HIPP) Program, pays health insurance premiums for Medicaid eligible children. HIPP works with other state agencies, private employers, and private health coverage providers to ensure that Medicaid eligible children are able to take advantage of health coverage to which they have access. Given the broader scope of Medicaid benefits relative to the typical defined benefits package, children are able to take advantage of both public and private resources in receiving the services they need.

The Texas Title V Program for Children with Special Health Care Needs (CSHCN) has a similar program that pays private health coverage premiums when doing so is cost effective for CSHCN and when the family is unable to afford the premiums. This program serves children with family incomes up to 200 percent of FPL.

2.3. Describe the procedures the state uses to accomplish coordination of CHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as Title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. *(Previously 4.4.5.)*
(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

Linkages established with other public/private health insurance partnerships provide opportunities for collaboration and mutually supportive operations.

Coordination with Medicaid is achieved through coordinated outreach efforts and a joint children's application. Outreach efforts are coordinated through contracts with local, community-based organizations (CBOs). The CBOs were selected based on their local expertise and experience with low-income populations. CHIP enrollment information is routinely shared with Texas' Title V agency in order to coordinate program benefits. Texas' CHIP coordination efforts are ongoing, but appear successful, as Texas' CHIP enrollment growth rate was at one time among the fastest in the nation.

Section 3. Methods of Delivery and Utilization Controls ~~(Section 2102)(a)(4))~~

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4 (Eligibility Standards and Methodology).

Child health benefits are delivered solely through managed care models, including a managed care organization (MCO) model and an exclusive provider organization (EPO) model used primarily in rural areas of the State. CHIP Dental services are delivered through a prepaid ambulatory health plan (PAHP). In the MCO and EPO models, the State contracts to deliver health care services, relying on managed care principles that will include a service manager or coordinator or "medical home" and utilization controls on inpatient hospital and certain other services in the case of the MCO model and the latter only in the case of the EPO. The same requirements are applied to both MCOs and EPOs.

The CHIP procurement of health plan services is aligned as closely as possible with other programs, such as Medicaid and the Title V Children with Special Health Care Needs (CSHCN) program, to improve continuity of care. Enrollees are given a choice of at least two plans whenever possible, and Medicaid plans are given extra consideration in the procurement of CHIP health plans.

~~The State ensures that federally qualified health centers (FQHCs) and rural health clinics (RHCs) receive the full Medicaid encounter rate for services rendered to CHIP Members on or after October 1, 2009, consistent with section 1902(bb) and section 2107(e)(1)(I) of the Social Security Act.~~

~~The rate-setting methodologies for FQHCs and RHCs are set out below:~~

~~FQHCs~~

~~An FQHC will be reimbursed for a visit for CHIP-covered services if the visit is a face-to-face encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, visiting nurse, psychologist, clinical social worker, other health professional for mental health services, dentist, dental hygienist, or optometrist.~~

~~Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day, and at a single location, constitute a single visit unless:~~

- ~~After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; or~~
- ~~The FQHC patient has a medical visit and an "other" health visit.~~

~~An "other" health visit includes a face-to-face encounter between an FQHC patient and a psychologist, clinical social worker, other health professional for mental health services, dentist, dental hygienist, or optometrist, as well as an Early and Periodic Screening, Diagnostic and Treatment medical checkup.~~

~~An FQHC is reimbursed a full encounter rate for all CHIP-covered services. The full encounter rate is calculated using one of two prospective payment methodologies: the Prospective Payment System (PPS) Methodology and the Alternative Prospective Payment System (APPS) Methodology. Each FQHC selects the payment methodology it prefers in a signed, written document.~~

~~An MCO or dental maintenance organization will pay to an FQHC the FQHC's full encounter rate for covered services. The State will reimburse the MCO the difference between the amount the MCO paid the FQHC and the amount the MCO has contracted to pay the FQHC. The State's supplemental payment obligation to the MCO will be determined by subtracting the baseline payment under the contract for services being provided from the Medicaid encounter rate without regard to the effects of financial incentives that are linked to utilization outcomes, reductions in patient costs or bonuses. If the contracted amount paid to an FQHC by an MCO or dental maintenance organization is less than the amount the~~

FQHC would receive under PPS or APPS, whichever applies, the State will ensure the FQHC is reimbursed the difference on at least a quarterly basis.

The change of effective rate cost report is used by in-state or out-of-state FQHCs that are requesting a change in their effective rate due to a change in scope or operating in an efficient manner. The cost report must contain at least six months of financial information.

If the FQHC disagrees with the results of the review or rate, the FQHC may request a formal appeal.

RHCs

Each RHC is reimbursed a full encounter rate calculated using the PPS methodology.

An RHC will be reimbursed for a visit for a CHIP-covered service if the visit is a face-to-face encounter between an RHC patient and a physician, physician assistant, advanced nurse practitioner, certified nurse-midwife, visiting nurse, or clinical nurse practitioner. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit unless:

- After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; or
- The RHC patient has a medical visit and an "other" health visit.

An "other" health visit includes a face-to-face encounter between an RHC patient and a clinical social worker.

An RHC is paid in full by the MCO and the MCO is paid as part of the MCO's HHSC-contracted capitation rate. The State does not make supplemental payments to an RHC unless the RHC is underpaid for a valid claim and has pursued all appeals with the MCO. The State will ensure the RHC is reimbursed the difference on at least a quarterly basis. By signing the contract with the MCO, the RHC indicates agreement with the payment methodology.

Guidance: In Section 3.1, describe all delivery methods the State will use to provide services to enrollees, including: (1) contracts with managed care organizations (MCO), prepaid inpatient health plans (PIHP), prepaid ambulatory health plans (PAHP), primary care case management entities (PCCM entities), and primary care case managers (PCCM); (2) contracts with indemnity health insurance plans; (3) fee-for-service (FFS) paid by the State to health care providers; and (4) any other arrangements for health care delivery. The State should describe any variations based upon geography and by population (including the conception to birth population). States must submit the managed care contract(s) to CMS' Regional Office for review.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. **(Section 2102)(a)(4) (42CFR 457.490(a))**

Child health benefits are delivered solely through managed care models, including a managed care organization (MCO) model and an exclusive provider organization (EPO) model used primarily in rural areas of the State. CHIP Dental services are delivered through a prepaid ambulatory health plan (PAHP). In the MCO and EPO models, the State contracts to deliver health care services, relying on managed care principles that will include a service manager or coordinator or "medical home" and utilization controls on inpatient hospital and certain other services in the case of the MCO model and the latter only in the

~~case of the EPO. The MCO and EPO models are subject to the same CHIP state and federal laws.~~

~~The CHIP procurement of health plan services is aligned with Medicaid to improve continuity of care. Enrollees are given a choice of at least two plans whenever possible, and Medicaid plans are given extra consideration in the procurement of CHIP health plans.~~

~~The State ensures that federally qualified health centers (FQHCs) and rural health clinics (RHCs) receive the full Medicaid encounter rate for services rendered to CHIP Members on or after October 1, 2009, consistent with section 1902(bb) and section 2107(e)(1)(I) of the Social Security Act.~~

~~The rate-setting methodologies for FQHCs and RHCs are set out below:~~

~~a.) FQHCs~~

~~An FQHC will be reimbursed for a visit for CHIP-covered services if the visit is a face-to-face encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, visiting nurse, psychologist, clinical social worker, other health professional for mental health services, dentist, dental hygienist, or optometrist.~~

~~Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit unless:~~

- ~~After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; or~~

~~• The FQHC patient has a medical visit and an "other" health visit.~~

~~An "other" health visit includes a face-to-face encounter between an FQHC patient and a psychologist, clinical social worker, other health professional for mental health services, dentist, dental hygienist, or optometrist, as well as an Early and Periodic Screening, Diagnostic and Treatment medical checkup.~~

~~An FQHC is reimbursed a full Medicaid encounter rate for all CHIP-covered services. The full Medicaid encounter rate is calculated using one of two prospective payment methodologies: the Prospective Payment System (PPS) Methodology or the Alternative Prospective Payment System (APPS) Methodology. Each FQHC selects the payment methodology it prefers in a signed, written document.~~

~~An MCO or dental maintenance organization will pay to an FQHC the FQHC's full Medicaid encounter rate for covered services. The State will reimburse the MCO the difference between the amount the MCO paid the FQHC and the amount the MCO has contracted to pay the FQHC. The State's supplemental payment obligation to the MCO will be determined by subtracting the baseline payment under the contract for services being provided from the Medicaid encounter rate without regard to the effects of financial incentives that are linked to utilization outcomes, reductions in patient costs or bonuses. If the contracted amount paid to an FQHC by an MCO or dental maintenance organization is less than the amount the FQHC would receive under PPS or APPS, whichever applies, the State will ensure the FQHC is reimbursed the difference on at least a quarterly basis.~~

~~If the FQHC disagrees with the results of the review or rate, the FQHC may request a formal appeal.~~

~~b.) RHCs~~

~~Each RHC is reimbursed a full Medicaid encounter rate calculated using the PPS methodology.~~

~~An RHC will be reimbursed for a visit for a CHIP-covered service if the visit is a face-to-face encounter between an RHC patient and a physician, physician assistant, advanced nurse practitioner, certified nurse-midwife, visiting nurse, or clinical nurse practitioner.~~

~~Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit unless:~~

~~• After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; or~~
~~• The RHC patient has a medical visit and an "other" health visit.~~

~~An "other" health visit includes a face-to-face encounter between an RHC patient and a clinical social worker.~~

~~An RHC is paid in full by the MCO and the MCO is paid as part of the MCO's HHSC contracted capitation rate. The State does not make supplemental payments to an RHC unless the RHC is underpaid for a valid claim and has pursued all appeals with the MCO. The State will ensure the RHC is reimbursed the difference on at least a quarterly basis. By signing the contract with the MCO, the RHC indicates agreement with the payment methodology.~~

~~3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. (Section 2102)(a)(4) (42CFR 457.490(b))~~

~~Under the HMO/EPO model, plans are required to provide the range of children's health services for a contracted per member/per month cost determined through actuarial analysis. The state monitors utilization of HMO/EPO services as part of its overall monitoring program. Please see section 7 for more information on the state's monitoring efforts.~~

~~The HMO model includes a number of utilization management controls. Inpatient hospital stays and other services determined by the Medical Director are subject to prospective review for medical necessity and appropriateness of proposed care before services can be rendered. Clients are required to obtain authorized referrals from their primary care providers to other professional providers. The state or its designee also conduct retrospective utilization review activities to examine services to clients directly provided by the network's primary care provider specialty, services performed with authorization, and other services such as emergency room services. The same controls are used in the EPO model, except that the EPO operates without a gatekeeper function being performed by the HMO model's PCP.~~

3.1. Delivery Systems (Section 2102(a)(4)) (42 CFR 457.490; Part 457, Subpart L)

3.1.1 Choice of Delivery System

3.1.1.1 Does the State use a managed care delivery system for its CHIP populations? Managed care entities include MCOs, PIHPs, PAHPs, PCCM entities and PCCMs as defined in 42 CFR 457.10. Please check the box and answer the questions below that apply to your State.

☐ No, the State does not use a managed care delivery system for any CHIP populations.

☒ Yes, the State uses a managed care delivery system for all CHIP populations.

☐ Yes, the State uses a managed care delivery system; however, only some of the CHIP population is included in the managed care delivery system and some of the CHIP population is included in a fee-for-service system.

If the State uses a managed care delivery system for only some of its CHIP populations and a fee-for-service system for some of its CHIP populations, please describe which populations are, and which are not, included in the State's managed care delivery system for CHIP. States will be asked to specify which managed care entities are used by the State in its managed care delivery system below in Section 3.1.2.

Guidance: Utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42 CFR 457.490(b))

If the State does not use a managed care delivery system for any or some of its CHIP populations, describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of:

- The methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102(a)(4); 42 CFR 457.490(a))
- The utilization control systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102(a)(4); 42 CFR 457.490(b))

Guidance: Only States that use a managed care delivery system for all or some CHIP populations need to answer the remaining questions under Section 3 (starting with 3.1.1.2). If the State uses a managed care delivery system for only some of its CHIP population, the State's responses to the following questions will only apply to those populations.

3.1.1.2 Do any of your CHIP populations that receive services through a managed care delivery system receive any services outside of a managed care delivery system?

☒ No
☐ Yes

If yes, please describe which services are carved out of your managed care delivery system and how the State provides these services to an enrollee, such as through fee-for-service. Examples of carved out services may include transportation and dental, among others.

3.1.2 Use of a Managed Care Delivery System for All or Some of the State's CHIP Populations

3.1.2.1 Check each of the types of entities below that the State will contract with under its managed care delivery system, and select and/or explain the method(s) of payment that the State will use:

☒ Managed care organization (MCO) (42 CFR 457.10)
- ☒ Capitation payment

  CHIP capitation rates are defined on a per member, per month basis by the rate cells applicable to a service area. CHIP rate cells are based on the member's age group. CHIP Perinatal capitation rates are also defined on a per member, per month basis by the rate cells applicable to a service area. CHIP Perinatal rate cells are based on the member's birth status and household income.

  Describe population served:

  CHIP covers children under 19 years of age in families who have too much income to qualify for Medicaid but cannot afford to buy private health insurance. CHIP Perinatal services are for the unborn children of pregnant women who are uninsured and do not qualify for Medicaid due to income or immigration status, and whose household income is at or below 202 percent of the FPL.

☐ Prepaid inpatient health plan (PIHP) (42 CFR 457.10)
- ☐ Capitation payment
- ☐ Other (please explain)

  Describe population served:

Guidance: If the State uses prepaid ambulatory health plan(s) (PAHP) to exclusively provide non-emergency medical transportation (a NEMT PAHP), the State should not check the following box for that plan. Instead, complete section 3.1.3 for the NEMT PAHP.

☒ Prepaid ambulatory health plan (PAHP) (42 CFR 457.10)
- ☒ Capitation payment
- ☐ Other (please explain)

  Describe population served:

  CHIP dental services are delivered through PAHPs.

☐ Primary care case manager (PCCM) (individual practitioners) (42 CFR 457.10)
- ☐ Case management fee
- ☐ Other (please explain)

☐ Primary care case management entity (PCCM Entity) (42 CFR 457.10)
- ☐ Case management fee
- ☐ Shared savings, incentive payments, and/or other financial rewards for improved quality outcomes (see 42 CFR 457.1240(f))
- ☐ Other (please explain)

If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as described in 42 CFR 457.10), in addition to PCCM services:

- ☐ Provision of intensive telephonic case management
- ☐ Provision of face-to-face case management
- ☐ Operation of a nurse triage advice line
- ☐ Development of enrollee care plans
- ☐ Execution of contracts with fee-for-service (FFS) providers in the FFS program
- ☐ Oversight responsibilities for the activities of FFS providers in the FFS program
- ☐ Provision of payments to FFS providers on behalf of the State
- ☐ Provision of enrollee outreach and education activities
- ☐ Operation of a customer service call center
- ☐ Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement
- ☐ Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers
- ☐ Coordination with behavioral health systems/providers
- ☐ Other (please describe)

3.1.2.2 ☒ The State assures that if its contract with an MCO, PAHP, or PIHP allows the entity to use a physician incentive plan, the contract stipulates that the entity must comply with the requirements set forth in 42 CFR 422.208 and 422.210. (42 CFR 457.1201(h), cross-referencing to 42 CFR 438.3(i))

3.1.3 Nonemergency Medical Transportation PAHPs

Guidance: Only complete Section 3.1.3 if the State uses a PAHP to exclusively provide non-emergency medical transportation (a NEMT PAHP). If a NEMT PAHP is the only managed care entity for CHIP in the State, please continue to Section 4 after checking the assurance below. If the State uses a PAHP that does not exclusively provide NEMT and/or uses other managed care entities beyond a NEMT PAHP, the State will need to complete the remaining sections within Section 3.

☐ The State assures that it complies with all requirements applicable to NEMT PAHPs, and through its contracts with such entities, requires NEMT PAHPs to comply with all applicable requirements, including the following (from 42 CFR 457.1206(b)):

- All contract provisions in 42 CFR 457.1201 except those set forth in 42 CFR 457.1201(h) (related to physician incentive plans) and 42 CFR 457.1201(l) (related to mental health parity).
- The information requirements in 42 CFR 457.1207 (see Section 3.5 below for more details).
- The provision against provider discrimination in 42 CFR 457.1208.
- The State responsibility provisions in 42 CFR 457.1212 (about disenrollment), 42 CFR 457.1214 (about conflict of interest safeguards), and 42 CFR 438.62(a), as cross-referenced in 42 CFR 457.1216 (about continued services to enrollees).
- The provisions on enrollee rights and protections in 42 CFR 457.1220, 457.1222, 457.1224, and 457.1226.
- The PAHP standards in 42 CFR 438.206(b)(1), as cross-referenced by 42 CFR 457.1230(a) (about availability of services), 42 CFR 457.1230(d) (about coverage and authorization of services), and 42 CFR 457.1233(a), (b) and (d) (about structure and operation standards).

- An enrollee's right to a State review under subpart K of 42 CFR 457.
- Prohibitions against affiliations with individuals debarred or excluded by Federal agencies in 42 CFR 438.610, as cross referenced by 42 CFR 457.1285.
- Requirements relating to contracts involving Indians, Indian Health Care Providers, and Indian managed care entities in 42 CFR 457.1209.

3.2. General Managed Care Contract Provisions

3.2.1 ☒ The State assures that it provides for free and open competition, to the maximum extent practical, in the bidding of all procurement contracts for coverage or other services, including external quality review organizations, in accordance with the procurement requirements of 45 CFR part 75, as applicable. (42 CFR 457.940(b); 42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(e))

3.2.2 ☒ The State assures that it will include provisions in all managed care contracts that define a sound and complete procurement contract, as required by 45 CFR part 75, as applicable. (42 CFR 457.940(c))

3.2.3 ☒ The State assures that each MCO, PIHP, PAHP, PCCM, and PCCM entity complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its employees and contract providers observe and protect those rights (42 CFR 457.1220, cross-referencing to 42 CFR 438.100). These Federal and State laws include: Title VI of the Civil Rights Act of 1964 (45 CFR part 80), Age Discrimination Act of 1975 (45 CFR part 91), Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, Titles II and III of the Americans with Disabilities Act, and section 1557 of the Patient Protection and Affordable Care Act.

3.2.4 ☒ The State assures that it operates a Web site that provides the MCO, PIHP, PAHP, and PCCM entity contracts. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(3))

3.3 Rate Development Standards and Medical Loss Ratio

3.3.1 The State assures that its payment rates are:

☒ Based on public or private payment rates for comparable services for comparable populations; and

☒ Consistent with actuarially sound principles as defined in 42 CFR 457.10. (42 CFR 457.1203(a))

Guidance: States that checked both boxes under 3.3.1 above do not need to make the next assurance. If the state is unable to check both boxes under 3.1.1 above, the state must check the next assurance.

☐ If the State is unable to meet the requirements under 42 CFR 457.1203(a), the State attests that it must establish higher rates because such rates are necessary to ensure sufficient provider participation or provider access or to enroll providers who demonstrate exceptional efficiency or quality in the provision of services. (42 CFR 457.1203(b))

3.3.2 ☒ The State assures that its rates are designed to reasonably achieve a medical loss ratio standard equal to at least 85 percent for the rate year and provide for reasonable administrative costs. (42 CFR 457.1203(c))

3.3.3 ☒ The State assures that it will provide to CMS, if requested by CMS, a description of the manner in which rates were developed in accordance with the requirements of 42 CFR 457.1203(a) through (c). (42 CFR 457.1203(d))

3.3.4 ☒ The State assures that it annually submits to CMS a summary description of the reports pertaining to the medical loss ratio received from the MCOs, PIHPs, and PAHPs. (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(a))

3.3.5 Does the State require an MCO, PIHP, or PAHP to pay remittances through the contract for not meeting the minimum MLR required by the State? (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(b)(1))

☒ No, the State does not require any MCO, PIHP, or PAHP to pay remittances.
☐ Yes, the State requires all MCOs, PIHPs, and PAHPs to pay remittances.
☐ Yes, the State requires some, but not all, MCOs, PIHPs, and PAHPs to pay remittances.

If the State requests some, but not all, MCOs, PIHPs, and PAHPs to pay remittances through the contract for not meeting the minimum MLR required by the State, please describe which types of managed care entities are and are not required to pay remittances. For example, if a state requires a medical MCO to pay a remittance but not a dental PAHP, please include this information.

If the answer to the assurance above is yes for any or all managed care entities, please answer the next assurance:

☐ The State assures that it if a remittance is owed by an MCO, PIHP, or PAHP to the State, the State:

- Reimburses CMS for an amount equal to the Federal share of the remittance, taking into account applicable differences in the Federal matching rate; and
- Submits a separate report describing the methodology used to determine the State and Federal share of the remittance with the annual report provided to CMS that summarizes the reports received from the MCOs, PIHPs, and PAHPs. (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(b))

3.3.6 ☒ The State assures that each MCO, PIHP, and PAHP calculates and reports the medical loss ratio in accordance with 42 CFR 438.8. (42 CFR 457.1203(f))

3.4 Enrollment

☒ The State assures that its contracts with MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities provide that the MCO, PIHP, PAHP, PCCM or PCCM entity:

- Accepts individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the contract (42 CFR 457.1201(d), cross-referencing to 42 CFR 438.3(d)(1));
- Will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll (42 CFR 457.1201(d), cross-referencing to 42 CFR 438.3(d)(3)); and
- Will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation,

gender identity or disability. (42 CFR 457.1201(d), cross-referencing to 438.3(d)(4))

3.4.1 Enrollment Process

3.4.1.1 ☒ The State assures that it provides informational notices to potential enrollees in an MCO, PIHP, PAHP, PCCM, or PCCM entity that includes the available managed care entities, explains how to select an entity, explains the implications of making or not making an active choice of an entity, explains the length of the enrollment period as well as the disenrollment policies, and complies with the information requirements in 42 CFR 457.1207 and accessibility standards established under 42 CFR 457.340. (42 CFR 457.1210(c))

3.4.1.2 ☒ The State assures that its enrollment system gives beneficiaries already enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity priority to continue that enrollment if the MCO, PIHP, PAHP, PCCM, or PCCM entity does not have the capacity to accept all those seeking enrollment under the program. (42 CFR 457.1210(b))

3.4.1.3 Does the State use a default enrollment process to assign beneficiaries to an MCO, PIHP, PAHP, PCCM, or PCCM entity? (42 CFR 457.1210(a))

☒ Yes
☐ No

If the State uses a default enrollment process, please make the following assurances:

☒ The State assigns beneficiaries only to qualified MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities that are not subject to the intermediate sanction of having suspension of all new enrollment (including default enrollment) under 42 CFR 438.702 and have capacity to enroll beneficiaries. (42 CFR 457.1210(a)(1)(i))

☒ The State maximizes continuation of existing provider-beneficiary relationships under 42 CFR 457.1210(a)(1)(ii) or if that is not possible, distributes the beneficiaries equitably and does not arbitrarily exclude any MCO, PIHP, PAHP, PCCM or PCCM entity from being considered. (42 CFR 457.1210(a)(1)(ii), 42 CFR 457.1210(a)(1)(iii))

3.4.2 Disenrollment

3.4.2.1 ☒ The State assures that the State will notify enrollees of their right to disenroll consistent with the requirements of 42 CFR 438.56 at least annually. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f)(2))

3.4.2.2 ☒ The State assures that the effective date of an approved disenrollment, regardless of the procedure followed to request the disenrollment, will be no later than the first day of the second month following the month in which the enrollee requests disenrollment or the MCO, PIHP, PAHP, PCCM or PCCM entity refers the request to the State. (42 CFR 457.1212, cross-referencing to 438.56(e)(1))

3.4.2.3 ☒ If a beneficiary disenrolls from an MCO, PIHP, PAHP, PCCM, or PCCM entity, the State assures that the beneficiary is provided the option to enroll in another plan or receive benefits from an alternative delivery system. (Section 2103(f)(3) of the Social

Security Act, incorporating section 1932(a)(4); 42 CFR 457.1212, cross referencing to 42 CFR 438.56; State Health Official Letter #09-008)

Texas CHIP is only delivered through a managed care delivery method. If a beneficiary disenrolls from an MCO, the beneficiary may enroll in another plan.

3.4.2.4 MCO, PIHP, PAHP, PCCM and PCCM Entity Requests for Disenrollment.

☒ The State assures that contracts with MCOs, PIHPs, PAHPs, PCCMs and PCCM entities describe the reasons for which an MCO, PIHP, PAHP, PCCM and PCCM entity may request disenrollment of an enrollee, if any. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(b))

Guidance: Reasons for disenrollment by the MCO, PIHP, PAHP, PCCM, and PCCM entity must be specified in the contract with the State. Reasons for disenrollment may not include an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO, PIHP, PAHP, PCCM or PCCM entity seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(b)(2))

3.4.2.5 Enrollee Requests for Disenrollment.

Guidance: The State may also choose to limit disenrollment from the MCO, PIHP, PAHP, PCCM, or PCCM entity, except for either: 1) for cause, at any time; or 2) without cause during the latter of the 90 days after the beneficiary's initial enrollment or the State sends the beneficiary notice of that enrollment, at least once every 12 months, upon reenrollment if the temporary loss of CHIP eligibility caused the beneficiary to miss the annual disenrollment opportunity, or when the State imposes the intermediate sanction specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c))

Does the State limit disenrollment from an MCO, PIHP, PAHP, PCCM and PCCM entity by an enrollee? (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c))

☐ Yes
☒ No

If the State limits disenrollment by the enrollee from an MCO, PIHP, PAHP, PCCM and PCCM entity, please make the following assurances (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)):

☐ The State assures that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(1))
☐ The State assures that beneficiary requests to disenroll for cause will be permitted at any time by the MCO, PIHP, PAHP, PCCM or PCCM entity. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(1) and (d)(2))
☐ The State assures that beneficiary requests for disenrollment without cause will be permitted by the MCO, PIHP, PAHP, PCCM or PCCM entity at the following times:

- During the 90 days following the date of the beneficiary's initial enrollment into the MCO, PIHP, PAHP, PCCM, or PCCM entity, or during the 90 days following the date the State sends the beneficiary notice of that enrollment, whichever is later;
- At least once every 12 months thereafter;
- If the State plan provides for automatic reenrollment for an individual who loses CHIP eligibility for a period of 2 months or less and the temporary loss of CHIP eligibility has caused the beneficiary to miss the annual disenrollment opportunity; and
- When the State imposes the intermediate sanction on the MCO, PIHP, PAHP, PCCM or PCCM entity specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(2))

3.4.2.6 ☐ The State assures that the State ensures timely access to a State review for any enrollee dissatisfied with a State agency determination that there is not good cause for disenrollment. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(2))

3.5 Information Requirements for Enrollees and Potential Enrollees

3.5.1 ☒ The State assures that it provides, or ensures its contracted MCOs, PAHPs, PIHPs, PCCMs and PCCM entities provide, all enrollment notices, informational materials, and instructional materials related to enrollees and potential enrollees in accordance with the terms of 42 CFR 457.1207, cross-referencing to 42 CFR 438.10.

3.5.2 ☒ The State assures that all required information provided to enrollees and potential enrollees are in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(1))

3.5.3 ☒ The State assures that it operates a Web site that provides the content specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)-(i) either directly or by linking to individual MCO, PIHP, PAHP and PCCM entity Web sites.

3.5.4 ☒ The State assures that it has developed and requires each MCO, PIHP, PAHP and PCCM entity to use:

- Definitions for the terms specified under 42 CFR 438.10(c)(4)(i), and
- Model enrollee handbooks, and model enrollee notices. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(4))

3.5.5 ☒ If the State, MCOs, PIHPs, PAHPs, PCCMs or PCCM entities provide the information required under 42 CFR 457.1207 electronically, check this box to confirm that the State assures that it meets the requirements under 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(6) for providing the material in an accessible manner. Including that:

- The format is readily accessible;
- The information is placed in a location on the State, MCO's, PIHP's, PAHP's, or PCCM's, or PCCM entity's Web site that is prominent and readily accessible;
- The information is provided in an electronic form which can be electronically retained and printed;
- The information is consistent with the content and language requirements in 42 CFR 438.10; and
- The enrollee is informed that the information is available in paper form without charge upon

request and is provided the information upon request within 5 business days.

3.5.6 ☒ The State assures that it meets the language and format requirements set forth in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(d), including but not limited to:

- Establishing a methodology that identifies the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State, and in each MCO, PIHP, PAHP, or PCCM entity service area;
- Making oral interpretation available in all languages and written translation available in each prevalent non-English language;
- Requiring each MCO, PIHP, PAHP, and PCCM entity to make its written materials that are critical to obtaining services available in the prevalent non-English languages in its particular service area;
- Making interpretation services available to each potential enrollee and requiring each MCO, PIHP, PAHP, and PCCM entity to make those services available free of charge to each enrollee; and
- Notifying potential enrollees, and requiring each MCO, PIHP, PAHP, and PCCM entity to notify its enrollees:
  - That oral interpretation is available for any language and written translation is available in prevalent languages;
  - That auxiliary aids and services are available upon request and at no cost for enrollees with disabilities; and
  - How to access the services in 42 CFR 457.1207, cross-referencing 42 CFR 438.10(d)(5)(i) and (ii).

3.5.7 ☒ The State assures that the State or its contracted representative provides the information specified in 42 CFR 457.1207, cross-referencing to 438.10(e)(2), and includes the information either in paper or electronic format, to all potential enrollees at the time the potential enrollee becomes eligible to enroll in a voluntary managed care program or is first required to enroll in a mandatory managed care program and within a timeframe that enables the potential enrollee to use the information to choose among the available MCOs, PIHPs, PAHPs, PCCMs and PCCM entities:

- Information about the potential enrollee's right to disenroll consistent with the requirements of 42 CFR 438.56 and which explains clearly the process for exercising this disenrollment right, as well as the alternatives available to the potential enrollee based on their specific circumstance;
- The basic features of managed care;
- Which populations are excluded from enrollment in managed care, subject to mandatory enrollment, or free to enroll voluntarily in the program;
- The service area covered by each MCO, PIHP, PAHP, PCCM, or PCCM entity;
- Covered benefits including:
  - Which benefits are provided by the MCO, PIHP, or PAHP; and which, if any, benefits are provided directly by the State; and
  - For a counseling or referral service that the MCO, PIHP, or PAHP does not cover because of moral or religious objections, where and how to obtain the service;
- The provider directory and formulary information required in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h) and (i);
- Any cost-sharing for the enrollee that will be imposed by the MCO, PIHP, PAHP, PCCM, or

PCCM entity consistent with those set forth in the State plan;
- The requirements for each MCO, PIHP or PAHP to provide adequate access to covered services, including the network adequacy standards established in 42 CFR 457.1218, cross-referencing 42 CFR 438.68;
- The MCO, PIHP, PAHP, PCCM and PCCM entity's responsibilities for coordination of enrollee care; and
- To the extent available, quality and performance indicators for each MCO, PIHP, PAHP and PCCM entity, including enrollee satisfaction.

3.5.8 ☒ The State assures that it will provide the information specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) to all enrollees of MCOs, PIHPs, PAHPs and PCCM entities, including that the State must notify all enrollees of their right to disenroll consistent with the requirements of 42 CFR 438.56 at least annually.

3.5.9 ☒ The State assures that each MCO, PIHP, PAHP and PCCM entity will provide the information specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) to all enrollees of MCOs, PIHPs, PAHPs and PCCM entities, including that:
- The MCO, PIHP, PAHP and, when appropriate, the PCCM entity, must make a good faith effort to give written notice of termination of a contracted provider within the timeframe specified in 42 CFR 438.10(f), and
- The MCO, PIHP, PAHP and, when appropriate, the PCCM entity must make available, upon request, any physician incentive plans in place as set forth in 42 CFR 438.3(i).

3.5.10 ☒ The State assures that each MCO, PIHP, PAHP and PCCM entity will provide enrollees of that MCO, PIHP, PAHP or PCCM entity an enrollee handbook that meets the requirements as applicable to the MCO, PIHP, PAHP and PCCM entity, specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(1)-(2), within a reasonable time after receiving notice of the beneficiary's enrollment, by a method consistent with 42 CFR 438.10(g)(3), and including the following items:

- Information that enables the enrollee to understand how to effectively use the managed care program, which, at a minimum, must include:
  - Benefits provided by the MCO, PIHP, PAHP or PCCM entity;
  - How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided; and
  - In the case of a counseling or referral service that the MCO, PIHP, PAHP, or PCCM entity does not cover because of moral or religious objections, the MCO, PIHP, PAHP, or PCCM entity must inform enrollees that the service is not covered by the MCO, PIHP, PAHP, or PCCM entity and how they can obtain information from the State about how to access these services;
- The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled;
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider;
- The extent to which, and how, after-hours and emergency coverage are provided, including:

- What constitutes an emergency medical condition and emergency services;
- The fact that prior authorization is not required for emergency services; and
- The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care;

- Any restrictions on the enrollee's freedom of choice among network providers;
- The extent to which, and how, enrollees may obtain benefits, including family planning services and supplies from out-of-network providers;
- Cost sharing, if any is imposed under the State plan;
- Enrollee rights and responsibilities, including the elements specified in 42 CFR §438.100;
- The process of selecting and changing the enrollee's primary care provider;
- Grievance, appeal, and review procedures and timeframes, consistent with 42 CFR 457.1260, in a State-developed or State-approved description, including:
  - The right to file grievances and appeals;
  - The requirements and timeframes for filing a grievance or appeal;
  - The availability of assistance in the filing process; and
  - The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee;
- How to access auxiliary aids and services, including additional information in alternative formats or languages;
- The toll-free telephone number for member services, medical management, and any other unit providing services directly to enrollees; and
- Information on how to report suspected fraud or abuse.

3.5.11 ☒ The State assures that each MCO, PIHP, PAHP and PCCM entity will give each enrollee notice of any change that the State defines as significant in the information specified in the enrollee handbook at least 30 days before the intended effective date of the change. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(4))

3.5.12 ☒ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available a provider directory for the MCO's, PIHP's, PAHP's or PCCM entity's network providers, including for physicians (including specialists), hospitals, pharmacies, and behavioral health providers, that includes information as specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(1)-(2) and (4).

3.5.13 ☒ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will update any information included in a paper provider directory at least monthly and in an electronic provider directories as specified in 42 CFR 438.10(h)(3). (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(3))

3.5.14 ☒ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available the MCO's, PIHP's, PAHP's, or PCCM entity's formulary that meets the requirements specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(i), including:

- Which medications are covered (both generic and name brand); and
- What tier each medication is on.

3.5.15 ☒ The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity follows the requirements for marketing activities under 42 CFR 457.1224, cross-referencing to 42 CFR 438.104 (except 42 CFR 438.104(c)).

Guidance: Requirements for marketing activities include, but are not limited to, that the MCO, PIHP, PAHP, PCCM, or PCCM entity does not distribute any marketing materials without first obtaining State approval; distributes the materials to its entire service areas as indicated in the contract; does not seek to influence enrollment in conjunction with the sale or offering of any private insurance; and does not, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities. (42 CFR 104(b))

Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the remaining assurances in Section 3.5 (3.5.16 through 3.5.18).

3.5.16 ☒ The State assures that each MCO, PIHP and PAHP protects communications between providers and enrollees under 42 CFR 457.1222, cross-referencing to 42 CFR 438.102.

3.5.17 ☒ The State assures that MCOs, PIHPs, and PAHPs have arrangements and procedures that prohibit the MCO, PIHP, and PAHP from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity. (42 CFR 457.1280(b)(2))

Guidance: States should also complete Section 3.9, which includes additional provisions about the notice procedures for grievances and appeals.

3.5.18 ☒ The State assures that each contracted MCO, PIHP, and PAHP comply with the notice requirements specified for grievances and appeals in accordance with the terms of 42 CFR 438, Subpart F, except that the terms of 42 CFR 438.420 do not apply and that references to reviews should be read to refer to reviews as described in 42 CFR 457, Subpart K. (42 CFR 457.1260)

3.6 Benefits and Services

Guidance: The State should also complete Section 3.10 (Program Integrity).

3.6.1 ☒ The State assures that MCO, PIHP, PAHP, PCCM entity, and PCCM contracts involving Indians, Indian health care providers, and Indian managed care entities comply with the requirements of 42 CFR 438.14. (42 CFR 457.1209)

3.6.2 ☒ The State assures that all services covered under the State plan are available and accessible to enrollees. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)

3.6.3 ☒ The State assures that it:

- Publishes the State's network adequacy standards developed in accordance with 42 CFR 457.1218, cross-referencing 42 CFR 438.68(b)(1) on the Web site required by 42 CFR 438.10;
- Makes available, upon request, the State's network adequacy standards at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services. (42 CFR 457.1218, cross-referencing 42 CFR 438.68(e))

Guidance: Only States with MCOs, PIHPs, or PAHPs need to complete the remaining assurances in Section 3.6 (3.6.4 through 3.6.20.

3.6.4 ☒ The State assures that each MCO, PAHP and PIHP meet the State's network adequacy standards. (42 CFR 457.1218, cross-referencing 42 CFR 438.68; 42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)

3.6.5 ☒ The State assures that each MCO, PIHP, and PAHP includes within its network of credentialed providers:

- A sufficient number of providers to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities;
- Women's health specialists to provide direct access to covered care necessary to provide women's routine and preventative health care services for female enrollees; and
- Family planning providers to ensure timely access to covered services. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)

Texas CHIP does not provide services for the purposes of family planning. However, services that are traditionally considered family planning services are provided to members when medically necessary, except for CHIP Perinatal. Services that are traditionally considered family planning services are not a CHIP Perinatal benefit.

3.6.6 ☒ The State assures that each contract under 42 CFR 457.1201 permits an enrollee to choose his or her network provider. (42 CFR 457.1201(j), cross-referencing 42 CFR 438.3(l))

3.6.7 ☒ The State assures that each MCO, PIHP, and PAHP provides for a second opinion from a network provider, or arranges for the enrollee to obtain one outside the network, at no cost. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(3))

3.6.8 ☒ The State assures that each MCO, PIHP, and PAHP ensures that providers, in furnishing services to enrollees, provide timely access to care and services, including by:

- Requiring the contract to adequately and timely cover out-of-network services if the provider network is unable to provide necessary services covered under the contract to a particular enrollee and at a cost to the enrollee that is no greater than if the services were furnished within the network;
- Requiring the MCO, PIHP and PAHP meet and its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services;
- Ensuring that the hours of operation for a network provider are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid or CHIP Fee-For-Service, if the provider serves only Medicaid or CHIP enrollees;
- Ensuring that the MCO, PIHP and PAHP makes available services include in the contract on a 24 hours a day, 7 days a week basis when medically necessary;
- Establishing mechanisms to ensure compliance by network providers;
- Monitoring network providers regularly to determine compliance;
- Taking corrective action if there is a failure to comply by a network provider. (42 CFR

457.1230(a), cross-referencing to 42 CFR 438.206(b)(4) and (5) and (c))

3.6.9 ☒ The State assures that each MCO, PIHP, and PAHP has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care. (42 CFR 457.1230(b), cross-referencing to 42 CFR 438.207)

3.6.10 ☒ The State assures that each MCO, PIHP, and PAHP will be required to submit documentation to the State, at the time of entering into a contract with the State, on an annual basis, and at any time there has been a significant change to the MCO, PIHP, or PAHP's operations that would affect the adequacy of capacity and services, to demonstrate that each MCO, PIHP, and PAHP for the anticipated number of enrollees for the service area:

- Offers an appropriate range of preventative, primary care and specialty services; and
- Maintains a provider network that is sufficient in number, mix, and geographic distribution. (42 CFR 457.1230, cross-referencing to 42 CFR 438.207(b))

3.6.11 ☒ Except that 42 CFR 438.210(a)(5) does not apply to CHIP, the State assures that its contracts with each MCO, PIHP, or PAHP comply with the coverage of services requirements under 42 CFR 438.210, including:

- Identifying, defining, and specifying the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer; and
- Permitting an MCO, PIHP, or PAHP to place appropriate limits on a service. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(a) except that 438.210(a)(5) does not apply to CHIP contracts)

3.6.12 ☒ Except that 438.210(b)(2)(iii) does not apply to CHIP, the State assures that its contracts with each MCO, PIHP, or PAHP comply with the authorization of services requirements under 42 CFR 438.210, including that:

- The MCO, PIHP, or PAHP and its subcontractors have in place and follow written policies and procedures;
- The MCO, PIHP, or PAHP have in place mechanisms to ensure consistent application of review criteria and consult with the requesting provider when appropriate; and
- Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual with appropriate expertise in addressing the enrollee's medical, or behavioral health needs. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(b), except that 438.210(b)(2)(iii) does not apply to CHIP contracts)

3.6.13 ☒ The State assures that its contracts with each MCO, PIHP, or PAHP require each MCO, PIHP, or PAHP to notify the requesting provider and given written notice to the enrollee of any adverse benefit determination to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(c))

3.6.14 ☒ The State assures that its contracts with each MCO, PIHP, or PAHP provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(e))

3.6.15 ☒ The State assures that it has a transition of care policy that meets the requirements of 438.62(b)(1) and requires that each contracted MCO, PIHP, and PAHP implements the policy. (42 CFR 457.1216, cross-referencing to 42 CFR 438.62)

3.6.16 ☒ The State assures that each MCO, PIHP, and PAHP has implemented procedures to deliver care to and coordinate services for all enrollees in accordance with 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208, including:

- Ensure that each enrollee has an ongoing source of care appropriate to his or her needs;
- Ensure that each enrollee has a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee;
- Provide the enrollee with information on how to contract their designated person or entity responsible for the enrollee's coordination of services;
- Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee between settings of care; with services from any other MCO, PIHP, or PAHP; with fee-for-service services; and with the services the enrollee receives from community and social support providers;
- Make a best effort to conduct an initial screening of each enrollees needs within 90 days of the effective date of enrollment for all new enrollees;
- Share with the State or other MCOs, PIHPs, or PAHPs serving the enrollee the results of any identification and assessment of the enrollee's needs;
- Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards; and
- Ensure that each enrollee's privacy is protected in the process of coordinating care is protected with the requirements of 45 CFR parts 160 and 164 subparts A and E. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(b))

Guidance: For assurances 3.6.17 through 3.6.20, applicability to PIHPs and PAHPs is based a determination by the State in relation to the scope of the entity's services and on the way the State has organized its delivery of managed care services, whether a particular PIHP or PAHP is required to implement the mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(a)(2))

3.6.17 ☒ The State assures that it has implemented mechanisms for identifying to MCOs, PIHPs, and PAHPs enrollees with special health care needs who are eligible for assessment and treatment services under 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c) and included the mechanism in the State's quality strategy.

3.6.18 ☒ The State assures that each applicable MCO, PIHP, and PAHP implements the mechanisms to comprehensively assess each enrollee identified by the state as having special health care needs. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(2))

3.6.19 ☒ The State assures that each MCO, PIHP, and PAHP will produce a treatment or service plan that meets the following requirements for enrollees identified with special health care needs:

- Is in accordance with applicable State quality assurance and utilization review standards;
- Reviewed and revised upon reassessment of functional need, at least every 12 months, or

when the enrollee's circumstances or needs change significantly. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(3))

3.6.20 ☒ The State assures that each MCO, PIHP, and PAHP must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs for enrollees identified with special health care needs who need a course of treatment or regular care monitoring. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(4))

3.7 Operations

3.7.1 ☒ The State assures that it has established a uniform credentialing and recredentialing policy that addresses acute, primary, behavioral, and substance use disorders providers and requires each MCO, PIHP and PAHP to follow those policies. (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(b)(1))

Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the remaining assurances in Section 3.7 (3.7.2 through 3.7.9).

3.7.2 The State assures each contracted MCO, PIHP and PAHP will comply with the provider selection requirements in 42 CFR 457.1208 and 457.1233(a), cross-referencing 42 CFR 438.12 and 438.214, including that:

- ☒ Each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of network providers (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(a));
- ☒ MCO, PIHP, and PAHP network provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(c));
- ☒ MCOs, PIHPs, and PAHPs do not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification, solely on the basis of that license or certification (42 CFR 457.1208, cross referencing 42 CFR 438.12(a));
- ☒ If an MCO, PIHP, or PAHP declines to include individual or groups of providers in the MCO, PIHP, or PAHP's provider network, the MCO, PIHP, and PAHP gives the affected providers written notice of the reason for the decision (42 CFR 457.1208, cross referencing 42 CFR 438.12(a)); and
- ☒ MCOs, PIHPs, and PAHPs do not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act. (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(d)).

3.7.3 The State assures that each contracted MCO, PIHP, and PAHP complies with the subcontractual relationships and delegation requirements in 42 CFR 457.1233(b), cross-referencing 42 CFR 438.230, including that:

- ☒ The MCO, PIHP, or PAHP maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State;
- ☒ All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor specify that all delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement, the subcontractor agrees

to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's, PIHP's, or PAHP's contract obligations, and the contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO, PIHP, or PAHP determine that the subcontractor has not performed satisfactorily;

☒ All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor must specify that the subcontractor agrees to comply with all applicable CHIP laws, regulations, including applicable subregulatory guidance and contract provisions; and

☒ The subcontractor agrees to the audit provisions in 438.230(c)(3).

3.7.4 ☒ The State assures that each contracted MCO and, when applicable, each PIHP and PAHP, adopts and disseminates practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field; consider the needs of the MCO's, PIHP's, or PAHP's enrollees; are adopted in consultation with network providers; and are reviewed and updated periodically as appropriate. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(b) and (c))

3.7.5 ☒ The State assures that each contracted MCO and, when applicable, each PIHP and PAHP makes decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(d))

3.7.6 ☒ The State assures that each contracted MCO, PIHP, and PAHP maintains a health information system that collects, analyzes, integrates, and reports data consistent with 42 CFR 438.242. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of CHIP eligibility. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242)

3.7.7 ☒ The State assures that it reviews and validates the encounter data collected, maintained, and submitted to the State by the MCO, PIHP, or PAHP to ensure it is a complete and accurate representation of the services provided to the enrollees under the contract between the State and the MCO, PIHP, or PAHP and meets the requirements 42 CFR 438.242 of this section. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242)

3.7.8 ☒ The State assures that it will submit to CMS all encounter data collected, maintained, submitted to the State by the MCO, PIHP, and PAHP once the State has reviewed and validated the data based on the requirements of 42 CFR 438.242. (CMS State Medicaid Director Letter #13-004)

3.7.9 ☒ The State assures that each contracted MCO, PIHP and PAHP complies with the privacy protections under 42 CFR 457.1110. (42 CFR 457.1233(e))

3.8 Beneficiary Protections

3.8.1 ☒ The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity has written policies regarding the enrollee rights specified in 42 CFR 438.100. (42 CFR 457.1220, cross-referencing to 42 CFR 438.100(a)(1))

3.8.2 ☒ The State assures that its contracts with an MCO, PIHP, PAHP, PCCM, or PCCM entity include a guarantee that the MCO, PIHP, PAHP, PCCM, or PCCM entity will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources. (42 CFR 457.1201(p))

3.8.3 ☒ The State assures that MCOs, PIHPs, and PAHPs do not hold the enrollee liable for the following:

- The MCO's, PIHP's or PAHP's debts, in the event of the entity's solvency. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(a))
- Covered services provided to the enrollee for which the State does not pay the MCO, PIHP or PAHP or for which the State, MCO, PIHP, or PAHP does not pay the individual or the health care provider that furnished the services under a contractual, referral or other arrangement. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(b))
- Payments for covered services furnished under a contract, referral or other arrangement that are in excess of the amount the enrollee would owe if the MCO, PIHP or PAHP covered the services directly. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(c))

3.9 Grievances and Appeals

Guidance: Only States with MCOs, PIHPs, or PAHPs need to complete Section 3.9. States with PCCMs and/or PCCM entities should be adhering to the State's review process for benefits.

3.9.1 ☒ The State assures that each MCO, PIHP, and PAHP has a grievance and appeal system in place that allows enrollees to file a grievance and request an appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c))

3.9.2 ☒ The State assures that each MCO, PIHP, and PAHP has only one level of appeal for enrollees. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(b))

3.9.3 ☒ The State assures that an enrollee may request a State review after receiving notice that the adverse benefit determination is upheld, or after an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 438.402(c))

3.9.4. Does the state offer and arrange for an external medical review?

☒ Yes
☐ No

Guidance: Only states that answered yes to assurance 3.9.4 need to complete the next assurance (3.9.5).

3.9.5 ☒ The State assures that the external medical review is:

- At the enrollee's option and not required before or used as a deterrent to proceeding to the State review;
- Independent of both the State and MCO, PIHP, or PAHP;
- Offered without any cost to the enrollee; and
- Not extending any of the timeframes specified in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(1)(i))

3.9.6 ☒ The State assures that an enrollee may file a grievance with the MCO, PIHP, or PAHP at any time. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(i))

3.9.7 ☒ The State assures that an enrollee has 60 calendar days from the date on an adverse benefit determination notice to file a request for an appeal to the MCO, PIHP, or PAHP. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(ii))

3.9.8 ☒ The State assures that an enrollee may file a grievance and request an appeal either orally or in writing. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(3)(i))

3.9.9 ☒ The State assures that each MCO, PIHP, and PAHP gives enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below in Section 3.9.10 and in 42 CFR 438.10.

3.9.10 ☒ The State assures that the notice of an adverse benefit determination explains:

- The adverse benefit determination.
- The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
- The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal and the right to request a State review.
- The procedures for exercising the rights specified above under this assurance.
- The circumstances under which an appeal process can be expedited and how to request it. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(b))

3.9.11 ☒ The State assures that the notice of an adverse benefit determination is provided in a timely manner in accordance with 42 CFR 457.1260. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(c))

3.9.12 ☒ The State assures that MCOs, PIHPs, and PAHPs give enrollees reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(a))

3.9.13 The state makes the following assurances related to MCO, PIHP, and PAHP processes for handling enrollee grievances and appeals:

☒ Individuals who make decisions on grievances and appeals were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

☒ Individuals who make decisions on grievances and appeals, if deciding any of the following, are individuals who have the appropriate clinical expertise in treating the enrollee's condition or disease:

- An appeal of a denial that is based on lack of medical necessity.
- A grievance regarding denial of expedited resolution of an appeal.
- A grievance or appeal that involves clinical issues.

☒ All comments, documents, records, and other information submitted by the enrollee or their representative will be taken into account, without regard to whether such information was submitted or considered in the initial adverse benefit determination.

☒ Enrollees have a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.

☒ Enrollees are provided the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.

☒ The enrollee and his or her representative or the legal representative of a deceased enrollee's estate are included as parties to the appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(b))

3.9.14 ☒ The State assures that standard grievances are resolved (including notice to the affected parties) within 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b))

HHSC requires the MCO to resolve enrollee complaints and appeals that are not elevated to the Texas Department of Insurance within 30 days from the date it is received unless the MCO can document that the enrollee requested an extension, or the MCO shows there is a need for additional information and the delay is in the enrollee's interest.

3.9.15 ☒ The State assures that standard appeals are resolved (including notice to the affected parties) within 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. The MCO, PIHP, or PAHP may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or the MCO, PIHP, or PAHP shows that there is need for additional information and that the delay is in the enrollee's interest. (42 CFR 457.1260, cross-referencing to 42 CFR 42 CFR 438.408(b) and (c))

HHSC requires the MCO to resolve enrollee complaints and appeals that are not elevated to the Texas Department of Insurance within 30 days from the date it is received unless the MCO can document that the enrollee requested an extension, or the MCO shows there is a need for additional information and the delay is in the enrollee's interest.

3.9.16 ☒ The State assures that each MCO, PIHP, and PAHP establishes and maintains an expedited review process for appeals that is no longer than 72 hours after the MCO, PIHP, or PAHP receives the appeal. The expedited review process applies when the MCO, PIHP, or PAHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b) and (c), and 42 CFR 438.410(a))

3.9.17 ☒ The State assures that if an MCO, PIHP, or PAHP denies a request for expedited resolution of an appeal, it transfers the appeal within the timeframe for standard resolution in accordance with 42 CFR 438.408(b)(2). (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(c)(1))

3.9.18 ☒ The State assures that if the MCO, PIHP, or PAHP extends the timeframes for an appeal not at the request of the enrollee or it denies a request for an expedited resolution of an appeal, it completes all of the following:

- Make reasonable efforts to give the enrollee prompt oral notice of the delay.
- Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.
- Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c) and 42 CFR 438.410(c))

3.9.19 ☒ The State assures that if an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process and the enrollee may initiate a State review. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c)(3))

3.9.20 ☒ The State assures that has established a method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at 42 CFR 438.10. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(1))

3.9.21 ☒ For all appeals, the State assures that each contracted MCO, PIHP, and PAHP provides written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 CFR 438.10. The notice of resolution includes at least the following items:

- The results of the resolution process and the date it was completed; and
- For appeals not resolved wholly in favor of the enrollees:
  - The right to request a State review, and how to do so.
  - The right to request and receive benefits while the hearing is pending, and how to make the request.
  - That the enrollee may, consistent with State policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(i) and (e))

3.9.22 ☒ For notice of an expedited resolution, the State assures that each contracted MCO, PIHP, or PAHP makes reasonable efforts to provide oral notice, in addition to the written notice of resolution. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(ii))

3.9.23 ☒ The State assures that if it offers an external medical review:

- The review is at the enrollee's option and is not required before or used as a deterrent to proceeding to the State review;
- The review is independent of both the State and MCO, PIHP, or PAHP; and
- The review is offered without any cost to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(f))

3.9.24 ☒ The State assures that MCOs, PIHPs, and PAHPs do not take punitive action against providers who request an expedited resolution or support an enrollee's appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(b))

3.9.25 ☒ The State assures that MCOs, PIHPs, or PAHPs must provide information specified in 42 CFR 438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. This includes:

- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee; and
- The fact that, when requested by the enrollee, benefits that the MCO, PIHP, or PAHP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State review within the timeframes specified for filing, and that the enrollee may, consistent with State policy, be required to pay the cost of services furnished while the appeal or State review is pending if the final decision is adverse to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.414)

3.9.26 ☒ The State assures that it requires MCOs, PIHPs, and PAHPs to maintain records of grievances and appeals and reviews the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy. The record must be accurately maintained in a manner accessible to the state and available upon request to CMS. (42 CFR 457.1260, cross-referencing to 42 CFR 438.416)

3.9.27 ☒ The State assures that if the MCO, PIHP, or PAHP, or the State review officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO, PIHP, or PAHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. (42 CFR 457.1260, cross-referencing to 42 CFR 438.424(a))

3.10 Program Integrity

Guidance: The State should complete Section 11 (Program Integrity) in addition to Section 3.10.

Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the first seven assurances (3.10.1 through 3.10.7).

3.10.1 The State assures that any entity seeking to contract as an MCO, PIHP, or PAHP under a separate child health program has administrative and management arrangements or procedures designed to safeguard against fraud and abuse, including:

- ☒ Enforcing MCO, PIHP, and PAHP compliance with all applicable Federal and State statutes, regulations, and standards;
- ☒ Prohibiting MCOs, PIHPs, or PAHPs from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity; and
- ☒ Including a mechanism for MCOs, PIHPs, and PAHPs to report to the State, to CMS, or to the Office of Inspector General (OIG) as appropriate, information on violations of law by subcontractors, providers, or enrollees of an MCO, PIHP, or PAHP and other individuals. (42 CFR 457.1280)

3.10.2 ☒ The State assures that it has in effect safeguards against conflict of interest on the part of State and local officers and employees and agents of the State who have responsibilities relating to the MCO, PIHP, or PAHP contracts or enrollment processes described in 42 CFR 457.1210(a). (42 CFR 457.1214, cross referencing 42 CFR 438.58)

3.10.3 ☒ The State assures that it periodically, but no less frequently than once every 3 years, conducts, or contracts for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO, PIHP or PAHP. (42 CFR 457.1285, cross referencing 42 CFR 438.602(e))

3.10.4 ☒ The State assures that it requires MCOs, PIHPs, PAHP, and or subcontractors (only to the extent that the subcontractor is delegated responsibility by the MCO, PIHP, or PAHP for coverage of services and payment of claims) implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following:

- A compliance program that include all of the elements described in 42 CFR 438.608(a)(1);
- Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State;
- Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility;
- Provision for notification to the State when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO, PIHP or PAHP;
- Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis;
- In the case of MCOs, PIHPs, or PAHPs that make or receive annual payments under the contract of at least $5,000,000, provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers;
- Provision for the prompt referral of any potential fraud, waste, or abuse that the MCO, PIHP, or PAHP identifies to the State Medicaid/CHIP program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit; and
- Provision for the MCO's, PIHP's, or PAHP's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR 455.23. (42 CFR 457.1285, cross referencing 42 CFR 438.608(a))

3.10.5 ☒ The State assures that each MCO, PIHP, or PAHP requires and has a mechanism for a network provider to report to the MCO, PIHP or PAHP when it has received an overpayment, to return the overpayment to the MCO, PIHP or PAHP within 60 calendar days after the date on which the overpayment was identified, and to notify the MCO, PIHP or PAHP in writing of the reason for the overpayment. (42 CFR 457.1285, cross referencing 42 CFR 438.608(d)(2))

3.10.6 ☒ The State assures that each MCO, PIHP, or PAHP reports annually to the State on their recoveries of overpayments. (42 CFR 457.1285, cross referencing 42 CFR 438.608(d)(3))

3.10.7 ☒ The State assures that it screens and enrolls, and periodically revalidates, all network providers of MCOs, PIHPs, and PAHPs, in accordance with the requirements of part 455, subparts B and E. This requirement also extends to PCCMs and PCCM entities to the extent that the primary care case manager is not otherwise enrolled with the State to provide services to fee-for-service beneficiaries. (42 CFR 457.1285, cross referencing 42 CFR 438.602(b)(1) and 438.608(b))

3.10.8 ☒ The State assures that it reviews the ownership and control disclosures submitted by the MCO, PIHP, PAHP, PCCM or PCCM entity, and any subcontractors. (42 CFR 457.1285, cross referencing 42 CFR 438.602(c))

3.10.9 ☒ The State assures that it confirms the identity and determines the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases. If the State finds a party that is excluded, the State promptly notifies the MCO, PIHP, PAHP, PCCM, or PCCM entity and takes action consistent with 42 CFR 438.610(c). (42 CFR 457.1285, cross referencing 42 CFR 438.602(d))

3.10.10 ☒ The State assures that it receives and investigates information from whistleblowers relating to the integrity of the MCO, PIHP, PAHP, PCCM, or PCCM entity, subcontractors, or network providers receiving Federal funds under this part. (42 CFR 457.1285, cross referencing 42 CFR 438.602(f))

3.10.11 ☒ The State assures that MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities with which the State contracts are not located outside of the United States and that no claims paid by an MCO, PIHP, or PAHP to a network provider, out-of-network provider, subcontractor or financial institution located outside of the U.S. are considered in the development of actuarially sound capitation rates. (42 CFR 457.1285, cross referencing to 42 CFR 438.602(i); Section 1902(a)(80) of the Social Security Act)

3.10.12 The State assures that MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities submit to the State the following data, documentation, and information:

- ☒ Encounter data in the form and manner described in 42 CFR 438.818.
- ☒ Data on the basis of which the State determines the compliance of the MCO, PIHP, or PAHP with the medical loss ratio requirement described in 42 CFR 438.8.
- ☒ Data on the basis of which the State determines that the MCO, PIHP or PAHP has made adequate provision against the risk of insolvency as required under 42 CFR 438.116.
- ☒ Documentation described in 42 CFR 438.207(b) on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 CFR 438.206.
- ☒ Information on ownership and control described in 42 CFR 455.104 of this chapter from MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors as governed by 42 CFR 438.230.

☒ The annual report of overpayment recoveries as required in 42 CFR 438.608(d)(3). (42 CFR 457.1285, cross referencing 42 CFR 438.604(a))

3.10.13 The State assures that:

☒ It requires that the data, documentation, or information submitted in accordance with 42 CFR 457.1285, cross referencing 42 CFR 438.604(a), is certified in a manner that the MCO's, PIHP's, PAHP's, PCCM's, or PCCM entity's Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. (42 CFR 457.1285, cross referencing 42 CFR 438.606(a))

☒ It requires that the certification includes an attestation that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 CFR 438.604 are accurate, complete, and truthful. (42 CFR 457.1285, cross referencing 42 CFR 438.606(b)); and

☒ It requires the MCO, PIHP, PAHP, PCCM, or PCCM entity to submit the certification concurrently with the submission of the data, documentation, or information required in 42 CFR 438.604(a) and (b). (42 CFR 457.1285, cross referencing 42 CFR 438.604(c))

3.10.14 ☒ The State assures that each MCO, PIHP, PAHP, PCCM, PCCM entity, and any subcontractors provides: written disclosure of any prohibited affiliation under 42 CFR 438.610, written disclosure of and information on ownership and control required under 42 CFR 455.104, and reports to the State within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract. (42 CFR 457.1285, cross referencing 42 CFR 438.608(c))

3.10.15 ☒ The State assures that services are provided in an effective and efficient manner. (Section 2101(a))

3.10.16 ☒ The State assures that it operates a Web site that provides:

- The documentation on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services;
- Information on ownership and control of MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors; and
- The results of any audits conducted under 42 CFR 438.602(e). (42 CFR 457.1285, cross-referencing to 42 CFR 438.602(g)).

3.11 Sanctions

Guidance: Only States with MCOs need to answer the next three assurances (3.11.1 through 3.11.3).

Intermediate sanctions are defined at 42 CFR 438.702(a)(4) as: (1) Civil money penalties; (2) Appointment of temporary management (for an MCO); (3) Granting enrollees the right to terminate enrollment without cause; (4) Suspension of all new enrollment; and (5) Suspension of payment for beneficiaries.

3.11.1 ☒ The State assures that it has established intermediate sanctions that it may impose if it makes the determination that an MCO has acted or failed to act in a manner specified in 438.700(b)-(d). (42 CFR 457.1270, cross referencing 42 CFR 438.700)

3.11.2 ☒ The State assures that it will impose temporary management if it finds that an MCO has repeatedly failed to meet substantive requirements of part 457 subpart L. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))

3.11.3 ☒ The State assures that if it imposes temporary management on an MCO, the State allows enrollees the right to terminate enrollment without cause and notifies the affected enrollees of their right to terminate enrollment. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))

Guidance: Only states with PCCMs, or PCCM entities need to answer the next assurance (3.11.4).

3.11.4 Does the State establish intermediate sanctions for PCCMs or PCCM entities?

☐ Yes
☐ No

Guidance: Only states with MCOs and states that answered yes to assurance 3.11.4 need to complete the next three assurances (3.11.5 through 3.11.7).

3.11.5 ☒ The State assures that before it imposes intermediate sanctions, it gives the affected entity timely written notice. (42 CFR 457.1270, cross referencing 42 CFR 438.710(a))

3.11.6 ☒ The State assures that if it intends to terminate an MCO, PCCM, or PCCM entity, it provides a pre-termination hearing and written notice of the decision as specified in 42 CFR 438.710(b). If the decision to terminate is affirmed, the State assures that it gives enrollees of the MCO, PCCM or PCCM entity notice of the termination and information, consistent with 42 CFR 438.10, on their options for receiving CHIP services following the effective date of termination. (42 CFR 457.1270, cross referencing 42 CFR 438.710(b))

3.11.7 ☒ The State assures that it will give CMS written notice that complies with 42 CFR 438.724 whenever it imposes or lifts a sanction for one of the violations listed in 42 CFR 438.700. (42 CFR 457.1270, cross referencing 42 CFR 438.724)

3.12 Quality Measurement and Improvement; External Quality Review

Guidance: The State should complete Sections 7 (Quality and Appropriateness of Care) and 9 (Strategic Objectives and Performance Goals and Plan Administration) in addition to Section 3.12.

Guidance: States with MCO(s), PIHP(s), PAHP(s), or certain PCCM entity/ies (PCCM entities whose contract with the State provides for shared savings, incentive payments or other financial reward for improved quality outcomes - see 42 CFR 457.1240(f)) - should complete the applicable sub-sections for each entity type in this section, regarding 42 CFR 457.1240 and 1250.

3.12.1 Quality Strategy

Guidance: All states with MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities need to complete section 3.12.1.

3.12.1.1 ☒ The State assures that it will draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished CHIP enrollees as described in 42 CFR 438.340(a). The quality strategy must include the following items:

- The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by 42 CFR 438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with 42 CFR 438.236;
- A description of:
  - The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP with which the State contracts, including but not limited to, the performance measures reported in accordance with 42 CFR 438.330(c); and
  - The performance improvement projects to be implemented in accordance with 42 CFR 438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP;
- Arrangements for annual, external independent reviews, in accordance with 42 CFR 438.350, of the quality outcomes and timeliness of, and access to, the services covered under each contract;
- A description of the State's transition of care policy required under 42 CFR 438.62(b)(3);
- The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, and primary language;
- For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of 42 CFR Part 438;
- A description of how the State will assess the performance and quality outcomes achieved by each PCCM entity;
- The mechanisms implemented by the State to comply with 42 CFR 438.208(c)(1) (relating to the identification of persons with special health care needs);
- Identification of the external quality review (EQR)-related activities for which the State has exercised the option under 42 CFR 438.360 (relating to nonduplication of EQR-related activities), and explain the rationale for the State's determination that the private accreditation activity is comparable to such EQR-related activities;
- Identification of which quality measures and performance outcomes the State will publish at least annually on the Web site required under 42 CFR 438.10(c)(3); and
- The State's definition of a "significant change" for the purposes of updating the quality strategy under 42 CFR 438.340(c)(3)(ii). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b))

3.12.1.2 ☒ The State assures that the goals and objectives for continuous quality improvement in the quality strategy are measurable and take into consideration the health status of all populations in the State served by the MCO, PIHP, and PAHP. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b)(2))

3.12.1.3 ☒ The State assures that for purposes of the quality strategy, the State provides the demographic information for each CHIP enrollee to the MCO, PIHP or PAHP at the time of enrollment. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b)(6))

3.12.1.4 ☒ The State assures that it will review and update the quality strategy as needed, but no less than once every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2))

3.12.1.5 ☒ The State assures that its review and updates to the quality strategy will include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years and the recommendations provided pursuant to 42 CFR 438.364(a)(4). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2)(i) and (iii).

3.12.1.6 ☒ The State assures that it will submit to CMS:

- A copy of the initial quality strategy for CMS comment and feedback prior to adopting it in final; and
- A copy of the revised strategy whenever significant changes are made to the document, or whenever significant changes occur within the State's CHIP program, including after the review and update required every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(3))

3.12.1.7 ☒ Before submitting the strategy to CMS for review, the State assures that when it drafts or revises the State's quality strategy it will:

- Make the strategy available for public comment; and
- If the State enrolls Indians in the MCO, PIHP, or PAHP, consult with Tribes in accordance with the State's Tribal consultation policy. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(1))

3.12.1.8 ☒ The State assures that it makes the results of the review of the quality strategy (including the effectiveness evaluation) and the final quality strategy available on the Web site required under 42 CFR 438.10(c)(3). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2)(ii) and (d))

3.12.2 Quality Assessment and Performance Improvement Program

3.12.2.1 Quality Assessment and Performance Improvement Program: Measures and Projects

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete the next two assurances (3.12.2.1.1 and 3.12.2.1.2).

3.12.2.1.1 ☒ The State assures that it requires that each MCO, PIHP, and PAHP establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply. The elements of the assessment and program include at least:

- Standard performance measures specified by the State;
- Any measures and programs required by CMS (42 CFR 438.330(a)(2);
- Performance improvement projects that focus on clinical and non-clinical areas, as specified in 42 CFR 438.330(d);
- Collection and submission of performance measurement data in accordance with 42 CFR 438.330(c);

- Mechanisms to detect both underutilization and overutilization of services; and
- Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by the State in the quality strategy under 42 CFR 457.1240(e) and Section 3.12.1 of this template). (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(b) and (c)(1))

Guidance: A State may request an exemption from including the performance measures or performance improvement programs established by CMS under 42 CFR 438.330(a)(2), by submitting a written request to CMS explaining the basis for such request.

3.12.2.1.2 ☒ The State assures that each MCO, PIHP, and PAHP's performance improvement projects are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. The performance improvement projects include at least the following elements:

- Measurement of performance using objective quality indicators;
- Implementation of interventions to achieve improvement in the access to and quality of care;
- Evaluation of the effectiveness of the interventions based on the performance measures specified in 42 CFR 438.330(d)(2)(i); and
- Planning and initiation of activities for increasing or sustaining improvement. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(2))

Guidance: Only states with a PCCM entity whose contract with the State provides for shared savings, incentive payments or other financial reward for improved quality outcomes need to, complete the next assurance (3.12.2.1.3).

3.12.2.1.3 ☐ The State assures that it requires that each PCCM entity establishes and implements an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply. The assessment and program must include:

- Standard performance measures specified by the State;
- Mechanisms to detect both underutilization and overutilization of services; and
- Collection and submission of performance measurement data in accordance with 42 CFR 438.330(c). (42 CFR 457.1240(a) and (b), cross referencing to 42 CFR 438.330(b)(3) and (c))

3.12.2.2 Quality Assessment and Performance Improvement Program: Reporting and Effectiveness

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete Section 3.12.2.2.

3.12.2.2.1 ☒ The State assures that each MCO, PIHP, and PAHP reports on the status and results of each performance improvement project conducted by the MCO, PIHP, and PAHP to the State as required by the State, but not less than once per year. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(3))

3.12.2.2.2 ☒ The State assures that it annually requires each MCO, PIHP, and PAHP to:
1) Measure and report to the State on its performance using the standard measures required by the State;
2) Submit to the State data specified by the State to calculate the MCO's, PIHP's, or PAHP's performance using the standard measures identified by the State; or
3) Perform a combination of options (1) and (2) of this assurance. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(c)(2))

3.12.2.2.3 ☒ The State assures that the State reviews, at least annually, the impact and effectiveness of the quality assessment and performance improvement program of each MCO, PIHP, PAHP and PCCM entity. The State's review must include:

- The MCO's, PIHP's, PAHP's, and PCCM entity's performance on the measures on which it is required to report; and
- The outcomes and trended results of each MCO's, PIHP's, and PAHP's performance improvement projects. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(e)(1))

3.12.3 Accreditation

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete Section 3.12.3.

3.12.3.1 ☒ The State assures that it requires each MCO, PIHP, and PAHP to inform the state whether it has been accredited by a private independent accrediting entity, and, if the MCO, PIHP, or PAHP has received accreditation by a private independent accrediting agency, that the MCO, PIHP, and PAHP authorizes the private independent accrediting entity to provide the State a copy of its recent accreditation review that includes the MCO, PIHP, and PAHP's accreditation status, survey type, and level (as applicable); accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and expiration date of the accreditation. (42 CFR 457.1240(c), cross referencing to 42 CFR 438.332(a) and (b)).

3.12.3.2 ☒ The State assures that it will make the accreditation status for each contracted MCO, PIHP, and PAHP available on the Web site required under 42 CFR 438.10(c)(3), including whether each MCO, PIHP, and PAHP has been accredited and, if applicable, the name of the accrediting entity, accreditation program, and accreditation level; and update this information at least annually. (42 CFR 457.1240(c), cross referencing to 42 CFR 438.332(c))

3.12.4 Quality Rating

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete Section 3.12.4.

☒ The State assures that it will implement and operate a quality rating system that issues an annual quality rating for each MCO, PIHP, and PAHP, which the State will prominently display on the Web site required under 42 CFR 438.10(c)(3), in accordance with the requirements set forth in 42 CFR 438.334. (42 CFR 457.1240(d))

Guidance: States will be required to comply with this assurance within 3 years after CMS, in consultation with States and other Stakeholders and after providing public notice and opportunity for

comment, has identified performance measures and a methodology for a Medicaid and CHIP managed care quality rating system in the Federal Register.

3.12.5 Quality Review

Guidance: All states with MCOs, PIHPs, PAHPs, PCCMs or PCCM entities need to complete Sections 3.12.5 and 3.12.5.1.

☒ The State assures that each contract with a MCO, PIHP, PAHP, or PCCM entity requires that a qualified EQRO performs an annual external quality review (EQR) for each contracting MCO, PIHP, PAHP or PCCM entity, except as provided in 42 CFR 438.362. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(a))

3.12.5.1 External Quality Review Organization

3.12.5.1.1 ☒ The State assures that it contracts with at least one external quality review organization (EQRO) to conduct either EQR alone or EQR and other EQR-related activities. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(a))

3.12.5.1.2 ☒ The State assures that any EQRO used by the State to comply with 42 CFR 457.1250 must meet the competence and independence requirements of 42 CFR 438.354 and, if the EQRO uses subcontractors, that the EQRO is accountable for and oversees all subcontractor functions. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.354 and 42 CFR 438.356(b) through (d))

3.12.5.2 External Quality Review-Related Activities

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete the next three assurances (3.12.5.2.1 through 3.12.5.2.3). Under 42 CFR 457.1250(a), the State, or its agent or EQRO, must conduct the EQR-related activity under 42 CFR 438.358(b)(1)(iv) regarding validation of the MCO, PIHP, or PAHP's network adequacy during the preceding 12 months; however, the State may permit its contracted MCO, PIHP, and PAHPs to use information from a private accreditation review in lieu of any or all the EQR-related activities under 42 CFR 438.358(b)(1)(i) through (iii) (relating to the validation of performance improvement projects, validation of performance measures, and compliance review).

3.12.5.2.1 ☒ The State assures that the mandatory EQR-related activities described in 42 CFR 438.358(b)(1)(i) through (iv) (relating to the validation of performance improvement projects, validation of performance measures, compliance review, and validation of network adequacy) will be conducted on all MCOs, PIHPs, or PAHPs. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(b)(1))

3.12.5.2.2 ☒ The State assures that if it elects to use nonduplication for any or all of the three mandatory EQR-related activities described at 42 CFR 438.358(b)(1)(i) – (iii), the State will document the use of nonduplication in the State's quality strategy. (42 CFR 457.1250(a), cross referencing 438.360, 438.358(b)(1)(i) through (b)(1)(iii), and 438.340)

3.12.5.2.3 ☒ The State assures that if the State elects to use nonduplication for any or all of the three mandatory EQR-related activities described at 42 CFR 438.358(b)(1)(i) – (iii), the State will ensure that all information from a Medicare or private accreditation review for an MCO, PIHP, or PAHP will be furnished to the EQRO for analysis and inclusion in the EQR technical report described in 42 CFR 438.364. ((42 CFR 457.1250(a), cross referencing to 42 CFR 438.360(b))

Guidance: Only states with PCCM entities need to complete the next assurance (3.12.5.2.4).

3.12.5.2.4 ☐ The State assures that the mandatory EQR-related activities described in 42 CFR 438.358(b)(2) (cross-referencing 42 CFR 438.358(b)(1)(ii) and (b)(1)(iii)) will be conducted on all PCCM entities, which include:

- Validation of PCCM entity performance measures required in accordance with 42 CFR 438.330(b)(2) or PCCM entity performance measures calculated by the State during the preceding 12 months; and
- A review, conducted within the previous 3-year period, to determine the PCCM entity's compliance with the standards set forth in subpart D of 42 CFR part 438 and the quality assessment and performance improvement requirements described in 42 CFR 438.330. (42 CFR 457.1250(a), cross referencing to 438.358(b)(2))

3.12.5.3 External Quality Review Report

Guidance: All states with MCOs, PIHPs, PAHPs, PCCMs or PCCM entities need to complete Sections 3.12.5.3.

3.12.5.3.1 ☒ The State assures that data obtained from the mandatory and optional, if applicable, EQR-related activities in 42 CFR 438.358 is used for the annual EQR to comply with 42 CFR 438.350 and must include, at a minimum, the elements in §438.364(a)(2)(i) through (iv). (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(a)(2))

3.12.5.3.2 ☒ The State assures that only a qualified EQRO will produce the EQR technical report (42 CFR 438.364(c)(1)).

3.12.5.3.3 ☒ The State assures that in order for the qualified EQRO to perform an annual EQR for each contracting MCO, PIHP, PAHP or PCCM entity under 42 CFR 438.350(a) that the following conditions are met:

- The EQRO has sufficient information to use in performing the review;
- The information used to carry out the review must be obtained from the EQR-related activities described in 42 CFR 438.358 and, if applicable, from a private accreditation review as described in 42 CFR 438.360;
- For each EQR-related activity (mandatory or optional), the information gathered for use in the EQR must include the elements described in 42 CFR 438.364(a)(2)(i) through (iv); and
- The information provided to the EQRO in accordance with 42 CFR 438.350(b) is obtained through methods consistent with the protocols established by the Secretary in accordance with 42 CFR 438.352. (42 CFR

457.1250(a), cross referencing to 42 CFR 438.350(b) through (e))

3.12.5.3.4 ☒ The State assures that the results of the reviews performed by a qualified EQRO of each contracting MCO, PIHP, PAHP, and PCCM entity are made available as specified in 42 CFR 438.364 in an annual detailed technical report that summarizes findings on access and quality of care. The report includes at least the following items:

- A description of the manner in which the data from all activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR 438.310(c)(2));
- For each EQR-related activity (mandatory or optional) conducted in accordance with 42 CFR 438.358:
  - Objectives;
  - Technical methods of data collection and analysis;
  - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with 42 CFR 438.358(b)(1)(i) and (ii); and
  - Conclusions drawn from the data;
- An assessment of each MCO's, PIHP's, PAHP's, or PCCM entity's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
- Recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, or PCCM entity, including how the State can target goals and objectives in the quality strategy, under 42 CFR 438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
- Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with 42 CFR 438.352(e); and
- An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(f) and 438.364(a))

3.12.5.3.5 ☒ The State assures that it does not substantively revise the content of the final EQR technical report without evidence of error or omission. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(b))

3.12.5.3.6 ☒ The State assures that it finalizes the annual EQR technical report by April 30th of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(1))

3.12.5.3.7 ☒ The State assures that it posts the most recent copy of the annual EQR technical report on the Web site required under 42 CFR 438.10(c)(3) by April 30th of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(i))

3.12.5.3.8 ☒ The State assures that it provides printed or electronic copies of the information specified in 42 CFR 438.364(a) for the annual EQR technical report, upon

request, to interested parties such as participating health care providers, enrollees and potential enrollees of the MCO, PIHP, PAHP, or PCCM, beneficiary advocacy groups, and members of the general public. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(ii))

3.12.5.3.9 ☒ The State assures that it makes the information specified in 42 CFR 438.364(a) for the annual EQR technical report available in alternative formats for persons with disabilities, when requested. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(3))

3.12.5.3.10 ☒ The State assures that information released under 42 CFR 438.364 for the annual EQR technical report does not disclose the identity or other protected health information of any patient. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(d))

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section 5.

TX RESPONSE: Please see approved CS3 template.

CHIP Eligibility

State Name: Texas

OMB Control Number: 0938-1148

Transmittal Number: TX - 14 - 0033

Expiration date: 10/31/2014

Eligibility for Medicaid Expansion Program	CS3

42 CFR 457.320(a)(2) and (3)

Income eligibility for children under the Medicaid Expansion is determined in accordance with the following income standards:

There should be no overlaps or gaps for the ages entered.

Age and Household Income Ranges

	From Age	To Age	Above (% FPL)	Up to & including (% FPL)	
+	6	19	109	133	X

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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NOV 0 5 2014

CHIP SPA# TX-14-0033

Approval Date: _____

Effective Date: _____

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4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

TX RESPONSE: Please see approved CS18 template.

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
Non-Financial Eligibility - Citizenship **CS18**

Sections 2105(c)(9) and 2107(e)(1)(J) of the SSA and 42 CFR 457.320(b)(6), (c) and (d)

Citizenship

☑ The CHIP Agency provides CHIP eligibility to otherwise eligible citizens and nationals of the United States and certain non-citizens, including the time period during which they are provided with reasonable opportunity to submit verification of their citizenship, national status or satisfactory immigration status.

■ The CHIP Agency provides eligibility under the Plan to otherwise eligible individuals:

Who are citizens or nationals of the United States; or

Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); or

Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality, or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), and 1902(ee) of the Act, and 42 CFR 435.406, 407, 956 and 457.380.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.	No
The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual.	Yes

The date benefits are furnished is:

◉ The date of application containing the declaration of citizenship or immigration status.

○ The date the reasonable opportunity notice is sent.

○ Other date, as described:

The CHIP Agency elects the option to provide CHIP coverage to otherwise eligible children up to age 19, lawfully residing in the United States, as provided in Section 2107(e)(1)(J) of the SSA (Section 214 of CHIPRA 2009, P.L. 111-3).	Yes

Otherwise eligible children means children meeting the eligibility requirements of targeted low-income children with the exception of non-citizen status.

☑ The CHIP Agency provides assurance that lawfully residing children are also covered under the state's Medicaid program.

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CMS

CHIP Eligibility

The CHIP Agency elects the option to provide CHIP coverage to otherwise eligible pregnant women, lawfully residing in the United States, as provided in Section 214 of CHIPRA 2009, P.L. 111-3. The state may not select this option unless the state also elects to cover lawfully residing children. A state may not select this option unless the state also covers Targeted Low-Income Pregnant Women.	No

☒ An individual is considered to be lawfully residing in the United States if he or she is lawfully present and meets state residency requirements.

☒ An individual is considered to be lawfully present in the United States if he or she is:

1. A qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);

2. A non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));

3. A non-citizen who has been paroled into the United States in accordance with 8 U.S.C.1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

4. A non-citizen who belongs to one of the following classes:

   (i) Granted temporary resident status in accordance with 8 U.S.C.1160 or 1255a, respectively;

   (ii) Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;

   (iii) Granted employment authorization under 8 CFR 274a.12(c);

   (iv) Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;

   (v) Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

   (vi) Granted Deferred Action status;

   (vii) Granted an administrative stay of removal under 8 CFR 241;

   (viii) Beneficiary of approved visa petition who has a pending application for adjustment of status;

5. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C.1231,or under the Convention Against Torture, who:

   (i) Has been granted employment authorization; or

   (ii) Is under the age of 14 and has had an application pending for at least 180 days;

6. Has been granted withholding of removal under the Convention Against Torture;

7. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C.1101(a)(27)(J);

8. Is lawfully present in American Samoa under the immigration laws of American Samoa; or

9. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b)).

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Approval Date: DEC 2 3 2015

Effective Date: January 1, 2014
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CMS

CHIP Eligibility

10. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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These standards are used for Texas CHIP:

4.1.1. ☐ Geographic area served by the Plan: Eligible children throughout the state will receive services.

4.1.2. ☒ Age: Children through the age of 18 years will be eligible.

4.1.2.1 ☒ Age: For unborn children, coverage can begin from the confirmation of pregnancy and enrollment in CHIP Perinatal Program.

4.1.3. ☒ Income: Children whose countable family income (gross income minus all eligible childcare expenses) is at or below 200 percent of FPL will be eligible.

TX RESPONSE: Please see approved CS7, CS9 and CS14 templates.

CHIP Eligibility

State Name: Texas

OMB Control Number: 0938-1148

Transmittal Number: TX - 14 - 0032

Expiration date: 10/31/2014

Separate Child Health Insurance Program
Eligibility - Targeted Low-Income Children **CS7**

2102(b)(1)(B)(v) of the SSA and 42 CFR 457.310, 315 and 320

■ **Targeted Low-Income Children -** Uninsured children under age 19 whose household income is within standards established by the state.

☑ The CHIP Agency operates this covered group in accordance with the following provisions:

Age

Must be under age 19.

Income Standards

Income standards are applied statewide. Yes

Are there any exceptions, e.g. populations in a county which may qualify under either a statewide income standard or a county income standard? No

Statewide Income Standards

Begin with lowest age range first.

Please note that the lower bound for CHIP eligibility should be the highest standard used for Medicaid poverty-level children for the same age group or groups entered here.

	From Age	To Age	Above (% FPL)	Up to & including (% FPL)	
+	0	1	198	201	X
+	1	6	144	201	X
+	6	19	133	201	X

Age ranges may overlap. If there is an overlap, provide an explanation. Include the age ranges for each income standard that has overlapping ages and the reason for having different income standards.

Special Program for Children with Disabilities

Does the state have a special program for children with disabilities? No

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CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
Eligibility - Coverage From Conception to Birth **CS9**

42 CFR 457.10

■ **Coverage From Conception to Birth** - Coverage from conception to birth when the mother is not eligible for Medicaid.

☑ The CHIP Agency operates this covered group in accordance with the following provisions:

Age Standard

From conception through birth.

Does the state have an additional age definition or other age-related conditions? No

Income Standards

Income standards are applied statewide. Yes

Are there any exceptions, e.g. populations in a county which may qualify under either a statewide income standard or a county income standard? No

Statewide Income Standard

The statewide income standard is: From zero up to 202 % FPL

■ Exempted from requirement of providing or applying for a Social Security Number.

■ Exempted from requirement of verifying citizenship status.

PRA Disclosure Statement

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4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources): Family resources are not taken into account in the determination of eligibility for children at or below 150 percent of FPL.

Not applicable

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Child Health Insurance Program
Eligibility - Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards CS14

Section 2101(f) of the ACA and 42 CFR 457.310(d)

☑ Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards

The CHIP agency provides coverage for this group of children as follows:

○ The state has received approval from CMS to maintain Medicaid eligibility for children who would otherwise be subject to Section 2101(f) such that no child in the state will be subject to this provision.

◉ The state assures that separate CHIP coverage will be provided for children ineligible for Medicaid due to the elimination of income disregards in accordance with 42 CFR 457.310(d). Coverage for this population will cease when the last child protected from loss of Medicaid coverage as a result of the elimination of income disregards has been afforded 12 months of coverage in a separate CHIP (expected to be no later than April 1, 2016).

Describe the methodology used by the state to identify and enroll children in a separate CHIP who are subject to the protection afforded by Section 2101(f) of the Affordable Care Act:

◉ The state has demonstrated and CMS has agreed that all children qualifying for section 2101(f) protection will qualify for the state's existing separate CHIP.

○ The state will enroll all children in a separate CHIP who lose Medicaid eligibility because of an increase in family income at their first renewal applying MAGI methods.

○ The state will enroll children in a separate CHIP whose family income falls above the converted MAGI Medicaid FPL but at or below the following percentage of FPL. The state has demonstrated and CMS has agreed that all or almost all the children who would have maintained Medicaid eligibility if former disregards were applied will be within this income range and therefore covered in the separate CHIP.

[ ] % FPL

○ The state will enroll children in a separate CHIP who are found to be ineligible for Medicaid based on MAGI but whose family income has not increased since the child's last determination of Medicaid eligibility or who would have remained eligible for Medicaid (based on the 2013 Medicaid income standard) if the value of their 2013 disregards had been applied to the family income as determined by MAGI methodology.

○ Other.

Describe the benefits provided to this population:

○ This population will be provided the same benefits as are provided to children in the state's Medicaid program.

◉ This population will be provided the same benefits as are provided to children in the state's separate CHIP.

○ Other (consistent with Section 2103 of the SSA and 42 CFR 457 Subpart D).

Describe premiums and cost sharing required of this population:

○ Cost sharing is the same as for children in the Medicaid program.

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CHIP Eligibility

- (●) Premiums and cost sharing are the same as for targeted low-income children in the state's separate CHIP.
- ( ) No premiums, copayments, deductibles, coinsurance or other cost sharing is required.
- ( ) Other premiums and/or cost-sharing requirements (consistent with Section 2103(e) of the SSA and 42 CFR 457 Subpart E).

PRA Disclosure Statement

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4.1.5. ☒ Residency (so long as residency requirement is not based on length of time in state): Children must be residents of Texas to be eligible for services.

TX RESPONSE: Please see approved CS17 template.

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
Non-Financial Eligibility - Residency **CS17**

42 CFR 457.320

Residency

☑ The CHIP Agency provides CHIP to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

A child is considered to be a resident of the state under the following conditions:

■ A non-institutionalized child, if capable of indicating intent and who is emancipated or married, if the child is living in the state and:

1. Intends to reside in the state, including without a fixed address, or
2. Has entered the state with a job commitment or seeking employment, whether or not currently employed.

■ A non-institutionalized child not described above and a child who is not a ward of the state:

1. Residing in the state, with or without a fixed address, or
2. The state of residency of the parent or caretaker, in accordance with 42 CFR.435.403(h)(1), with whom the individual resides.

■ An institutionalized child, who is not a ward of the state, if the state is the state of residence of the child's custodial parent or caretaker at the time of placement, or

■ A child who is a ward of the state regardless of where the child lives, or

■ A child physically located in the state when there is a dispute with one or more states as to the child's actual state of residence.

If the state covers pregnant women, a pregnant woman is considered to be a resident under the following conditions:

■ A non-institutionalized pregnant woman who is living in the state and:

1. Intends to reside in the state, including without a fixed address, or if incapable of indicating intent, is living in the state, or
2. Entered with a job commitment or seeking employment, whether or not currently employed.

■ An institutionalized pregnant woman placed in an out-of-state-institution, as defined in 42 CFR 435.1010, including foster care homes, by an agency of the state, or

■ An institutionalized pregnant woman residing in an in-state-institution, as defined in 42 CFR 435.1010, whether or not the individual established residency in the state prior to entering the institution, or

■ A pregnant woman physically located in the state when there is a dispute with one or more states as to the pregnant woman's actual state of residence.

The state has in place related to the residency of children and pregnant women (if covered by the state):

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CHIP Eligibility

One or more interstate agreement(s). No

A policy related to individuals in the state only for educational purposes. No

PRA Disclosure Statement

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4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility): Not applicable.

4.1.7. ☒ Access to or coverage under other health coverage: The application form asks for information on the insurance status of children making application. Children with existing health insurance are denied eligibility for Texas CHIP. Unborn children with existing health insurance are denied eligibility for Texas CHIP.

4.1.8. ☒ Duration of eligibility: Eligible children in the traditional CHIP Program with incomes at or below 185 FPL receive coverage for 12 continuous months. Eligible children in the traditional CHIP Program with incomes above 185 percent of FPL receive coverage for up to 12 months and are required to verify income eligibility at month six of their 12-month CHIP coverage period. Eligible unborn children receive coverage for 12 continuous months, except when labor with delivery is paid for by Medicaid and the newborn is deemed eligible for Medicaid.

TX RESPONSE: Please see approved CS27 template.

CHIP Eligibility

State Name: Texas

OMB Control Number: 0938-1148

Transmittal Number: TX - 22 - 0004

Separate Child Health Insurance Program
General Eligibility - Continuous Eligibility **CS27**

2105(a)(4)(A) of the SSA and 42 CFR 457.342 and 435.926; 2107(e)(1)(J) and 1902(e)(16) of the SSA

Mandatory 12-Month Postpartum Continuous Eligibility in CHIP for States Electing This Option in Medicaid

At state option in Medicaid, states may elect to provide continuous eligibility for an individual's 12-month postpartum period consistent with section 1902(e)(16) of the SSA. If elected under Medicaid, states are required to provide the same continuous eligibility and extended postpartum period for pregnant individuals in its separate CHIP. A separate CHIP cannot implement this option if not also elected under the Medicaid state plan.

State elected the Medicaid option to provide continuous eligibility through the 12- month postpartum period: No

Optional Continuous Eligibility for Children

The CHIP Agency may provide that children who have been determined eligible under the state plan shall remain eligible, regardless of any changes in the family's circumstances, during a continuous eligibility period up to 12 months, or until the time the child reaches an age specified by the state (not to exceed age 19), whichever is earlier.

The CHIP Agency elects to provide continuous eligibility to children under this provision: Yes

- (•) For children up to age 19
- ( ) For children up to age

The continuous eligibility period begins on the effective date of the child's most recent determination or redetermination of eligibility, and ends:

- [■] At the end of the 12 months continuous eligibility period.

The state assures that a child's eligibility is not terminated during a continuous eligibility period, regardless of any changes in circumstances, unless:

- [■] The child attains the age specified by the state Agency or age 19.
- [■] The child or child's representative requests voluntary disenrollment.
- [■] The child is no longer a resident of the state.
- [■] The Agency determines that eligibility was erroneously granted at the most recent determination or renewal of eligibility because of Agency error or fraud, abuse, or perjury attributed to child or child's representative.
- [■] The child dies.
- [■] The child becomes eligible for Medicaid
- [■] There is a failure to pay required premiums or enrollment fees on behalf of a child, as provided for in the state plan.

Effective Date: January 1, 2022

Approval Date: August 11, 2022

CHIP Eligibility

PRA Disclosure Statement

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Effective Date: January 1, 2022 Approval Date: August 11, 2022

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4.1.9. ☒ Other standards (identify and describe): Immigration status: children who are legal residents but have not passed the five year bar are enrolled at the cost of the State.

TX RESPONSE: Please see approved CS19 template.

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
Non-Financial Eligibility - Social Security Number **CS19**

42 CFR 457.340(b)

Social Security Number

As a condition of eligibility, the CHIP Agency must require individuals who have a social security number or are eligible for one as determined by the Social Security Administration, to furnish their social security number, or numbers if they have more than one number.

☑ The CHIP Agency requires individuals, as a condition of eligibility, to furnish their social security number(s), with the following exceptions:

Individuals refusing to obtain a social security number (SSN) because of well established religious objections, or

Individuals who are not eligible for an SSN, or

Individuals who are issued an SSN only for a valid non-work purpose.

■ The CHIP Agency assists individuals, who are required to provide their SSN, to apply for or obtain an SSN from the Social Security Administration if the individual does not have or forgot their SSN.

■ The CHIP Agency informs individuals required to provide their SSN:

By what statutory authority the number is solicited; and

How the state will use the SSN.

☑ The CHIP Agency provides assurance that it will verify each SSN furnished by an applicant or beneficiary with the Social Security Administration, not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's SSN by the Social Security Administration and that the state's utilization of the SSNs is consistent with sections 205 and 1137 of the Social Security Act and the Privacy Act of 1974.

The state may request non-applicant household members to voluntarily provide their SSN, if the state meets the requirements below.

The state requests non-applicant household members to voluntarily provide their SSN. Yes

☑ When requesting an SSN for non-applicant household members, the state assures that:

■ At the time such SSN is requested, the state informs the non-applicant that this information is voluntary and provides information regarding how the SSN will be used; and

■ The state only uses the SSN for determination of eligibility for CHIP or other insurance affordability programs, or for a purpose directly connected with the administration of the state plan.

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CHIP Eligibility

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4.1.10. ☒ Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to provide coverage to the following children as specified below who are lawfully residing in the United States, and consist of the following:

A child shall be considered lawfully present if he or she is:

(1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);

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

(3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. § 1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;

(4) An alien who belongs to one of the following classes:

(i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);

(ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;

(iii) Aliens who have been granted employment authorization under 8 CFR 274a,12(c)(9), (10), (16) (18), (20), (22), or (24);

(iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;

(v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;

(vi) Aliens currently in deferred action status; or

(vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;

(5) A pending applicant for asylum under section 208(a) of the INA (8 U, S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U,S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;

(6) An alien who has been granted withholding of removal under the Convention Against Torture;

(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 10 1 (a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J));

(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or

(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

☒ The State elects the CHIPRA section 214 option for children up to age 19.

☐ The State elects the CHIPRA section 214 option for pregnant women through the 60-day postpartum period.

TX RESPONSE: Please see approved CS18 template.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42CFR457.320(b))**

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)) (42CFR 457.350)**

TX RESPONSE: Please see approved CS24, CS15 and CS10 templates.

In the event of a FEMA- or Governor- declared disaster, the State will notify CMS of the intent to provide temporary adjustments to its eligibility and enrollment policies, the effective dates of such adjustments, and the counties/ areas impacted by the disaster.

In the event of a FEMA- or Governor- declared disaster and at the State's discretion, enrollees may be granted eligibility and receive services beyond their certification period and may be provided additional time to submit a renewal or verification.

In the event of a FEMA- or Governor- declared disaster and at the State's discretion, eligibility verification requirements may be waived at application and renewal. The state may allow self-attestation to complete the eligibility determination, in accordance with 42 CFR 457.380.

In the event of a FEMA- or Governor- declared disaster and at the State's discretion, the State may waive or delay collection of enrollment fees in accordance with Sections 8.2.1 and 8.2.3.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). **(Section 2106(b)(7)) (42CFR 457.305(b))**

☒ Check here if this section does not apply to your state.

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
General Eligibility - Eligibility Processing CS24

2102(b)(3) & 2107(e)(1)(O) of the SSA and 42 CFR 457, subpart C

☑ The CHIP Agency meets all of the requirements of 42 CFR 457, subpart C for application processing, eligibility screening and enrollment.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard:

☐ The single, streamlined application developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act.

☒ An alternative single, streamlined application developed by the state and approved by the Secretary in accordance with section 1413(b)(1)(B) of the Affordable Care Act.

An attachment is submitted.

☒ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

☑ The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in CFR 457.340(a), by telephone, via mail, in person and other commonly available electronic means.

The agency accepts applications in the following other electronic means.

☒ Other electronic means:

	Name of method	Description	
+	Facsimile	Applications for CHIP can be submitted by fax to 1-877-HHSC-TEX (1-877-447-2839).	X

Screen and Enroll Process

☑ The CHIP Agency has coordinated eligibility and enrollment screening procedures in place that are applied at time of initial application, periodic redeterminations, and follow-up eligibility determinations. The procedures ensure that only targeted low-income children are provided CHIP coverage and that enrollment is facilitated for applicants found to be potentially eligible for other insurance affordability programs.

Procedures include:

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CHIP Eligibility

- [x] Screening of application to identify all individuals eligible or potentially eligible for CHIP or other insurance affordability programs; and
- [x] Income eligibility test, with calculation of household income consistent with 42 CFR 457.315 for individuals identified as potentially eligible for Medicaid or other insurance affordability programs based on household income; and
- [x] Screening process for individuals who may qualify for Medicaid on a basis other than having household income at or below the applicable MAGI standard, based on information in the single streamlined application.

The CHIP agency has entered into an arrangement with the Exchange to make eligibility determinations for advanced premium tax credits in accordance with section 1943(b)(2) of the SSA. **No**

Redetermination Processing

- [ ] Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 457.343:
  - [x] Once every 12 months.
  - [x] Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency.
  - [x] If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

Screening by Other Insurance Affordability Programs

- [x] The CHIP Agency provides assurance that it has adopted procedures to accept and process electronic accounts of individuals screened as potentially eligible for CHIP by other insurance affordability programs in accordance with the requirements of 42 CFR 457.348(b) and to determine eligibility in accordance with 42 CFR 457.340 in the same manner as if the application had been submitted directly to, and processed by the state.
- [ ] The CHIP Agency elects the option to accept CHIP eligibility decisions made by the Exchange or other agencies administering insurance affordability programs as provided in 42 CFR 457.348 and to furnish CHIP in accordance with requirements of 42 CFR 457.340 to the same extent and in the same manner as if the applicant had been determined by the state to be eligible for CHIP.
- [x] The CHIP Agency has entered into an agreement with agencies administering other insurance affordability programs to fulfill the requirements of 457.348(b) and will provide this agreement to the Secretary upon request.

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CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
MAGI-Based Income Methodologies **CS15**

2102(b)(1)(B)(v) of the SSA and 42 CFR 457.315

☑ The CHIP Agency will apply Modified Adjusted Gross Income methodologies for all separate CHIP covered groups, as described below, and consistent with 42 CFR 457.315 and 435.603(b) through (i).

In the case of determining ongoing eligibility for enrollees determined eligible for CHIP on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility, whichever is later.

If the state covers pregnant women, in determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- ◉ The pregnant woman is counted just as herself.
- ○ The pregnant woman is counted just as herself, plus one.
- ○ The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- ◉ Current monthly household income and family size.
- ○ Projected annual household income for the remaining months of the current calendar year and family size.

In determining current monthly or projected annual household income, the state will use reasonable methods to:

- ☒ Include a prorated portion of the reasonably predictable increase in future income and/or family size.
- ☒ Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 457.315 and 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent. Yes

☑ The CHIP Agency certifies that it has submitted and received approval for the conversion for all separate CHIP covered group income standards to MAGI-equivalent standards.

An attachment is submitted.

PRA Disclosure Statement

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CMS

CHIP Eligibility

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CHIP Eligibility

State Name: Texas

OMB Control Number: 0938-1148

Transmittal Number: TX - 14 - 0032

Expiration date: 10/31/2014

Separate Child Health Insurance Program
Eligibility - Children Who Have Access to Public Employee Coverage **CS10**

Sec. 2110(b)(2)(B) and (b)(6) of the SSA

■ **Children Who Have Access to Public Employee Coverage** - Otherwise eligible targeted low-income children who have access to public employee coverage on the basis of a family member's employment.

☑ The CHIP Agency operates this covered group in accordance with the following provisions:

Select one of the following conditions as described in Section 2110(b)(6) of the Social Security Act:

○ Maintenance of agency contribution as provided in 2110(b)(6)(B) of the SSA.

◉ Hardship criteria as provided in section 2110(b)(6)(C) of the Social Security Act.

Coverage under this option is extended to children whose household income is:

Select one of the options for the income standard when compared to Targeted Low Income Children

◉ The same as the standards for Targeted Low-Income Children

○ Lower than the income standards for Targeted Low-Income Children

Indicate whether coverage under this option is extended to all children who have access to public employee coverage, or only certain children:

○ All children who have access to public employee coverage

◉ Certain children who have access to public employee coverage:

☐ Employees of certain public agencies.

☒ Certain types of public employees.

	Describe type of public employees	
+	Active school district employees	X
+	State employees	X

■ Attach methodology the state has used to calculate financial hardship.

An attachment is submitted.

☑ The state provides assurance that the state will, on an annual basis, recalculate the financial status to determine if the hardship condition continues to be met.

☑ Children who are eligible for public employee health benefits coverage who are not described above are excluded from eligibility under the plan.

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CHIP Eligibility

☑ Children considered to have access to public employee coverage, and therefore not excluded from CHIP through this option, otherwise meet the definition of targeted low-income child provided at 42 CFR 457.310.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer. Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415

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4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan.
(Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))

TX RESPONSE: Please see approved CS24 template.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX.
(Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))

4.4.3. The State is taking steps to assist in the enrollment in CHIP of children determined ineligible for Medicaid.
(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

TX RESPONSE: Please see approved CS10 template.

Attachment 1 - 2015
Hardship Exception for Children of Texas Public Employees and Public Education Employees

Hardship Exception Threshold for Families at 200% FPL

	200% FPL	5% Limit
Family of 3	$40,180	$2,009
Family of 4	$48,500	$2,425
Family of 5	$56,820	$2,841
Family of 6	$65,140	$3,257

TEACHERS RETIREMENT SYSTEM OF TEXAS

2014-2015 Plan Year - Teachers Retirement System of Texas (TRS) PPO Premiums

	Plan 1		Plan 2		Plan 3	
	Children	Family	Children	Family	Children	Family
Monthly Premium	$572	$1,145	$709	$1,238	$875	$1,323
Minimum State Payment	$75	$75	$75	$75	$75	$75
Minimum School Payment	$150	$150	$150	$150	$150	$150
Monthly Premium Per Employee	$347	$920	$484	$1,013	$650	$1,098
Annual Premium Per Employee	$4,164	$11,040	$5,808	$12,156	$7,800	$13,176
Deductible	$5,000	$5,000	$3,600	$3,600	$0	$0
Total (Premium + Deductible)	**$9,164**	**$16,040**	**$9,408**	**$15,756**	**$7,800**	**$13,176**

2014-2015 Plan Year - TRS HMO Premiums

	HMO 1		HMO 2		HMO 3	
	Children	Family	Children	Family	Children	Family
Monthly Premium	$717	$1,132	$627	$989	$619	$987
Minimum State Payment	$75	$75	$75	$75	$75	$75
Minimum School Payment	$150	$150	$150	$150	$150	$150
Monthly Premium Per Employee	$492	$907	$402	$764	$394	$762
Annual Premium Per Employee	**$5,908**	**$10,878**	**$4,826**	**$9,171**	**$4,727**	**$9,149**

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EMPLOYEES RETIREMENT SYSTEM OF TEXAS

FY2015 Annual Premium for Employees Retirement System (ERS) HealthSelect Participants with Children - $2,473.68

Additional Annual Cost Sharing Amount per Client under ERS HealthSelect Cost Sharing Requirements

Cost Sharing Type	Amount
Additional Co-pay – Office Visits	$69.26
Additional Cost Sharing – Prescription Drugs	$180.41
Additional Cost Sharing – Inpatient Hospital	$26.45
Additional Cost Sharing – Outpatient Hospital	$30.74
Additional Cost Sharing – Emergency Visit	$71.03
Total additional annual cost sharing per client	$377.89

Note: Additional cost sharing amounts calculated based on determining Texas CHIP costs for each service category and adjusting these costs to reflect the difference in payment rates between CHIP and ERS HealthSelect. ERS HealthSelect co-insurance and co-payment requirements were then applied to this adjusted cost data and annual, per-client utilization data for the Texas CHIP population.

Annual ERS HealthSelect Premiums and Cost Sharing Compared to the Hardship Exception Threshold

	Annual Income – 200% FPL[1]	5% Limit	Annual HealthSelect Premiums + Additional Cost Sharing[2]
Family of 3	$40,180	$2,009	$2,852
Family of 4	$48,500	$2,425	$3,229
Family of 5	$56,820	$2,841	$3,607
Family of 6	$65,140	$3,257	$3,985

Notes:
[1]Annual income amounts are based on 2015 federal poverty guidelines.
[2]Additional cost-sharing calculated assuming a two-parent household.

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EMPLOYEES RETIREMENT SYSTEM OF TEXAS

FY2014 Annual Premium for Employees Retirement System (ERS) HealthSelect Participants with Children - $2,314.32

Additional Annual Cost Sharing Amount per Client under ERS HealthSelect Cost Sharing Requirements

Cost Sharing Type	Amount
Additional Co-pay – Office Visits	$69.26
Additional Cost Sharing – Prescription Drugs	$180.41
Additional Cost Sharing – Inpatient Hospital	$26.45
Additional Cost Sharing – Outpatient Hospital	$30.74
Additional Cost Sharing – Emergency Visit	$71.03
Total additional annual cost sharing per client	$377.89

Note: Additional cost sharing amounts calculated based on determining Texas CHIP costs for each service category and adjusting these costs to reflect the difference in payment rates between CHIP and ERS HealthSelect. ERS HealthSelect co-insurance and co-payment requirements were then applied to this adjusted cost data and annual, per-client utilization data for the Texas CHIP population.

Annual ERS HealthSelect Premiums and Cost Sharing Compared to the Hardship Exception Threshold

	Annual Income – 200% FPL[1]	5% Limit	Annual HealthSelect Premiums + Additional Cost Sharing[2]
Family of 3	$39,580	$1,979	$2,692
Family of 4	$47,700	$2,385	$3,070
Family of 5	$55,820	$2,791	$3,448
Family of 6	$63,940	$3,197	$3,826

Notes:
[1]Annual income amounts are based on 2014 federal poverty guidelines.
[2]Additional cost-sharing calculated assuming a two-parent household.

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Attachment 2 - 2014
Hardship Exception for Children of Texas Public Employees and Public Education Employees

Hardship Exception Threshold for Families at 200% FPL

	200% FPL	5% Limit
Family of 3	$39,580	$1,979
Family of 4	$47,700	$2,385
Family of 5	$55,820	$2,791
Family of 6	$63,940	$3,197

TEACHERS RETIREMENT SYSTEM OF TEXAS

2013-2014 Plan Year - Teachers Retirement System of Texas (TRS) PPO Premiums

	Plan 1		Plan 2		Plan 3	
	Children	Family	Children	Family	Children	Family
Monthly Premium	$572	$1,060	$841	$1,323	$1,269	$1,990
Minimum State Payment	$75	$75	$75	$75	$75	$75
Minimum School Payment	$150	$150	$150	$150	$150	$150
Monthly Premium Per Employee	$347	$835	$616	$1,098	$1,044	$1,765
Annual Premium Per Employee	$4,164	$10,020	$7,392	$13,176	$12,528	$21,180
Deductible	$4,800	$4,800	$3,000	$3,000	$0	$0
Total (Premium + Deductible)	**$8,964**	**$14,820**	**$10,392**	**$16,176**	**$12,528**	**$21,180**

2013-2014 Plan Year - TRS HMO Premiums

	HMO 1		HMO 2		HMO 3	
	Children	Family	Children	Family	Children	Family
Monthly Premium	$664	$1,049	$608	$960	$623	$995
Minimum State Payment	$75	$75	$75	$75	$75	$75
Minimum School Payment	$150	$150	$150	$150	$150	$150
Monthly Premium Per Employee	$439	$824	$383	$735	$398	$770
Annual Premium Per Employee	**$5,268**	**$9,882**	**$4,594**	**$8,822**	**$4,771**	**$9,238**

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Attachment 3 - 2013
Hardship Exception for Children of Texas Public Employees and Public Education Employees

Hardship Exception Threshold for Families at 200% FPL

	200% FPL	5% Limit
Family of 3	$39,060	$1,953
Family of 4	$47,100	$2,355
Family of 5	$55,140	$2,757
Family of 6	$63,180	$3,159

TEACHERS RETIREMENT SYSTEM OF TEXAS

2012-2013 Plan Year - Teachers Retirement System of Texas (TRS) PPO Premiums

	Plan 1		Plan 2		Plan 3	
	Children	Family	Children	Family	Children	Family
Monthly Premium	$466	$957	$731	$1,150	$1,015	$1,592
Minimum State Payment	$75	$75	$75	$75	$75	$75
Minimum School Payment	$150	$150	$150	$150	$150	$150
Monthly Premium Per Employee	$241	$732	$506	$925	$790	$1,367
Annual Premium Per Employee	$2,892	$8,784	$6,072	$11,100	$9,480	$16,404
Deductible	$2,400	$2,400	$2,250	$2,250	$0	$0
Total (Premium + Deductible)	**$5,292**	**$11,184**	**$8,322**	**$13,350**	**$9,480**	**$16,404**

2012-2013 Plan Year - TRS HMO Premiums

	HMO 1		HMO 2		HMO 3	
	Children	Family	Children	Family	Children	Family
Monthly Premium	$608	$971	$641	$997	$608	$960
Minimum State Payment	$75	$75	$75	$75	$75	$75
Minimum School Payment	$150	$150	$150	$150	$150	$150
Monthly Premium Per Employee	$383	$746	$416	$772	$383	$735
Annual Premium Per Employee	**$4,591**	**$8,948**	**$4,992**	**$9,264**	**$4,594**	**$8,822**

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EMPLOYEES RETIREMENT SYSTEM OF TEXAS

FY2013 Annual Premium for Employees Retirement System (ERS) HealthSelect Participants with Children - $2,162.88

Additional Annual Cost Sharing Amount per Client under ERS HealthSelect Cost Sharing Requirements

Cost Sharing Type	Amount
Additional Co-pay – Office Visits	$69.26
Additional Cost Sharing – Prescription Drugs	$180.41
Additional Cost Sharing – Inpatient Hospital	$26.45
Additional Cost Sharing – Outpatient Hospital	$30.74
Additional Cost Sharing – Emergency Visit	$71.03
Total additional annual cost sharing per client	$377.89

Note: Additional cost sharing amounts calculated based on determining Texas CHIP costs for each service category and adjusting these costs to reflect the difference in payment rates between CHIP and ERS HealthSelect. ERS HealthSelect co-insurance and co-payment requirements were then applied to this adjusted cost data and annual, per-client utilization data for the Texas CHIP population.

Annual ERS HealthSelect Premiums and Cost Sharing Compared to the Hardship Exception Threshold

	Annual Income – 200% FPL[1]	5% Limit	Annual HealthSelect Premiums + Additional Cost Sharing[2]
Family of 3	$39,060	$1,953	$2,541
Family of 4	$47,100	$2,355	$2,919
Family of 5	$55,140	$2,757	$3,297
Family of 6	$63,180	$3,159	$3,674

Notes:
[1]Annual income amounts are based on 2013 federal poverty guidelines.
[2]Additional cost-sharing calculated assuming a two-parent household.

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Attachment 4 - 2012
Hardship Exception for Children of Texas Public Employees and Public Education Employees

Hardship Exception Threshold for Families at 200% FPL

	200% FPL	5% Limit
Family of 3	$38,180	$1,909
Family of 4	$46,100	$2,305
Family of 5	$54,020	$2,701
Family of 6	$61,940	$3,097

TEACHERS RETIREMENT SYSTEM OF TEXAS

2011-2012 Plan Year - Teachers Retirement System of Texas (TRS) PPO Premiums

	Plan 1		Plan 2		Plan 3	
	Children	Family	Children	Family	Children	Family
Monthly Premium	$519	$817	$690	$1,085	$931	$1,461
Minimum State Payment	$75	$75	$75	$75	$75	$75
Minimum School Payment	$150	$150	$150	$150	$150	$150
Monthly Premium Per Employee	$294	$592	$465	$860	$706	$1,236
Annual Premium Per Employee	$3,528	$7,104	$5,580	$10,320	$8,472	$14,832
Deductible	$3,000	$3,000	$2,250	$2,250	$900	$900
Total (Premium + Deductible)	**$6,528**	**$10,104**	**$7,830**	**$12,570**	**$9,372**	**$15,732**

2011-2012 Plan Year - TRS HMO Premiums

	HMO 1		HMO 2		HMO 3	
	Children	Family	Children	Family	Children	Family
Monthly Premium	$586	$937	$624	$969	$590	$932
Minimum State Payment	$75	$75	$75	$75	$75	$75
Minimum School Payment	$150	$150	$150	$150	$150	$150
Monthly Premium Per Employee	$361	$712	$399	$744	$365	$707
Annual Premium Per Employee	**$4,336**	**$8,540**	**$4,787**	**$8,927**	**$4,384**	**$8,489**

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. **(Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))**

TX RESPONSE: Please see approved CS20 template.

4.4.4.1. ☐

Coverage provided to children in families at or below 200 percent FPL: describe the methods of monitoring substitution.

4.4.4.2. ☐ Coverage provided to children in families over 200 percent and up to 250 percent FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. ☐ Coverage provided to children in families above 250 percent FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. ☐ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

CHIP Eligibility

State Name: Texas

OMB Control Number: 0938-1148

Transmittal Number: TX - 14 - 0036

Expiration date: 10/31/2014

Separate Child Health Insurance Program
Non-Financial Eligibility - Substitution of Coverage **CS20**

Section 2102(b)(3)(C) of the SSA and 42 CFR 457.340(d)(3), 457.350(i), and 457.805

Substitution of Coverage

☑ The CHIP Agency provides assurance that it has methods and policies in place to prevent the substitution of group health coverage or other commercial health insurance with public funded coverage. These policies include:

■ Substitution of coverage prevention strategy:

	Name of policy	Description	
+	Waiting Period	The CHIP eligibility date begins 90 days after the last month in which the applicant was covered by a third party health benefits plan. The waiting period does not apply to the CHIP Perinatal program.	X

A waiting period during which an individual is ineligible due to having dropped group health coverage. Yes

How long is the waiting period?

- ○ One month
- ○ Two months
- ◉ 90 days
- ○ Other

■ The state allows exemptions from the waiting period for the following reasons:

- ■ The premium paid by the family for coverage of the child under the group health plan exceeded 5 percent of household income.
- ■ The child's parent is determined eligible for advance payment of the premium tax credit for enrollment in a QHP through the Marketplace because the ESI in which the family was enrolled is determined unaffordable in accordance with 26 CFR 1.36B–2(c)(3)(v).
- ■ The cost of family coverage that includes the child exceeded 9.5 percent of the household income.
- ■ The employer stopped offering coverage of dependents (or any coverage) under an employer-sponsored health insurance plan.
- ■ A change in employment, including involuntary separation, resulted in the child's loss of employer-sponsored insurance (other than through full payment of the premium by the parent under COBRA).
- ■ The child has special health care needs.
- ■ The child lost coverage due to the death or divorce of a parent.

Does the state allow other exemptions in addition to those listed above? Yes

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CHIP Eligibility

	Describe	
+	Termination of continuation coverage under COBRA where the termination is based upon the expiration of the period of coverage (usually 18 months).	X
+	Unborn children enrolled in the CHIP Perinatal Program are exempt from the waiting period.	X
+	The Health and Human Services Commission (HHSC) determines that good cause exists based on information provided by the applicant or information otherwise obtained by HHSC.	X
+	The child is no longer covered by the Texas Employee Retirement System.	X
+	The child loses CHIP eligibility from another state.	X
+	The child loses Medicaid eligibility.	X

■ Describe the processes the state employs to facilitate enrollment of CHIP-eligible children who have satisfied the waiting period.

The enrollment process, as outlined in Template CS24, Separate Child Health Insurance Program General Eligibility – Eligibility Processing, is the same regardless of whether a child is subject to the 90-day waiting period. If the child is subject to a waiting period, his or her eligibility begins upon completion of the 90-day waiting period.

■ Describe the processes the state employs to coordinate coverage of children subject to a waiting period with other insurance affordability programs, including safeguards to prevent gaps in coverage for children transitioning from another insurance affordability program to CHIP after satisfying the waiting period.

If a client is determined eligible for CHIP and is subject to the 90-day waiting period, the State transfers that individual's account information, including the CHIP eligibility effective date, to the federal Marketplace to be assessed for eligibility for other health care coverage programs. The transfer of the client's account information to the federal Marketplace allows the individual to access coverage during the 90-day waiting period and avoid sanctions for failing to acquire health coverage.

The state provides assurance that:

☑ It does not require a new application or the submission of information already provided by the family immediately preceding the waiting period for the purpose of enrolling CHIP-eligible children who have satisfied a waiting period.

☑ For children subject to the waiting period, it will promptly transfer each individual's electronic account to the applicable insurance affordability program and notify such program of the date on which the waiting period ends for each individual.

☑ If the state covers pregnant women, the waiting period does not apply to pregnant women.

If the state elects to offer dental only supplemental coverage, the following assurances apply:

☐ The other coverage exclusion does not apply to children who are otherwise eligible for dental only supplemental coverage as provided in section 2110(b)(5) of the SSA.

☐ The waiting period does not apply to children eligible for dental only supplemental coverage.

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4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: **(Section 2102(c)(1)) (42CFR 457.90)**

Historical Background

Outreach in the first two years of TexCare, which was the State's generic outreach campaign for Children's Medicaid and CHIP, focused on a statewide media/marketing campaign focused on a call-to-action to families to call the TexCare hotline or send in a written application; direct application assistance by TexCare's CBOs' outreach staff; and mass dissemination of information about the program. These strategies were appropriate for the "start-up" phase, as the challenge was to reach hundreds of thousands of unidentified families eligible for children's health insurance.

TexCare was designed to outreach on behalf of both Children's Medicaid and CHIP. However, because CHIP was a new and separately financed program that offered the first-ever opportunity of coverage to hundreds of thousands of families, much of the focus of state and local stakeholders has been on assuring the achievement of the ambitious CHIP "start-up" goal. Now that CHIP has been successfully launched, Texas is entering a new outreach phase that is dominated by the need to promote renewal and appropriate utilization of services. The Medicaid focus of the outreach effort has been sharpened with the implementation of SB 43, 77th Legislature, Regular Session, 2001, which is state legislation simplifying Children's Medicaid. This legislation benefits many families because it mandates that the application and enrollment process for Children's Medicaid-eligible families is as seamless, simple, and transparent as that enjoyed by CHIP-eligible families.

Texas' call-to-action outreach efforts in the first two years of the program have not stopped. In 2006, however, the TexCare logo was retired and replaced with CHIP/Children's Medicaid as the State integrated the applications for CHIP and Children's Medicaid into one application form. With the implementation of HB 109, 80th Legislature, Regular Session, 2007, the outreach focus shifted to include the permanent incorporation of CHIP/Children's Medicaid information in systems (e.g., schools, emergency rooms, provider offices, pharmacies) in the community and the perpetuation and appropriate utilization of existing coverage.

In all aspects of implementing CHIP/Children's Medicaid, Texas has learned from the experience of other states. A review of that experience suggests that a broadening of Texas' strategy was appropriate. By diversifying beyond mass information dissemination and direct application assistance, the program will benefit

from:

- increasing the efficiency of efforts to identify and target under-served populations;
- broadening and incorporating automatic information dissemination systems within organizations that have frequent contact with families;
- increasing the emphasis on all aspects of disease and disability prevention;
- communicating the fact that, through CHIP/Children's Medicaid, families can afford to keep their children healthy and protected in the event of illness; and
- emphasizing family maintenance of health care coverage and appropriate utilization of services.

Other states' experience also shows that the program and the enrolled children benefit when efforts are made to keep enrolled children in health care coverage when their first period of eligibility expires.

Based on this experience, the State adopted the following goals for the next phase of outreach for CHIP/Children's Medicaid:

- a long-term, integrated communication plan that includes coordinated community-based and statewide initiatives;
- an appropriate level of call-to-action through broad appeals and mass communications to reach eligible families;
- mass media messages and activities by CHIP/Children's Medicaid contracted CBOs and health plans shifting primary emphasis from a call-to-action to the idea that through CHIP/Children's Medicaid, families can afford to keep their children healthy and protected in the event of illness;
- increased emphasis on activities by CHIP/Children's Medicaid CBOs and stakeholders to place CHIP/Children's Medicaid information in the hands of families at times and places in which they are likely to be motivated by and interested in the information;
- activities by CHIP/Children's Medicaid CBOs and stakeholders to work within organizations that have regular contact with families (e.g. emergency rooms, provider offices, pharmacies, schools) to set in place automatic and recurring "systems" to inform families and help them apply for health care coverage through CHIP/Children's Medicaid; and
- continued activities to support enrollee families in successfully completing their annual renewal process, involving health plans, the administrative services contractor, and CHIP/Children's Medicaid CBOs.

Outreach has become more strategic in nature as Texas has sought to work with entities in all sectors of the community to broaden and institutionalize the message to include the value of insurance, the importance of renewal, and education on appropriate utilization of services.

Outreach strategies will result in the identification of non-Medicaid eligible pregnant women whose unborn children may be eligible for this program.

Based on previous experience, the State will develop:

- a long-term, integrated communication plan that includes coordinated community-based and statewide initiatives;
- an appropriate level of call-to-action through broad appeals;
- increased emphasis on activities by CBOs and stakeholders to place information in the hands of women at times and places in which they are likely to be motivated by and interested in the information; and
- activities by CBOs and stakeholders to work within organizations that have regular contact with pregnant women such as provider offices.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42CFR 457.410(a))**

6.1.1. ☐ Benchmark coverage; **(Section 2103(a)(1) and 42 CFR 457.420)**

6.1.1.1. ☐ FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)

6.1.1.2. ☐ State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ☐ HMO with largest insured commercial enrollment **(Section 2103(b)(3))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2 ☐ Benchmark-equivalent coverage; **(Section 2103(a)(2) and 42 CFR 457.430)** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431**. See instructions.**

6.1.3. ☐ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If an existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for an existing comprehensive state-based coverage.

6.1.4. ☒ Secretary-Approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**

6.1.4.1. ☐ Coverage the same as Medicaid State plan

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. ☒ Other (Describe) The state elects to provide a basic set of health care benefits that are focused on primary health care needs and that contain the cost of the benefit package. Specific covered services are described in Section 6.2 below.

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a)) (42CFR 457.490)**

6.2.1. ☒ Inpatient services **(Section 2110(a)(1))**

Covered, medically necessary inpatient services are unlimited and include, but are not limited to: Semi-private room and board (or private if medically necessary as certified by attending); general nursing care; ICU and services; patient meals and special diets; operating, recovery and other treatment rooms; anesthesia and administration (facility technical component); surgical dressings, trays, casts, splints, drugs, medications and biologicals; X-rays, imaging and other radiological tests (facility technical component); laboratory and pathology services (facility technical component); machine diagnostic tests (EEGs, EKGs, etc); oxygen services and inhalation therapy; radiation and chemotherapy; access to DSHS-designated Level III perinatal centers or hospitals meeting equivalent levels of care; hospital-provided physician services (facility technical component); and, in-network or out-of-network facility and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.

Exclusions and Limitations include: Infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system; personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone,

television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment of sickness or injury; experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community; treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court; custodial care; mechanical organ replacement devices, including, but not limited to artificial heart; private duty nursing services when performed on an inpatient basis; and, hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by the Health Plan.

The health plan may require prior authorization for: non-emergency care and following stabilization of an emergency condition; and, for in-network or out-of-network facility and physician services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by caesarian section.

CHIP Perinatal Program:

- Inpatient facility services are not a covered benefit for unborn children at or below 198 percent of the Federal Poverty Level (FPL). Once the child is born, they will receive full CHIP benefits.
- Covered medically necessary inpatient services are limited to labor and delivery until birth for unborn children.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

6.2.2. ☒ Outpatient services **(Section 2110(a)(2))**

Covered, medically necessary outpatient services are unlimited and include, but are not limited to, the following services provided in a hospital clinic, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: X-ray, imaging, and radiological tests (technical component); laboratory and pathology services (technical component); machine diagnostic tests; ambulatory surgical facility services; drugs, medications and biologicals; casts, splints, dressings; preventive health services; physical occupational and speech therapy; renal dialysis; respiratory services; radiation and chemotherapy; and blood or blood products (if not provided free-of-charge to the patient) and the administration of these products.

Exclusions and Limitations include: The health plan may require prior authorization and physician prescription for outpatient services.

CHIP Perinatal Program:

- Covered, medically necessary outpatient services for the unborn child are limited to those outpatient services that directly relate to prenatal or postpartum care and/or the delivery of the covered unborn child until birth.
- Outpatient observation is a covered benefit under the CHIP Perinatal Program.
- Ultrasound of the pregnant uterus is a covered benefit of the CHIP Perinatal Program when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age confirmation.
- Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentrsis, and FIUT are covered benefits of the CHIP Perinatal Program with an appropriate diagnosis.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

6.2.3. ☒ Physician services **(Section 2110(a)(3))**

Covered, medically necessary physician and physician extender services are unlimited and include, but are not limited to, the following: American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations); physician office visits; inpatient and outpatient services; laboratory, x-rays, imaging and pathology services and professional interpretation; medications, biologicals and materials administered in the physician's office; allergy testing, serum and injections; (in/outpatient) surgical services, including surgeons for surgical procedures including appropriate follow-up care, administration of anesthesia by physician (other than surgeon) or CRNA, second surgical opinions, same-day surgery performed in a hospital without an over-night stay; invasive diagnostic procedures such as endoscopic examination; hospital-based physician services (including physician-performed technical and interpretative components); and, in-network and out-of-network physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.

Exclusions to physician services include: infertility treatments, prostate and mammography screening; reproductive services other than prenatal care, labor and delivery, and care related to diseases, illnesses, or abnormalities related to the reproductive system; elective surgery to correct vision; gastric procedures for weight loss; cosmetic

surgery/services solely for cosmetic purposes; cut-of-network services not authorized by the Health Plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section; services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan; acupuncture services, naturopathy and hypnotherapy; immunizations solely for foreign travel; routine foot care such as hygienic care; and diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails).

The Health Plan may require prior authorization for specialty physician services.

CHIP Perinatal Program:

- Covered, medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.
- Ultrasound of the pregnant uterus is a covered benefit of the CHIP Perinatal Program when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age conformation.
- Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentrsis, and FIUT are covered benefits of the CHIP Perinatal Program with an appropriate diagnosis.

6.2.4. ☒ Surgical services **(Section 2110(a)(4)).**
Covered, unlimited medically necessary surgical services, and limitations and exclusions to surgical services are described under inpatient, outpatient, and physician services.

CHIP Perinatal Program:

- Covered, medically necessary surgical services for the unborn child are limited to services that directly relate to the delivery of the unborn child enrolled in the program until birth.
- Coverage for the CHIP Perinatal newborn is the same as

coverage for traditional CHIP clients.

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5))**
Covered, unlimited medically necessary clinic services (including health center services) and other ambulatory health care services, and limitations and exclusions to these services are described under outpatient services.

CHIP Perinatal Program:

- Covered, medically necessary clinic services for the unborn child are limited to prenatal and postpartum care and/or the delivery of the unborn child until birth.
- Ultrasound of the pregnant uterus is a covered benefit of the CHIP Perinatal Program when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age conformation.
- Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentrsis, and FIUT are covered benefits of the CHIP Perinatal Program with an appropriate diagnosis.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

6.2.6. ☒ Prescription drugs **(Section 2110(a)(6))**
Open formulary based on the Texas Medicaid Program open formulary. Covered, unlimited medically necessary prescription drugs include non-experimental, FDA-approved physician-prescribed drugs that are prescribed for the medical treatment of illness or injuries.

Exclusions include: contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care, and medications for weight loss or gain.

The state will require prior authorization for selected drugs. The state will also implement a preferred drug list (with provisions for medically necessary exceptions) and may establish a four-prescription limit on brand name drugs and a thirty-four day supply limit, if determined to be cost effective. Medically necessary exceptions will also apply to both of these limits.

CHIP Perinatal Program:

- Covered medically necessary prescription and injection drugs

are a covered benefit for the unborn child.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

6.2.7. ☐ Over-the-counter medications **(Section 2110(a)(7))**

6.2.8. ☒ Laboratory and radiological services **(Section 2110(a)(8))**
Covered, unlimited, medically necessary laboratory and radiological services, and limitations and exclusions to laboratory and radiological services are described under inpatient, outpatient, and physician services.

CHIP Perinatal Program:
- Covered, medically necessary laboratory and radiological services for the unborn child are limited to services that directly relate to antepartum care and/or the delivery of the covered unborn child until birth.
- Ultrasound of the pregnant uterus is a covered benefit of the CHIP Perinatal Program when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age conformation.
- Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits of the CHIP Perinatal Program with an appropriate diagnosis.
- Laboratory tests for the unborn child are limited to: nonstress testing, contraction stress testing, hemoglobin or hematocrit, or complete blood count (CBC), urinanalysis, blood type and Rh antibody screen, rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks).
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

6.2.9. ☒ Prenatal care and prepregnancy family services and supplies **(Section 2110(a)(9))**
Covered, unlimited prenatal care and medically necessary care related to diseases, illnesses, or abnormalities related to the reproductive

system, and limitations and exclusions to these services are described under inpatient, outpatient, and physician services.

Primary and preventive health benefits do not include pre-pregnancy family reproductive services and supplies, or prescription medications prescribed only for the purpose of primary and preventive reproductive health care.

CHIP Perinatal Program:

- Prenatal care and prepregnancy family services and supplies are limited to an initial visit and subsequent prenatal (antepartum) care visits that include: one visit every four weeks for the first 28 weeks of pregnancy; one visit every two to three weeks from 28 to 36 weeks of pregnancy; and one visit per week from 36 weeks to delivery. More frequent visits are allowed as medically necessary.
- Limit of 20 prenatal visits and two postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk obstetrical visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review.
- Subsequent visits must include: interim history (problems, marital status, fetal status), physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) and laboratory tests (urinanalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16 to 20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24 to 28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18, but including services furnished in a state-operated facility and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**

Covered, medically necessary inpatient mental health services include, but are not limited to, mental health services furnished in a

free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, as well as neuropsychological and psychological testing.

When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities, the court order serves as a binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.

Prior authorization may be required for non-emergency inpatient mental health services; however, PCP referral is not required.

CHIP Perinatal Program:

- Inpatient mental health services are not a covered benefit for the unborn child.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated facility and including community-based services. **(Section 2110(a)(11)**
Covered, medically necessary outpatient mental health services include, but are not limited to, mental health services provided on an outpatient basis, neuropsychological and psychological testing, medication management, rehabilitative day treatments, residential treatment services, sub-acute outpatient services (partial hospitalization or rehabilitative day treatment), and skills training (psycho-educational skills development).

When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities, the court order serves as a binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.

The visits can be furnished in a variety of community-based settings (including school and home-based settings) or in a state-operated facility.

Prior authorization may be required for outpatient mental health

services; however, these services do not require PCP referral.

CHIP Perinatal Program:

- Outpatient mental health benefits are not a covered benefit for the unborn child.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

6.2.12. ☒ Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**
Covered services includes durable medical equipment (DME) (equipment which can withstand repeated use, and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness, injury or disability, and is appropriate for use in the home), and other medically-related or remedial devices that are medically necessary and necessary for one or more activities of daily living, and appropriate to assist in the treatment of a medical condition. These devices include, but are not limited to: orthotic braces and orthotics; prosthetic devices such as artificial eyes, limbs and braces; prosthetic eyeglasses and contact lenses for the management of severe opthomological disease; hearing aids; other artificial aides including surgical implants.

DME and other medically related or remedial devices are for a 12-month coverage period. Limitations include: $20,000 per 12-month coverage period limit for DME, prosthetics, devices, and disposable medical supplies (implantable devices and diabetic supplies and equipment are not counted against this cap).

Exclusions include: Replacement or repair of prosthetic devices and DME due to misuse, abuse, or loss when confirmed by the member or the vendor; corrective orthopedic shoes; convenience items; diagnosis and treatment of flat feet; routine refractory services and glasses/contacts; and orthotics primarily used for athletic or recreational purposes.

The health plan may require prior authorization and physician prescription.

CHIP Perinatal Program:

- DME or other medically related remedial devices are not a covered benefit for the unborn child.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

6.2.13. ☒ Disposable medical supplies **(Section 2110(a)(13))**

Covered benefits include diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formulas and dietary supplements. However, coverage is limited to formulas prescribed for chronic hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 days when prescribed by the physician and authorized by the Health Plan) are covered.

Limitations and exclusions: Disposable medical supplies are included under the $20,000 limit per term of coverage Durable Medical Equipment cap; however, diabetic supplies and equipment are exempted from this cap.

CHIP Perinatal Program

- Disposable medical supplies are not a covered benefit for the unborn child.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

6.2.14. ☒ Home and community-based health care services (See instructions) **(Section 2110(a)(14))**

Covered, medically necessary home and community-based health care services include, but are not limited to: Speech, physical, and occupational therapy; home infusion; respiratory therapy; skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.); home health aide services, when provided under the supervision of a R.N. and included as part of a plan of care during a period that skilled visits have been approved.

Limitations and exclusions to home and community-based health care services are: Excludes custodial care that assists a child with the activities of daily living and does not require the continuing attention of trained medical or paramedical personnel; excludes services intended to replace the child's caretaker or to provide relief for the caretaker; skilled nursing visits are provided on an intermittent level and are not intended to provide 24-hour skilled nursing services; services are for blocks of time and are not intended to replace 24-hour inpatient or skilled nursing facility services; excludes housekeeping services; excludes public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities; excludes services or supplies received from a nurse, which do not require the skill and training of a nurse.

The health plan may require prior authorization and physician prescription.

CHIP Perinatal Program:

- Home and community-based health care services are not a covered benefit for the unborn child.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

6.2.15. ☒ Nursing care services (See instructions) **(Section 2110(a)(15))**
Covered, unlimited medically necessary nursing care services include home visits for private duty nursing (R.N., L.V.N., block of time)

The health plan may require prior authorization and physician prescription.

CHIP Perinatal Program:

- Nursing care services are not a covered benefit for the unborn child.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

6.2.16. ☐ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**

6.2.17. ☒ Dental services **(Section 2110(a)(17))**
The state will provide dental coverage to children through one of the following (Section 2103(a)(5)):

6.2.17.1 ☒ State Dental Benefit Package. The State assures coverage of dental services from each of the following categories:

1. Diagnostic (must follow periodicity schedule);
2. Preventive (must follow periodicity schedule);
3. Restorative;
4. Endodontic;
5. Periodontic;
6. Prosthodontic;
7. Oral and Maxillofacial;
8. Orthodontics; and
9. Emergency Dental Services.

Covered services are subject to dental necessity requirements and include: oral evaluations, routine checkups, x-rays, cleanings, topical fluoride, sealants, space maintainers, fillings, crowns/caps,

pulpotomy/pulpectomy, root canals, gingivectomy/gingivoplasty, periodontal scaling, debridement, dentures, extractions, surgical extractions, orthodontic services (limited to pre- and post-surgical orthodontic services to treat craniofacial anomalies requiring surgical intervention), and emergency dental services.

The dental benefit covers up to $564 annually per CHIP member. Limitations to dental services are limited to a 12-month coverage period. Emergency dental services are not subject to the dental benefit limit and do not count toward a CHIP member's benefit limit.

Exceptions to the $564 annual benefit maximum are:

(1) the preventative services identified in the 2009 American Academy of Pediatric Dentistry periodicity schedule (Volume 32, Issue Number 6, at pp. 93-100); and

(2) other medically necessary services approved through a prior authorization process. These services must be necessary to allow a plan member to return to normal, pain and infection-free oral functioning. Typically this includes:

- Services related to the relief of significant pain or to eliminate acute infection;
- Services related to treat traumatic clinical conditions;
- Services that allow a patient to attain the basic human functions (e.g. eating, speech, etc.); and
- Services that prevent a condition from seriously jeopardizing one's health/functioning or deteriorating in an imminent timeframe to a more serious and costly dental problem.

CHIP Perinatal Program:

- Dental services are not a covered benefit for the unborn child.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

6.2.17.1.1 Periodicity Schedule. Please select and include a description.

☐ Medicaid

☒ American Academy of Pediatric Dentistry recommendations for age appropriate dental care including but not limited to: clinical oral evaluations, cleanings and topical fluoride treatment, x-rays, caries-risk assessment, sealants,

and treatment for dental disease and injury.

☐ Other Nationally recognized periodicity schedule: (Please Specify)_____

6.2.17.2. ☐ Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410 and 42 CFR 457.420) States must, in accordance with 42 CFR 457.410, provide coverage for dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions if these services are not provided in the chosen benchmark package.

6.2.17.3. ☐ FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach a copy of the dental supplemental plan benefits description and the applicable CDT codes. If the necessary dental services are not provided, please also include a description of, and the CDT code(s) for, the required service(s).)

6.2.17.4. ☐ State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the necessary dental services are not provided, please also include a description of, and the CDT code(s) for, the required service(s).)

6.2.17.5. ☐ HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the necessary dental services are not provided, please also include a description of, and the CDT code(s) for, the required service(s).)

6.2.18. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**
Covered, medically necessary services include, but are not limited to: inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs.

Prior authorization may be required for nonemergency services; however, PCP referral is not required.

CHIP Perinatal Program:

- Inpatient substance abuse treatment services and residential substance abuse treatment services are not a covered benefit for the unborn child.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

6.2.19. ☒ Outpatient substance abuse treatment services **(Section 2110(a)(19))**
Medically necessary outpatient substance abuse treatment services include, but are not limited to, prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment, and referral for chemical dependency disorders; intensive outpatient services; and partial hospitalization.

Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day. Outpatient treatment services is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training.

These services do not require a PCP referral, but prior authorization may be required.

CHIP Perinatal Program:

- Outpatient substance abuse treatment services and residential substance abuse treatment services are not a covered benefit for the unborn child.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

6.2.20. ☒ Case management services **(Section 2110(a)(20))**
Medically necessary case management services above and beyond those normally provided to all members are covered for Children with Complex Special Health Care Needs. These covered services include outreach, informing, intensive case management, care coordination and community referral.

State-certified Community Health Workers, also known as promotora(s), are utilized in target areas to focus education to under-served populations. The program aims to bridge social, economic and cultural gaps to provide information about effective utilization of CHIP and preventive care to enrolled families. Delivery of Community Health Worker training and services are designed to improve preventive care in CHIP.

CHIP Perinatal Program:

- Case management services are a covered benefit for the unborn child.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

6.2.21. ☒ Care coordination services **(Section 2110(a)(21))**

CHIP Perinatal Program:

- Care coordination services are a covered benefit for the unborn child.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**
Covered, medically necessary habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to physical, occupational, and speech therapy and developmental assessment.

Reimbursement for school-based services is not covered, except for therapy services ordered by the PCP.

The health plan may require authorization and physician prescription.

CHIP Perinatal Program:

- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders are not a covered benefit for the unborn child.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

6.2.23. ☒ Hospice Care **(Section 2110 (a) (23))**
Covered, medically necessary hospice services include, but are not limited to, palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death. Treatment for unrelated conditions is unaffected.

Hospice care services are for a six-month coverage period. Limitations include: Services apply only to the hospice diagnosis; limited to a maximum of 120 days with a six-month life expectancy; and, patients electing hospice may cancel this election at any time.

The health plan may require authorization and physician prescription.

CHIP Perinatal Program:

- Hospice care is not a covered benefit for the unborn child.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

6.2.24. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**

Skilled Nursing Facility (including Rehabilitation Hospital) Services
Covered, medically necessary skilled nursing facility and rehabilitation hospital services include, but are not limited to, semi-private room and board; regular nursing services; rehabilitation services; and medical supplies and use of appliances and equipment furnished by the facility. Skilled nursing facility services are for a 12-month coverage period. Coverage is limited to 60 days per 12-month coverage period. Private duty nurses, television and custodial care are excluded. The health plan may require authorization and physician prescription.

CHIP Perinatal Program:

- Skilled nursing facility and rehabilitation hospital services are not covered a benefit for the unborn child.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

Emergency Services including Emergency Hospitals and Physician
Covered, medically necessary services include:
emergency services based on prudent layperson definition of emergency health condition; hospital emergency department room and ancillary services and physician services 24 hours a day, seven days a week, both by in-network and out-of-network providers; medical screening examination; stabilization services; emergency dental coverage for a dislocated jaw, traumatic damage to teeth, removal of cysts, and treatment of oral abscess of tooth or gum origin; and access to designated Level I and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services. The health plan cannot require authorization as a condition for

payment for emergency conditions or labor and delivery; however, the health plan may require authorization for post-stabilization services.

CHIP Perinatal Program:

- Covered, medically necessary emergency services for the unborn child are limited to those emergency services that directly relate to the delivery of the unborn child until birth.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.
- Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinatal newborn are not a covered benefit.

Vision Services

Covered, medically necessary services include: one examination of the eyes to determine the need for, and prescription for, corrective lenses per 12-month coverage period, without health plan authorization; and one pair of non-prosthetic eyewear per 12-month coverage period. Vision services are for a 12-month coverage period. The health plan may reasonably limit the cost of frames/lenses. The health plan may require authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye. Vision training and vision therapy are excluded.

CHIP Perinatal Program:

- Vision services are not a covered benefit for the unborn child.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

Transplant Services

Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses are covered, if medically necessary. Donor non-medical expenses are not covered. The health plan may require prior authorization.

CHIP Perinatal Program:

- Transplant services are not a covered benefit for the unborn child.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

Tobacco Cessation Programs
A health plan-approved tobacco cessation program is covered up to a $100 limit per 12-month coverage period. Tobacco cessation program services are for a 12-month coverage period. The health plan may require prior authorization and use of a formulary.

CHIP Perinatal Program:

- Tobacco cessation programs are not a covered benefit for the unborn child.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

Chiropractic Services
Medically necessary services are limited to spinal sublaxation. Chiropractic services do not require physician prescription and are for a 12-month coverage period. These services are limited to 12 visits per 12-month coverage period (regardless of number of services or modalities provided in one visit). The health plan may require authorization for additional visits.

CHIP Perinatal Program:

- Chiropractic services are not a covered benefit for the unborn child.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

6.2.25. ☐ Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.26. ☒ Medical transportation **(Section 2110(a)(26))**
Emergency ground, air, or water transportation is a covered service.

CHIP Perinatal Program:

- Medical transportation is not a covered benefit for the unborn child.
- Ambulance services for labor and threatened labor are a covered benefit for the unborn child.
- Coverage for the CHIP Perinatal newborn is the same as coverage for traditional CHIP clients.

6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

6.2.28. ☒ Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**

Effective March 11, 2021 and through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act, and for all populations covered in the CHIP state child health plan:

COVID-19 Vaccine:

- The state provides coverage of COVID-19 vaccines and their administration, in accordance with the requirements of section 2103(c)(11)(A) of the Act.

COVID-19 Testing:

- The state provides coverage of COVID-19 testing, in accordance with the requirements of section 2103(c)(11)(B) of the Act.
- The state assures that coverage of COVID-19 testing is consistent with the Centers for Disease Control and Prevention (CDC) definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.
- The state assures that coverage includes all types of FDA authorized COVID-19 tests.

COVID-19 Treatment:

- The state assures that the following coverage of treatments for COVID-19 are provided without amount, duration, or scope limitations, in accordance with requirements of section 2103(c)(11)(B) of the Act:
    - The state provides coverage of treatments for COVID-19 including specialized equipment and therapies (including preventive therapies);
    - The state provides coverage of any non-pharmacological item or service described in section 2110(a) of the Act, that is medically necessary for treatment of COVID-19; and
    - The state provides coverage of any drug or biological that is approved (or licensed) by the U.S. Food & Drug Administration (FDA) or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, consistent with the applicable authorizations.

Coverage for a Condition That May Seriously Complicate the Treatment of COVID-19:

- The state provides coverage for treatment of a condition that may seriously complicate COVID-19 treatment without amount, duration, or scope limitations, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19, in accordance with the requirements of section 2103(c)(11)(B) of the Act.

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: **(42CFR 457.480)**

6.3.1. ☒ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii))**; **OR**

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: *Previously 8.6*

6.4 **Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: **(Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)**

6.4.1. ☐ **Cost Effective Coverage.** Payment may be made to a state in excess of the 10% on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following **(42CFR 457.1005(a))**:

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. **(Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above. Describe the cost of such coverage on an average per child basis. **(Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security

Act. Describe the community-based delivery system. **(Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

6.4.2. ☐ **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) **(Section 2105(c)(3)(A)) (42CFR 457.1010(a))**

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B)) (42CFR 457.1010(b))**

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. **(42CFR 457.1010(c))**

6.2- MHPAEA Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS's contract review process at 42 CFR 457.1201(l).

6.2.1- MHPAEA Before completing a parity analysis, the State must determine whether each covered benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice. (42 CFR 457.496(f)(1)(i))

6.2.1.1- MHPAEA Please choose the standard(s) the state uses to determine whether a covered benefit is a medical/surgical benefit, mental health benefit, or substance use disorder benefit. The most current version of the standard elected must be used. If different standards are used for different benefit types, please specify the benefit type(s) to which each standard is applied. If "Other" is selected, please provide a description of that standard.

☒ International Classification of Disease (ICD)

☐ Diagnostic and Statistical Manual of Mental Disorders (DSM)

☐ State guidelines (Describe:)

☐ Other (Describe:)

6.2.1.2- MHPAEA Does the State provide mental health and/or substance use disorder benefits?

☒ Yes

☐ No

Guidance: If the State does not provide any mental health or substance use disorder benefits, the mental health parity requirements do not apply ((42 CFR 457.496(f)(1)). Continue on to Section 6.3.

6.2.2- MHPAEA Section 2103(c)(6)(B) of the Social Security Act (the Act) provides that to the extent a State child health plan includes coverage of early and periodic screening, diagnostic, and treatment services (EPSDT) defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the plan shall be deemed to satisfy the parity requirements of section 2103(c)(6)(A) of the Act.

6.2.2.1- MHPAEA Does the State child health plan provide coverage of EPSDT? The State must provide for coverage of EPSDT benefits, consistent with Medicaid statutory requirements, as indicated in section 6.2.26 of the State child health plan in order to answer "yes."

☐ Yes

☒ No

Guidance: If the State child health plan *does not* provide EPSDT consistent with Medicaid statutory requirements at sections 1902(a)(43) and 1905(r) of the Act, please go to Section 6.2.3- MHPAEA to complete the required parity analysis of the State child health plan.

If the state *does* provide EPSDT benefits consistent with Medicaid requirements, please continue this section to demonstrate compliance with the statutory requirements of section 2103(c)(6)(B) of the Act and the mental health parity regulations of 42 CFR 457.496(b) related to deemed compliance. Please provide supporting documentation, such as contract language, provider manuals, and/or member handbooks describing the state's provision of EPSDT.

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

☐ All children covered under the State child health plan.

☐ A subset of children covered under the State child health plan.

Please describe the different populations (if applicable) covered under the State child health plan that are provided EPSDT benefits consistent with Medicaid statutory requirements.

Guidance: If only a subset of children are provided EPSDT benefits under the State child health plan, 42 CFR 457.496(b)(3) limits deemed compliance to those children only and Section 6.2.3- MHPAEA must be completed as well as the required parity analysis for the other children.

6.2.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (42 CFR 457.496(b)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

☐ All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of suspected illness or conditions. (Section 1905(r))

☐ All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan. (Section 1905(r))

☐ All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan. (Section 1905(r)(5))

☐ Treatment limitations applied to services provided under the EPSDT benefit are not limited based on a monetary cap or budgetary constraints and may be exceeded as medically necessary to correct or ameliorate a medical or physical condition or illness. (Section 1905(r)(5))

☐ Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner that does not preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness. (Section 1905(r)(5))

☐ EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis. (Section 1905(r)(5))

☐ The provision of all requested EPSDT screening services, as well as any corrective treatments needed based on those screening services, are provided or arranged for as necessary. (Section 1902(a)(43))

☐ All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them. (Section 1902(a)(43)(A))

Guidance: For states seeking deemed compliance for their entire State child health plan population, please continue to Section 6.3. If not all of the covered populations are offered EPSDT, the State must conduct a parity analysis of the benefit packages provided to those populations. Please continue to 6.2.3- MHPAEA.

Mental Health Parity Analysis Requirements for States Not Providing EPSDT to All Covered Populations

Guidance: The State must complete a parity analysis for each population under the State child health plan that is not provided the EPSDT benefit consistent with the requirements 42 CFR 457.496(b). If the State provides benefits or limitations that vary within the child or pregnant woman populations, states should perform a parity analysis for each of the benefit packages. For example, if different financial

requirements are applied according to a beneficiary's income, a separate parity analysis is needed for the benefit package provided at each income level.

Please ensure that changes made to benefit limitations under the State child health plan as a result of the parity analysis are also made in Section 6.2.

6.2.3- MHPAEA In order to conduct the parity analysis, the State must place all medical/surgical and mental health and substance use disorder benefits covered under the State child health plan into one of four classifications: Inpatient, outpatient, emergency care, and prescription drugs. (42 CFR 457.496(d)(2)(ii); 42 CFR 457.496(d)(3)(ii)(B))

To determine which benefits belonged in each of the classifications, or whether it belonged in more than one classification, Texas considered how the benefit would be claimed and the setting(s) in which the benefit would be delivered. Some benefits, because they can be delivered in multiple settings, were placed in more than one classification. Texas used the CHIP benefits detailed in state managed care contracts, which list out the benefit categories CHIP MCOs must provide, to guide the classification process. For example, benefits were placed in the inpatient classification if the managed care contracts explicitly identified the benefit as an inpatient benefit. The inpatient services are those known to be delivered in an inpatient setting (such as a hospital), billed on an inpatient claim, or billed as a diagnosis-related group.

Outpatient benefits are those that are specifically identified as outpatient in the managed care contracts, billed using an outpatient claim, or known to be delivered in an outpatient setting such as an office or home. Emergency services represent services delivered in an emergency department, emergency ambulance transport, or psychiatric crisis stabilization services.

The pharmacy classification consists of all prescription drugs available through a CHIP-enrolled pharmacy and included on the Texas Drug Code Index 9 (the state-administered formulary). Clinician-administered drugs, because they are delivered in an outpatient setting, were classified as outpatient benefits. In the CHIP benefit package, the state's CHIP program provides both mental health and substance use disorder (MH/SUD) benefits and medical/surgical in all four classifications.

6.2.3.1 MHPAEA Please describe below the standard(s) used to place covered benefits into one of the four classifications.

6.2.3.1.1 MHPAEA The State assures that:

☒ The State has classified all benefits covered under the State plan into one of the four classifications.

☒ The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

6.2.3.1.2- MHPAEA Does the State use sub-classifications to distinguish between office visits and other outpatient services?

☐ Yes

☒ No

6.2.3.1.2.1- MHPAEA If the State uses sub-classifications to distinguish between outpatient office visits and other outpatient services, the State assures the following:

☐ The sub-classifications are only used to distinguish office visits from other outpatient items and services, and are not used to distinguish between similar services on other bases (ex: generalist vs. specialist visits).

Guidance: For purposes of this section, any reference to "classification(s)" includes sub-classification(s) in states using sub-classifications to distinguish between outpatient office visits from other outpatient services.

6.2.3.2 MHPAEA The State assures that:

☒ Mental health/ substance use disorder benefits are provided in all classifications in which medical/surgical benefits are provided under the State child health plan.

Guidance: States are not required to cover mental health or substance use disorder benefits (42 CFR 457.496(f)(2)). However if a state does provide any mental health or substance use disorder benefits, those mental health or substance use disorder benefits must be provided in all the same classifications in which medical/surgical benefits are covered under the State child health plan (42 CFR 457.496(d)(2)(ii).

Annual and Aggregate Lifetime Dollar Limits

6.2.4- MHPAEA A State that provides both medical/surgical benefits and mental health and/or substance use disorder benefits must comply with parity requirements related to annual and aggregate lifetime dollar limits for benefits covered under the State child health plan. (42 CFR 457.496(c))

6.2.4.1- MHPAEA Please indicate whether the State applies an aggregate lifetime dollar limit and/or an annual dollar limit on any mental health or substance abuse disorder benefits covered under the State child health plan.

☐ Aggregate lifetime dollar limit is applied

☐ Aggregate annual dollar limit is applied

☒ No dollar limit is applied

Guidance: A monetary coverage limit that applies to *all* CHIP services provided under the State child health plan is not subject to parity requirements.

If there are no aggregate lifetime or annual dollar limits on any mental health or substance use disorder benefits, please go to section 6.2.5- MHPAEA.

6.2.4.2- MHPAEA Are there any medical/surgical benefits covered under the State child health plan that

have either an aggregate lifetime dollar limit or an annual dollar limit? If yes, please specify what type of limits apply.

☒ Yes (Type(s) of limit: There is a $20,000 annual dollar limit (12-month limit) for durable medical equipment, prosthetic devices, and disposable medical supplies (diabetic supplies and equipment are not counted against this cap).

Tobacco cessation is covered up to $100 for a 12-month period limit for a health-plan approved program.

☐ No

Guidance: If no aggregate lifetime dollar limit is applied to medical/ surgical benefits, the State may not impose an aggregate lifetime dollar limit on *any* mental health or substance use disorder benefits. If no aggregate annual dollar limit is applied to medical/surgical benefits, the State may not impose an aggregate annual dollar limit on *any* mental health or substance use disorder benefits. (42 CFR 457.496(c)(1))

6.2.4.3 – MHPAEA. States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (42 CFR 457.496(c)). The portion of medical/surgical benefits subject to the limit is based on the dollar amount expected to be paid for all medical/surgical benefits under the State plan for the State plan year or portion of the plan year after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar limits. (42 CFR 457.496(c)(3))

The State assures that it has developed a reasonable methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable.

Texas does not have an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits.

Guidance: Please include the state's methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit and the results as an attachment to the State child health plan.

6.2.4.3.1- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to a lifetime dollar limit:

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

6.2.4.3.2- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits

covered under the State plan which are subject to an annual dollar limit:

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

Guidance: If an aggregate lifetime limit is applied to less than one-third of all medical/surgical benefits, the State may not impose an aggregate lifetime limit on *any* mental health or substance use disorder benefits. If an annual dollar limit is applied to less than one-third of all medical surgical benefits, the State may not impose an annual dollar limit on *any* mental health or substance use disorder benefits (42 CFR 457.496(c)(1)). Skip to section 6.2.5-MHPAEA.

If the State applies an aggregate lifetime or annual dollar limit to at least one-third of all medical/surgical benefits, please continue below to provide the assurances related to the determination of the portion of total costs for medical/surgical benefits that are subject to either an annual or lifetime limit.

6.2.4.3.2.1- MHPAEA If the State applies an aggregate lifetime or annual dollar limit to at least 1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (42 CFR 457.496(c)(4)(i)(B)); (42 CFR 457.496(c)(4)(ii)):

☐ The State applies an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits.

Guidance: The state's methodology for calculating the average limit for medical/surgical benefits must be consistent with 42 CFR 457.496(c)(4)(i)(B) and 42 CFR 457.496(c)(4)(ii). Please include the state's methodology and results as an attachment to the State child health plan.

6.2.4.3.2.2- MHPAEA If at least 2/3 of all medical/surgical benefits are subject to an annual or lifetime limit, the State assures either of the following (42 CFR 457.496(c)(2)(i)); (42 CFR 457.496(c)(2)(ii)):

☐ The aggregate lifetime or annual dollar limit is applied to both medical/surgical benefits and mental health and substance use disorder benefits in a manner that does not distinguish between medical/surgical benefits and mental health and substance use disorder benefits; or

☐ The aggregate lifetime or annual dollar limit placed on mental health and substance use disorder benefits is no more restrictive than the aggregate lifetime or annual dollar limit on medical/surgical benefits.

Quantitative Treatment Limitations

6.2.5- MHPAEA Does the State apply quantitative treatment limitations (QTLs) on any mental health or substance use disorder benefits in any classification of benefits? If yes, specify the classification(s) of benefits in which the State applies one or more QTLs on any mental health or substance use disorder benefits.

☐ Yes

☒ No

Guidance: If the state does not apply any type of QTLs on any mental health or substance use disorder benefits in any classification, the state meets parity requirements for QTLs and should continue to Section 6.2.6 - MHPAEA. If the state does apply QTLs to any mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue.

6.2.5.1- MHPAEA Does the State apply any type of QTL on any medical/surgical benefits?

☒ Yes

☐ No

Guidance: If the State does not apply QTLs on any medical/surgical benefits, the State may not impose quantitative treatment limitations on mental health or substance use disorder benefits, please go to Section 6.2.6- MHPAEA related to non-quantitative treatment limitations.

6.2.5.2- MHPAEA Within each classification of benefits in which the State applies a type of QTL on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the classification which are subject to the limitation. More specifically, the State must determine the ratio of (a) the dollar amount of all payments expected to be paid under the State plan for medical and surgical benefits within a classification which are subject to the type of quantitative treatment limitation for the plan year (or portion of the plan year after a mid-year change affecting the applicability of a type of quantitative treatment limitation to any medical/surgical benefits in the class) to (b) the dollar amount expected to be paid for all medical and surgical benefits within the classification for the plan year. For purposes of this paragraph, all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (42 CFR 457.496(d)(3)(i)(C))

☐ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above for each classification within which the State applies QTLs to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state's methodology and results as an attachment to the State child health plan.

6.2.5.3- MHPAEA For each type of QTL applied to any mental health or substance use disorder

benefits within a given classification, does the State apply the same type of QTL to "substantially all" (defined as at least two-thirds) of the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

☐ Yes

☒ No

The State does not apply any QTL to any MH/SUD benefit.

Guidance: If the State does not apply a type of QTL to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose that type of QTL on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

6.2.5.3.1- MHPAEA For each type of QTL applied to mental health or substance use disorder benefits, the State must determine the predominant level of that type which is applied to medical/surgical benefits in the classification. The "predominant level" of a type of QTL in a classification is the level (or least restrictive of a combination of levels) that applies to more than one-half of the medical/surgical benefits in that classification, as described in 42 CFR 457.496(d)(3)(i)(B). The portion of medical/surgical benefits in a classification to which a given level of a QTL type is applied is based on the dollar amount of payments expected to be paid for medical/surgical benefits subject to that level as compared to all medical/surgical benefits in the classification, as described in 42 CFR 457.496(d)(3)(i)(C). For each type of quantitative treatment limitation applied to mental health or substance use disorder benefits, the State assures:

☐ The same reasonable methodology applied in determining the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation also is applied in determining the dollar amounts used to determine the predominant level of a type of quantitative treatment limitation applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

☐ The level of each type of quantitative treatment limitation applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of QTL that exceeds the one-half threshold, the State may combine levels within a type of QTL such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

Non-Quantitative Treatment Limitations

6.2.6- MHPAEA The State may utilize non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder benefits, but the State must ensure that those NQTLs comply with all the mental health parity requirements. (42 CFR 457.496(d)(4)); (42 CFR 457.496(d)(5))

6.2.6.1 – MHPAEA If the State imposes any NQTLs, complete this subsection. If the State does not impose NQTLs, please go to Section 6.2.7-MHPAEA.

☒ The State assures that the processes, strategies, evidentiary standards or other factors used in the application of any NQTL to mental health or substance use disorder benefits are no more stringent than the processes, strategies, evidentiary standards or other factors used in the application of NQTLs to medical/surgical benefits within the same classification.

Guidance: Examples of NQTLs include medical management standards to limit or exclude benefits based on medical necessity, restrictions based on geographic location, provider specialty, or other criteria to limit the scope or duration of benefits and provider network design (ex: preferred providers vs. participating providers). Additional examples of possible NQTLs are provided in 42 CFR 457.496(d)(4)(ii). States will need to provide a summary of its NQTL analysis, as well as supporting documentation as requested.

6.2.6.2 – MHPAEA The State or MCE contracting with the State must comply with parity if they provide coverage of medical or surgical benefits furnished by out-of-network providers.

6.2.6.2.1- MHPAEA Does the State or MCE contracting with the State provide coverage of medical or surgical benefits provided by out-of-network providers?

☐ Yes

☒ No

Guidance: The State can answer no if the State or MCE only provides out of network services in specific circumstances, such as emergency care, or when the network is unable to provide a necessary service covered under the contract.

6.2.6.2.2- MHPAEA If yes, the State must provide access to out-of-network providers for mental health or substance use disorder benefits. Please assure the following:

☐ The State attests that when determining access to out-of-network providers within a benefit classification, the processes, strategies, evidentiary standards, or other factors used to determine access to those providers for mental health/ substance use disorder benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used to determine access for out- of-network providers for medical/surgical benefits.

Availability of Plan Information

6.2.7- MHPAEA The State must provide beneficiaries, potential enrollees, and providers with information related to medical necessity criteria and denials of payment or reimbursement for mental health or substance use disorder services (42 CFR 457.496(e)) in addition to existing notice requirements at 42 CFR 457.1180.

6.2.7.1- MHPAEA Medical necessity criteria determinations must be made available to any current or potential enrollee or contracting provider, upon request. The state attests that the following entities provide this information:

- ☐ State
- ☒ Managed Care entities
- ☐ Both
- ☐ Other

Guidance: If other is selected, please specify the entity.

6.2.7.2- MHPAEA Reason for any denial for reimbursement or payment for mental health or substance use disorder benefits must be made available to the enrollee by the health plan or the State. The state attests that the following entities provide denial information:

- ☐ State
- ☒ Managed Care entities
- ☐ Both
- ☐ Other

Section 7. Quality and Appropriateness of Care

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. **(2102(a)(7)(A)) (42CFR 457.495(a))**

The state has used numerous methods to assure that CHIP beneficiaries receive quality services that are appropriate to their needs. These methods include the following:

- Requirement that health plans submit patient-level encounter data to the CHIP External Quality Review Organization (EQRO). The data is analyzed using HEDIS and other benchmarks to assess the provision of well-baby, well-child and immunization services.
- Assess health plan delivery of child health services through comprehensive surveys of the enrolled CHIP population.
- Requirement that HMOs and EPOs develop and maintain quality assurance and quality improvement programs.
- Verification that the HMOs and EPO have sufficient network providers and procedures to ensure that children have access to routine, urgent, and emergency services; telephone appointments; and advice and member service lines.
- Restrictions on physician incentive plans.
- Requirement that HMOs and EPOs provide training to providers on a number of topics including the special needs of CHIP Phase II clients.
- Requirement that HMOs and EPOs have health education and wellness promotion programs.
- Requirement that HMOs and EPOs maintain a toll-free member hotline 24 hours a day, seven days a week for obtaining assistance in accessing services.
- Requirement that HMOs and EPOs develop, implement and maintain a member complaint system.
- Requirement that HMOs and EPOs send notice to CHIP beneficiaries on the HMO's appeals process for services that are denied, delayed, reduced or terminated.

- Access to a grievance process to appeal an HMO or EPO action.

In addition to internal monitoring processes, an external quality monitor is used to evaluate quality assurance activities described above for the HMO and EPO models.

To ensure children receive proper well-baby and well-child care and immunizations, HMO and any EPO providers are required to do the following:

- Provide children with well-baby and well-child care and immunizations according to the American Academy of Pediatrics or DSHS periodicity schedule for children. Provide well-child care and immunizations to all children except when the family refuses services after being provided accurate and complete information about services.

- Ensure that families are provided information and education materials about well-child care and immunizations, especially the importance of well-child checkups, and about how and when to obtain the services.

- Provide training to network providers and provider staff about well-child care and immunizations.

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☒ Quality standards
Health Plans are encouraged to follow QISMC guidelines and other standards established by the state in the development and maintenance of their Quality Improvement Programs.

7.1.2. ☒ Performance measurement
Texas is using a variety of performance measures to assess program quality, including pediatric HEDIS measures, ambulatory care sensitive conditions, case-mix adjusted actual versus expected experience rankings, and consumer survey results (including results from the Consumer Assessment of Health Plans Study (CAHPS)).

7.1.3. ☒ Information strategies
The EQRO produces reports for analysis which focus on the review and assessment of quality of care given by CHIP health plans, detection of over and under-utilization, and other user-defined reporting criteria and standards.

7.1.4. ☒ Quality improvement strategies

The state requires all CHIP Health Plans to develop and maintain a Quality Improvement Program (QIP) system that complies with federal regulations relating to Quality Assurance systems, and state insurance department regulations. Each Health Plan QIP must be approved by the state. Health Plans must conduct focused health studies in areas established by the state. All aspects of the health plans QIP will be monitored by the state. The state will also perform ongoing medical record reviews, and retrospective medical record reviews for health plans.

7.2. Describe the methods used, including monitoring, to assure:
(2102(a)(7)(B)) (42CFR 457.495)

As a means of measuring accessibility**,** the state has established standard ratios of full-time equivalent PCPs to CHIP beneficiaries and full-time board certified/board eligible pediatricians to CHIP beneficiaries.

Network managers are required to ensure that primary care providers (PCP) are located no more than 30 miles from any member, unless approved by the state. Members are generally not required to travel in excess of 75 miles to secure initial contact with referral specialists; special hospitals, psychiatric hospitals; diagnostic and therapeutic services; and single service health care physicians or providers except when approved by the state. Networks must include pediatricians and physicians with pediatric experience that is adequate to provide eligible children and adolescents with the full scope of benefits.

Network managers are required to demonstrate their ability to monitor network capacity and member access to needed services throughout the geographic service area in order to maintain the adequacy of the network. Managers need to maintain systems for monitoring patient load so that they can effectively plan for future needs and recruit providers as necessary to assure adequate access to primary care and specialty care. Health plan are also required to routinely monitor and ensure the after-hours availability and accessibility of PCPs.

The state requires that networks provide access to urgent care within 24 hours of request and routine care within 2 weeks of request. The state also requires that networks provide medically necessary emergency services 24 hours a day, seven days a week, either by access to the PCP or after-hours coverage through the Health Plan's network facilities, or through reimbursement of out-of-network providers.

Networks are required to maintain a toll-free member hotline 24 hours a day, seven days a week for obtaining assistance in accessing services.

The state tracks network utilization controls and will monitor inpatient admissions, emergency room use, ancillary, and out-of-area services for CHIP network clients.

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. **(Section 2102(a)(7)) (42CFR 457.495(a))**
SEE 7.1

7.2.2 Access to covered services, including emergency services as defined in 42 CFR §457.10. **(Section 2102(a)(7)) (42CFR 457.495(b))**
SEE 7.2

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition.
(Section 2102(a)(7)) (42CFR 457.495(c))

The state monitors the status of children with special health care needs through quarterly reviews of encounter data and periodic surveys of the CHIP families. When deficiencies are identified, among particular plans, corrective action plans are implemented.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law **or,** in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services.
(Section 2102(a)(7)) (42CFR 457.495(d))

The state assures decisions related to the prior authorization of health services are completed in accordance with state law by reviewing quarterly member and provider complaint reports, conducting spot audits and completing, with the state's EQRO, a periodic Quality of Care Survey of members.

CHIP health plans are subject to state commercial insurance statutes and regulations regarding utilization review, which contain requirements as stringent as federal provisions.

Section 8. Cost-sharing and Payment (Section 2103(e))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42 CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

8.1.1. ☒ Yes
8.1.2. ☐ No, skip to question 8.8.

8.1.1-PW ☐ Yes
8.1.2-PW ☐ No, skip to question 8.8.

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2.1. ☐ Premiums:

8.2.2. ☐ Deductibles:

8.2.3. ☒ Coinsurance or copayments:

Effective March 11, 2021 and through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act, and for all populations covered in the CHIP state child health plan, the state assures the following:

COVID-19 Vaccine:

- The state provides coverage of COVID-19 vaccines and their administration without cost sharing, in accordance with the requirements of section 2103(c)(11)(A) and 2013(e)(2) of the Act.

COVID-19 Testing:

- The state provides coverage of COVID-19 testing without cost sharing, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act.

COVID-19 Treatment:

- The state provides coverage of COVID-19-related treatments without cost sharing, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act.

Coverage for a Condition That May Seriously Complicate the Treatment of COVID-19:

- The state provides coverage for treatment of a condition that may seriously complicate COVID-19 treatment without cost sharing, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act. This coverage includes items and services, including drugs, that were covered by the state as of March 11, 2021.

Cost-Sharing	
Enrollment Fees (for 12-month enrollment period):	**Charge**
At or below 151 % of FPL	$0
Above 151% up to and including 186% of FPL	$35
Above 186% up to and including 201% of FPL	$50
Co-Pays (per visit):	
At or below 100% of FPL	**Charge**
Office Visit*	$3
Non-Emergency ER	$3
Generic Drug	$0
Brand Drug	$3
Cost-sharing Cap	5% (of family's income)
Facility Co-pay, Inpatient	$15
Above 100% up to and including 151% of FPL	**Charge**
Office Visit*	$5
Non-Emergency ER	$5
Generic Drug	$0
Brand Drug	$5
Cost-sharing Cap	5% (of family's income)
Facility Co-pay, Inpatient (per admission)	$35
Above 151% up to and including 186% of FPL	**Charge**
Office Visit*	$20
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$25 for insulin, $35 for all other drugs**$
Cost-sharing Cap	5% (of family's income)
Facility Co-pay, Inpatient (per admission)	$75
Above 186% up to and including 201% of FPL	**Charge**
Office Visit*	$25
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$25 for insulin, $35 for all other drugs**$
Cost-sharing Cap	5% (of family's income)
Facility Co-pay, Inpatient (per admission)	$125
**The office visit co-payment amounts also apply to non-preventive dental visits.*	
***Copays for insulin cannot exceed $25 per prescription for a 30-day supply. See Section 8.8 for details.*	

In this section, "insulin" means a prescription drug that contains insulin and is used to treat diabetes. The term does not include an insulin drug that is administered to a patient intravenously. Pursuant to

the provisions of Texas Insurance Code Chapter 1358, Subchapter C, copays for insulin cannot exceed $25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription.

8.2.4. ☐ Other:

8.2-DS ☐ **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS ☐ Premiums:

8.2.2-DS ☐ Deductibles:

8.2.3-DS ☐ Coinsurance or copayments:

8.2.4-DS ☐ Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(A)) (42 CFR 457.505(b)) Texas Health and Human Services will update CHIP policy changes on the HHSC website. CHIP members will also receive notifications from their health plan.

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

8.4. The State assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42 CFR 457.530)

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42 CFR 457.520)

8.4.3 ☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42 CFR 457.515(f))

8.4.1- MHPAEA ☒ There is no separate accumulation of cumulative financial requirements, as defined in 42 CFR 457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits. (42 CFR 457.496(d)(3)(iii))

8.4.2- MHPAEA ☒ If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits. (42 CFR 457.496(d)(3)(ii)(A))

8.4.3- MHPAEA ☒ Cost sharing applied to benefits provided under the State child health plan will remain

capped at five percent of the beneficiary's income as required by 42 CFR 457.560 (42 CFR 457.496(d)(3)(i)(D)).

8.4.4- MHPAEA Does the State apply financial requirements to any mental health or substance use disorder benefits? If yes, specify the classification(s) of benefits in which the State applies financial requirements on any mental health or substance use disorder benefits.

☒ Yes

As of July 1, 2022, CHIP copayments do not apply to MH/SUD office visits and residential treatment services. Copayments are applied to inpatient care, and prescription drugs.

There is an income-based cap on out-of-pocket maximums. The out-of-pocket maximum is an aggregate cap per 12-month term of coverage that is based on 5 percent of a family's income that is applied across all income groups. This out-of-pocket maximum is cumulative and is not applied separately for MH/SUD and M/S benefits.

☐ No

Guidance: For the purposes of parity, financial requirements include deductibles, copayments, coinsurance, and out of pocket maximums; premiums are excluded from the definition. If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below.

Please ensure that changes made to financial requirements under the State child health plan as a result of the parity analysis are also made in Section 8.2.

8.4.5- MHPAEA Does the State apply any type of financial requirements on any medical/surgical benefits?

☒ Yes

☐ No

Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.

8.4.6- MHPAEA Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the class which are subject to the limitation.

☒ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2-MHPAEA) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state's methodology and results of the parity analysis as an attachment to the State child health plan.

8.4.7- MHPAEA For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of financial requirement to at least two-thirds ("substantially all") of all the medical/surgical benefits within the same classification? (42 CFR

457.496(d)(3)(i)(A))

☒ Yes

☐ No

Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose financial requirements on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

8.4.8- MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in 42 CFR 457.496(d)(3)(i)(B)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

☒ The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of financial requirement applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

☒ The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of financial requirement that exceeds the one-half threshold, the State may combine levels within a type of financial requirement such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

8.5. Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

8.6. Describe the procedures the State will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42 CFR 457.535)

8.7. Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42 CFR 457.570 and 457.505(c))

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

8.7.1. Provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (Section 2103(e)(3)(C))

8.7.1.1. ☐ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42 CFR 457.570(a))

8.7.1.2. ☐ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42 CFR 457.570(b))

8.7.1.3. ☐ In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42 CFR 457.570(b))

8.7.1.4 ☐ The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42 CFR 457.570(c))

CHIP Eligibility

State Name: Texas

OMB Control Number: 0938-1148

Transmittal Number: TX - 14 - 0036

Expiration date: 10/31/2014

Separate Child Health Insurance Program **Non-Financial Eligibility - Non-Payment of Premiums**	**CS21**
42 CFR 457.570	
Non-Payment of Premiums	
Does the state impose premiums or enrollment fees?	Yes
Can non-payment of premiums or enrollment fees result in loss of CHIP eligibility?	Yes
Does the state have a premium lock out period?	No
☑ The state assures that it provides enrollees with an opportunity for an impartial review to address disenrollment from the program in accordance with section 457.1130(a)(3).	

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415

SPA# TX-14-0036

Approval Date: DEC 2 3 2015

Effective Date: January 1, 2014

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8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.9.1. ☒ No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4)) (42CFR 457.220)**

8.9.2. ☒ No cost sharing (including premiums, deductibles, co-pays, coinsurance and all other types) will be used toward state matching requirements. **(Section 2105(c)(5) (42CFR 457.224)** (Previously 8.4.5)

8.9.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under this title. **(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))**

8.9.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.9.5. ☐ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B)) (42CFR 457.475)** NOT COVERED.

8.9.6. ☐ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)) (42CFR 457.475)** NOT COVERED.

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children:
(Section 2107(a)(2)) (42CFR 457.710(b))

Strategic Objective 1: Provide Increased Access to Health Care Coverage for the New CHIP-Enrolled Texas Children in Families with Income at or below 200% of Poverty.

Strategic Objective 2: Provide Increased Preventive and Primary Health Care Services to new CHIP-Enrolled Texas Children.

Strategic Objective 3: Provide Improved Health Outcomes for New CHIP-Enrolled Texas Children through Appropriate Utilization of Health Care Resources.

9.2. Specify one or more performance goals for each strategic objective identified:
(Section 2107(a)(3)) (42CFR 457.710(c))

Strategic Objective 1: Provide Increased Access to Health Care Coverage for the New CHIP-Enrolled Texas Children in Families with Income at or below 200% of Poverty.

Performance Goal A: Compare annual data of the number and percent of children enrolled in CHIP to the estimated number of potentially CHIP eligible children in the state.

Performance Goal B: Track participation by county, age, and racial/ethnic groups.

Strategic Objective 2: Provide Increased Preventive and Primary Health Care Services to new CHIP-Enrolled Texas Children.

Performance Goal A: Track number and percentage of CHIP-coverage children with completed immunizations at end of middle school (approximately 12-14 years of age).

Performance Goal B: Track number and percentage of CHIP-coverage children receiving well child checkups by county, age, and racial/ethnic groups.

Strategic Objective 3: Provide Improved Health Outcomes for New CHIP-Enrolled Texas Children through Appropriate Utilization of Health Care Resources.

Performance Goal A: Track number and percentage of CHIP-coverage children receiving well child checkups by county, age, and racial/ethnic groups.

Performance Goal B: Track number and percentage of CHIP-coverage children receiving emergency services by county and age.

Performance Goal C: Track number and percentage of CHIP-coverage children having hospital discharges by county and age.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A), (B)) (42CFR 457.710(d))

The strategic objectives and performance goals of the Title XXI CHIP program have been initiated for the first biennium based on the principal desire of the state to plan and implement a successful CHIP program in Texas. In order to be successful, the program design includes significant attention to outreach, eligibility determination, enrollment, and the participation of providers and children.

The state developed four strategic objectives to measure access, service provision, quality of care and health resources utilization as a means of evaluating the health status of children in the CHIP program. Data have been obtained from managed care plans, medical records and surveys. Health plan patient-level encounter data have been analyzed using case-mix adjustment process, including the Chronic Illness and Disability Payment System (CDPS) and Ambulatory Care Groups (ACGs) frameworks. In addition, the state has used encounter data to assess health plan performance on child and adolescent HEDIS measures. The state has also completed three enrollee surveys, including a survey of New Enrollees, Disenrollees, Established Enrollees Consumer Assessment of Health Plans Survey (CAHPS) of each health plan by service area.

Check the applicable suggested performance measurements listed below that the state plans to use: **(Section 2107(a)(4))**

9.3.1. ☐ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. ☒ The reduction in the percentage of uninsured children.

9.3.3. ☐ The increase in the percentage of children with a usual source of care.

9.3.4. ☐ The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5. ☒ HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.

9.3.7. ☒ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

9.3.7.1. ☒ Immunizations

9.3.7.2. ☒ Well-child care

9.3.7.3. ☒ Adolescent well visits

9.3.7.4. ☒ Satisfaction with care (Surveys)

9.3.7.5. ☒ Mental health

9.3.7.6. ☒ Dental care

9.3.7.7. ☐ Other, please list:

9.3.8. ☒ Performance measures for special targeted populations.
[Children with Special Health Care Needs (CSHCN) Screener questions included in Surveys]

9.4. ☒ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b)(1)) (42CFR 457.720)**

9.5. ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. **(Section 2107(b)(2)) (42CFR 457.750)**

Texas will develop the necessary data sources and baselines with which to assess and evaluate program performance consistent with Title XXI requirements and the requirements of day-to-day program management.

HHSC will dedicate staff or contracted resources to review program performance and develop strategies for improvement

9.6. ☒ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3)) (42CFR 457.720)**

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. **(42CFR 457.710(e))**

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **Section 2107(e)) (42CFR 457.135)**

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. **(Section 2107(c)) (42CFR 457.120(a) and (b))**

The state has actively sought the involvement of the public in the development of the Texas CHIP Phase II program through numerous avenues. The Lieutenant Governor established the Senate Interim Committee on Children's Health Insurance in March 1998, which heard extensive testimony during the summer from the public on the policy options and recommendations for CHIP. The Texas House Committee on Appropriations and the Texas House Committee on Public Health also participated in joint public hearings on CHIP with the Senate Interim Committee. Hearings were widely publicized through the Texas Register, media advisories, Internet web sites, and targeted mailings to advocacy groups. State agency representatives have met on a regular basis with legislative staff to gain legislative input on the development of draft proposals.

In addition to legislative public hearings, the Health and Human Services Commission, in collaboration with the Texas Department of Health, the Texas Department of Human Services, and the Texas Department of Mental Health and

Mental Retardation held 10 public hearings around the state throughout the fall of 1998 and early in 1999. The state made a concerted effort to attract families, providers, health officials, advocates, community-based organizations, and other community representatives to these hearings, specifically by working with state and local CHIP Coalitions representing a broad range of consumer and provider interests. Public hearings were held in late afternoon – early evening to better allow family members to attend. The state also hosted local discussions at each of the public hearing sites to establish community linkages and gain community input on local outreach strategies and other topics in a more informal setting. Local advisory groups are used to provide ongoing direction and input on outreach strategies for Texas CHIP.

A number of advocacy groups in Texas formed the CHIP Coalition in Spring 1998. State representatives meet regularly with the CHIP Coalition, making presentations on various aspects of the program design and seeking feedback throughout the development process. The state used the CHIP Coalition to provide input and guidance on program components as Texas CHIP was implemented. The State also meets with the Disability Policy Consortium, which represents statewide disability advocacy groups, to discuss developments in Texas CHIP.

State representatives meet with state provider organizations, such as the Texas Medical Association and the Texas Hospital Association. State staff present at numerous provider conferences and meetings. Continued involvement of these organizations is essential in the operation of Texas CHIP.

Public involvement in implementation of Texas CHIP was ensured through state agencies' rule-making processes and through public participation in outreach efforts. In addition, regional advisory committees with broad representation across provider and consumer groups and including parents of CHIP enrollees were formed to provide advice on program policy, management, and outreach.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR §457.125.
(Section 2107(c)) (42CFR 457.120(c))

HHSC requires health plans and dental plans to seek participation in its provider network from the tribal health clinics.

American Indian and Alaska Native children are exempt from cost sharing.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in §457.65 (b) through (d).

CHIP Program changes related to the time period for payment of cost sharing obligations – This amendment increases the amount of time that enrollees have to pay the enrollment fee upon renewal of their coverage. Prior public notice was provided through:

- Posting of a notice in the *Texas Register* regarding the submission of the CHIP state plan amendment, including contact information to obtain a copy of the amendment.

CHIP Program Changes related to extension of coverage for Prenatal Care and Associated Health Care Services:

- Public input was sought through meetings with interested stakeholders such as the Texas Hospital Association, the Texas CHIP Coalition, and the Texas Association of Health Plans.
- Eligibility and cost-sharing rules were presented to members of the Medical Care Advisory Committee and the Texas Health and Human Services Commission Agency Council.
- Public testimony was taken at both meetings, and an additional public hearing was held on November 1, 2005.
- Public notice was also submitted to the *Texas Register*.

CHIP Program Changes related to HB 109, 80th Legislature, Regular Session, 2007:

- Public testimony on H.B. 109 was received during legislative hearings held on March 1, 2007, March 8, 2007, and May 17, 2007.
- Public input was sought through meetings with interested stakeholders, including the meeting with the Texas CHIP Coalition on June 8, 2007. Additional public input was sought through a meeting with the Texas CHIP Coalition on June 15, 2007.
- Proposed eligibility and cost-sharing rules were presented to members of the Medical Care Advisory Committee on June 14, 2007, and to the Texas Health and Human Services Commission Council on June 21, 2007. Both meetings were open to the public.
- The eligibility and cost sharing rules were published in the *Texas Register* on July 6, 2007, with a 30-day public comment period.
- A public hearing was held on the proposed rules on July 19, 2007.
- A public notice was submitted to the *Texas Register* in July 2007 regarding the State's intent to submit the state plan amendment to CMS. The public will be able to request copies of the proposed state plan amendment.

CHIP income exemption for temporary census employees:

- A public notice was submitted to the *Texas Register* for publication in September 2008 regarding the State's intent to submit the state plan amendment to CMS. The public was able to request copies of the proposed state plan amendment.
- Notification was provided to the three Native American tribes in Texas in September 2008.
- Notification was provided to the Texas CHIP Coalition in September 2008.

CHIP eligibility expansion for Qualified Aliens:

- A public notice was submitted to the *Texas Register* for publication in May 2010 regarding the State's intent to submit the state plan amendment to CMS. The public was able to request copies of the proposed state plan amendment.
- Notification was provided to the three Native American tribes in Texas in May 2010.
- Notification was provided to stakeholders, including the Texas CHIP Coalition in May 2010.

CHIP changes for hospice care:

- A public notice was submitted to the *Texas Register* for publication in August 2010 regarding the State's intent to submit the state plan amendment to CMS. The public was able to request copies of the proposed state plan amendment.
- Notification was provided to the Native American tribes in Texas in August 2010.
- Notification was provided to the Texas CHIP Coalition in August 2010.

CHIP Perinatal Program to deem newborns to Medicaid for 12 continuous months of coverage if the family income is at or below 185 percent of FPL:

- Public notice was mailed to interested stakeholders on April 13, 2010.
- Public notice of the proposed amendment was published in the *Texas Register* on April 23, 2010. The public can request copies of the state plan amendment.
- Proposed eligibility rules were presented to the Texas Health and Human Services Commission Council in a meeting held on April 29, 2010. This meeting was open to the public.
- Notification was provided to the three Native American tribes in

Texas in August 2010.

CHIP method of finance change to provide federal matching funds for the children of public school employees:

- A public notice was submitted to the *Texas Register* for publication in January 2011 regarding the State's intent to submit the state plan amendment to CMS. The public was able to request copies of the proposed state plan amendment.
- Notification was provided to the three Native American tribes in Texas in January 2011.
- Notification was provided to the Texas CHIP Coalition in January 2011.

CHIP changes for behavioral health benefits and cost-sharing:

- A public notice was submitted to the *Texas Register* for publication in August 2010 regarding the State's intent to submit the state plan amendment to CMS. The public was able to request copies of the proposed state plan amendment.
- Notification was provided to the three Native American tribes in Texas in September 2010.
- Notification was provided to the Texas CHIP Coalition in September 2010.

CHIP change to provide federal matching funds for public employee children:

- A public notice was submitted to the *Texas Register* for publication in June 2011 regarding the State's intent to submit the state plan amendment to CMS. The public was able to request copies of the proposed state plan amendment.
- Notification was provided to the three Native American tribes in Texas in June 2011.
- Notification was provided to the Texas CHIP Coalition in June 2011.

CHIP dental program and cost-sharing changes:

- A public notice was submitted to the *Texas Register* for publication in October 2010 regarding the State's intent to submit the state plan amendment to CMS. The public was able to request copies of the proposed state plan amendment.
- Notification was provided to the three Native American tribes in Texas in October 2010.
- Notification was provided to the Texas CHIP Coalition in October 2010.

- The Texas Dental Association was provided notice in October 2010.
- A public notice was submitted to the *Texas Register* for publication in July 2011 regarding the State's intent to submit a revised state plan amendment to CMS. The public was able to request copies of the proposed state plan amendment.
- Updated notification was provided to the three Native American tribes in Texas in July 2011.
- Updated notification was provided to the Texas CHIP Coalition in July 2011.
- The Texas Dental Association was provided updated notice in July 2011.

CHIP eligibility changes pertaining to the Affordable Care Act for MAGI eligibility and methods:

- A public notice was submitted to the *Texas Register* for publication on February 28, 2014, regarding the State's intent to submit the state plan amendment to CMS.
- Notification was provided to the Indians Health Programs in Texas and the Urban Inter-Tribal Center of Texas on September 4, 2013.

CHIP eligibility changes pertaining to the Affordable Care Act for Medicaid expansion:

- A public notice was submitted to the *Texas Register* for publication on April 4, 2014, regarding the State's intent to submit the state plan amendment to CMS.
- Notification was provided to the Indians Health Programs in Texas and the Urban Inter-Tribal Center of Texas on September 4, 2013.

CHIP eligibility changes pertaining to the Affordable Care Act for section 2101 (f) Group Establishment:

- A public notice was submitted to the *Texas Register* for publication on April 11, 2014, regarding the State's intent to submit the state plan amendment to CMS.
- Notification was provided to the Indians Health Programs in Texas and the Urban Inter-Tribal Center of Texas on September 4, 2013.

CHIP eligibility changes pertaining to the Affordable Care Act for eligibility process:

- A public notice was submitted to the *Texas Register* for publication on December 27, 2013, regarding the State's intent to submit the state plan amendment to CMS.
- Notification was provided to the Indians Health Programs in Texas

and the Urban Inter-Tribal Center of Texas on September 4, 2013.

CHIP eligibility changes pertaining to the Affordable Care Act for Non-Financial Eligibility:

- A public notice was submitted to the *Texas Register* for publication on April 11, 2014, regarding the State's intent to submit the state plan amendment to CMS.
- Notification was provided to the Indians Health Programs in Texas and the Urban Inter-Tribal Center of Texas on September 4, 2013.

CHIP Eligibility changes pertaining to enrollment and cost continent:

- A public notice was submitted to the *Texas Register* for publication on January 20, 2017 regarding the State's intent to submit the state plan amendment to CMS.
- Notification was provided to the three federally-recognized tribes in Texas and the Urban Inter-Tribal Center of Texas on March 21, 2017.

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: **(Section 2107(d)) (42CFR 457.140)**

- Planned use of funds, including --
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.

Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees

CHIP Budget Plan

	Federal Fiscal Year 2017 Costs
Enhanced FMAP rate (state share)	0.0767
Benefit Costs	
Managed Care Premiums	
Per member/per month rate times the number of eligibles CHIP	944,341,167
Per member/per month rate times the number of eligibles Medicaid*	111,340,169
Fee for Service:	
Prescription Drugs CHIP	0
Prescription Drugs Medicaid*	0
Total Benefit Costs	1,055,681,336
(Offsetting beneficiary cost sharing payments)	(4,666,965)
Net Benefit Costs	**1,051,014,371**
Administration Costs	
Eligibility Enrollment and Outreach	49,089,848
Other Administration	25,600,599
Subtotal	74,690,447
Total Administration Costs	**74,690,447**
10% Administrative Cost Ceiling (benefits-cost share)/9)	116,779,375
Federal Share (multiplied by EFMAP rate)	1,039,363,259
State Share	86,341,560
TOTAL PROGRAM COSTS	**1,125,704,818**

Notes: The Federal Fiscal Year (FFY) runs from October 1st through September 30th. Members per Month and PMPM assumptions are derived from the FFY17 updated Fall forecast. Client Service cost include HMO/EPO Premiums, Dental, Vaccines, and Prescription Drugs. Prescription Drugs were included in managed care premiums beginning in March 2012.

Average Monthly Caseload for Federally-Funded CHIP (Traditional): FFY 2017 = 379,586. The PMPM assumptions are $133.66 for premiums, $25.80 for Dental, and $5.53 for Vaccines.

Average Monthly Caseload for the Federally-Funded CHIP Perinate program: FFY 2017 = 34,862. The PMPM assumptions are $460.81 for premiums, $0.01 for dental, and $0.13 for vaccines.

Average Monthly Caseload for Qualified Aliens in Medicaid (using Title XXI): FFY2017 = 26,340. The PMPM assumption is $157.13 for premiums.

Average Monthly Caseload for CHIP clients under 138% FPIL (using Title XXI): FFY2017= 253,927. The PMPM assumption is $20.24 for premiums.

Assumptions:

Benefit costs represent payments to health providers for providing health care services to CHIP enrollees. These cost estimates are based upon the yearly mean average of enrollees and the average cost per enrollee per month. Administration costs represent the cost of eligibility determination and enrollment services, outreach, quality assurance efforts by the agency, audits, and actuarial work.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: **(Section 2108(a)(1), (2)) (42CFR 457.750)**

10.1.1. ☒ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☒ The state assures it will comply with future reporting requirements as they are developed. **(42CFR 457.710(e))**

10.3. ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

10.3.1. ☒ The state assures that it will submit yearly the approved dental benefit package and submit quarterly the required information on dental providers in the state to the Human Resources and Services Administration for posting on the Insure Kids Now! website.

Section 11. Program Integrity (Section 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue to Section 12.

11.1 ☒ The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. **(Section 2101(a)) (42CFR 457.940(b))**

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.935(b))** The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)

11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)

11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)

11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)

11.2.4. ☒ Section 1128A (relating to civil monetary penalties)

11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)

11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and enrollee protections (Sections 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**.

Eligibility and Enrollment Matters

12.1 Please describe the review process for eligibility and enrollment matters that complies with 42 CFR §457.1120.

The HHSC review process is a program specific review, consisting of an impartial review performed by an HHSC unit that is separate from the unit that determines eligibility, as described below.

In 2007, the HHSC Request for Review unit was formed, consisting of a manager and ten review specialists. This unit works independently from the enrollment broker operations. No one in this review unit is directly involved in the initial eligibility determination, or any eligibility determination they are responsible for reviewing.

CHIP eligibility is determined by state staff, and enrollment is processed by the administrative services contractor. If the family disagrees with the outcome, the family may submit a written Request for Review (RFR) by mail or fax to HHSC.

An HHSC review specialist makes a decision that the RFR is either denied or approved, and the family is notified of the decision by letter.

The unit's independence from the staff performing the eligibility determinations helps to ensure that objective decisions are made. The review staff has no role in managing the vendor or measuring its performance, and has no role in the initial eligibility determinations. Persons who were directly involved "in the matter under review" do not participate in the review process. Additionally, the HHSC Eligibility Operations and Eligibility Services Support team completes audits to ensure requests for reviews were handled timely and accurately.

Eligibility and Enrollment Matters Review Process

1) **Matters Subject to Review.** An applicant or member may request a review of an initial adverse determination made by HHSC or its administrative contractor concerning the following:
    a) denial of eligibility;
    b) failure to make a timely determination of eligibility; and
    c) suspension or termination of enrollment (including disenrollment for failure to meet cost sharing obligations).

2) **Matters Not Subject to Review.** HHSC is not required to provide an opportunity for review if the sole purpose for the decision is:

   a) a provision in the State plan or in Federal or State law requiring an automatic change in eligibility, enrollment; or

   b) a change in coverage under the health benefits package that affects all applicants or members or a group of applicants or members without regard to their individual circumstances.

Notice of Adverse Determinations

HHSC or its designee will provide the applicant or member written notice of any adverse eligibility or enrollment determination. The notice must include:

1) the action or determination and the reasons therefore;
2) the individual's right to request review of the action or determination;
3) the process for initiating a review;
4) the time frame that applies to the review; and
5) the circumstances under which enrollment, if applicable, may continue pending review.

Requesting a Review

The applicant or member must submit a timely written request for review.

Conduct of the Review

Applicants and members have a right to:

1) represent themselves or have representatives of their choosing participate in the review;
2) timely review their files and other applicable information relevant to the review; and
3) participate fully in the review, including by presenting supplemental information in the review process, whether the review is conducted in person, in writing, or by telephone.

Disposition of the Review

Timely Review. HHSC or its designee will complete its decision on the review in a timely manner as specified in 42 C.F.R. 457.1160 and furnish a written decision to the applicant or member. This decision is final and there are no further appeals.

Expedited Review. If HHSC or its designee becomes aware that an enrollee's medical condition requires an immediate need for health services, HHSC or its designee will conduct an expedited review.

Continuation of Enrollment Pending Disposition of Review and Reconsideration

If an enrollee files a timely request for review of a suspension or termination of enrollment, HHSC or its designee will grant continuation of enrollment pending the review decision.

Timelines for Reviews

1) Families have 30 working days from date of notification letter to submit an appeal concerning HHSC's decision to deny eligibility or disenroll.
2) HHSC has 10 working days after receiving appeal (in writing) to respond with a notice that the decision has been upheld or has been reversed.
3) Families have 15 working from date of response letter to submit written request for additional HHSC review.
5) HHSC has 15 working days to respond to family of the decision.

~~Health Services Matters~~

12.2 **Health Services Matters-** Please describe the review process for **health services matters** that complies with 42 CFR §457.1120.

CHIP benefits are delivered solely through managed care delivery models, including a managed care organization (MCO) model and an exclusive provider organization (EPO) model which is used primarily in rural areas of the State. CHIP dental services are delivered through a prepaid ambulatory health plan (PAHP) referred to as a dental maintenance organization (DMO).

All health and dental plans must have an MCO/DMO internal appeal and complaint process to allow members to submit complaints (also called grievances) and appeal adverse benefit determinations, as the terms are defined in the Code of Federal Regulations. The MCO/DMO internal appeals and complaint process must ensure that member complaints and appeals are generally resolved within 30 calendar days. After a member exhausts his or her MCO/DMO internal appeal process rights, the member may request an external review by an independent review organization (IRO) of the MCO/DMO denial. The IRO process is the HHS-administered process.

The State elected to create CHIP under the Secretary-approved coverage option. Texas elects to have CHIP plans follow a statewide standard review process, under 42 CFR 457.1120(a)(2) for external reviews. Thus, for external reviews, CHIP plans follow the same grievance and appeal requirements as other health insurance issuers in the State.

~~HHSC requires health insurers to comply with State-specific grievance and appeal requirements currently in effect in the State. State laws concerning adverse determinations are found in the Texas Insurance Code, Chapter 843, subchapters G and H, and Chapter 4201.~~

Health Services Matters subject to External ~~r~~Review ~~are~~:

Dd~~d~~elay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services or any other matter that involves medical judgment.~~; and~~

~~1) failure to approve, furnish or provide payment for health services in a timely manner.~~

Matters Not Subject to External Review:~~.~~

HHSC is not required to provide an opportunity for review if the sole purpose for the decision is a provision in the State plan or in Federal or State law requiring an automatic change in eligibility, enrollment, or a change in coverage under the health benefits package that affects all applicants or members or a group of applicants or members without regard to their individual circumstances.

~~**Complaints Concerning Health Services Matters Pursuant to Insurance Code**~~

~~A member, or a person acting on the member's behalf, or the member's physician or health care provider may file a complaint about an adverse determination made by a health plan provider pursuant to the provisions of the Texas Insurance Code Chapter 843, subchapters G and H, and Chapter 4201.. Such a complaint may lead to review by an independent external review organization formed pursuant to Chapter 4202 of the Texas Insurance Code.~~

Expedited Process for Complaints Concerning Health Services Matters

Investigation and resolution of complaints concerning health services matters must be concluded in accordance with the medical needs of the patient.

~~**Member Complaint and Appeal Process**~~

~~The review process for health services matters is a Statewide Standard Review. All health and dental plans must have an internal appeals procedure to allow members to complain and appeal "adverse determinations," which are decisions made by: (1) a health plan that health care services provided or proposed to be provided to a member are not medically necessary or appropriate, or (2) a dental plan that the dental services provided or proposed to be provided to a member are not dentally necessary or appropriate.~~

~~The health and dental plans must ensure that member appeals are generally resolved within 30 calendar days. After a member exhausts his or her appeal rights within the health or dental plan, the member can request an Independent Review Organization (IRO) to review the denial and make a determination.~~

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR §457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.