

**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 (SCHIP). 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))

Albert Hawkins
(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: Chris Traylor	Position/Title: State Medicaid and CHIP Director
Name: Tom Suehs	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 SCHIP 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% 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 12/13/01, Effective 9/1/2001
- CHIP Cost Sharing Changes- Approved 5/1/02, Effective 3/1/02
- CHIP Car Seat Initiative- Approved 11/25/02, Effective 6/15/02
- 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 – Pending, 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 – Pending, Effective May 1, 2007.
- CHIP Program changes related to HB 109, 80th Legislature, Regular Session, 2007 – Pending, Effective September 1, 2007.
- CHIP Program changes related to dental benefits – Pending, Effective September 1, 2007.

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 2005 the population of children under age 19 in Texas will reach 6,625,000. The projected race/ethnic distribution is as follows: 2,657,000 (40%) Anglo; 830,000 (13%) African American; 2,910,000 (44%) Hispanic; and 228,000 (3%) for all other groups.

The March 2004 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 2003.

The survey indicates that in 2003 about 3.7 million (17%) of Texans had incomes below the federal poverty level (FPL). That total includes approximately 1.7 million children under age 19. The survey also indicates that in 2003 nearly 3.5 million (53%) of the 6.6 million children under age 19 were in families with incomes at or below 200% of FPL.

For 2003, the health insurance coverage status of Texas children under age 19 is estimated as follows*:

**Health Insurance Coverage in 2003
Texas Children Under Age 19**

Insurance Type	Number	Percent
Medicaid/CHIP/Medicare	2,006,000	30%
Private	3,278,000	50%
Uninsured	1,327,000	20%
Total	6,611,000	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 2003, the estimated number of uninsured Texas children under age 19 according to age group is as follows*:

Texas Uninsured Children in 2003 By Age Group

Age Group	Number of Children	Uninsured Children	Percent of Children Uninsured
0 – 5	2,249,000	391,000	17%
6 – 14	3,006,000	634,000	21%
15 – 18	1,356,000	302,000	22%
0 – 18	6,611,000	1,327,000	20%

For 2003, the estimated distribution of uninsured children under age 19 according to percent of poverty income category is as follows*:

**Texas Uninsured Children Under 19 in 2003
By Percent of Poverty Income Category**

Percent of Poverty Category	Uninsured Children	Percent of Uninsured Children
0 – 100%	460,000	35%
101 – 150%	270,000	20%
151 – 200%	243,000	18%
Above 200%	354,000	27%
Total	1,327,000	100%

For 2003, the estimated distribution of uninsured children according to age group and percent of poverty income category is as follows*:

Texas Uninsured Children in 2003 by Age And Percent of Poverty Income Category

Age Category	0 – 100%	101 – 150%	151 – 200%	Above 200%
0 – 5	131,000	82,000	75,000	103,000
6 – 14	222,000	127,000	115,000	170,000
15 – 18	106,000	61,000	54,000	81,000
0 – 18	459,000	270,000	244,000	354,000

* 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):

Children are identified and enrolled in Medicaid or SCHIP through a variety of mechanisms.

Medicaid applications are processed in local eligibility offices, hospitals, clinics throughout the state, and by the administrative services contractor. Applicants may apply in person, by phone, or by mail. The Texas Health and Human Services Commission (HHSC) processes all applications when families apply for children's Medicaid and other related programs (such as Medicaid for adults, TANF, etc.). The administrative services contractor processes all children's Medicaid applications when the application is only for children's Medicaid and/or SCHIP. The administrative services contractor collects all required verification and then transmits the application, along with the required verification, electronically, to a centralized State office where a Medicaid worker makes the final eligibility determination for children's Medicaid. HHSC is responsible for the administration of certain health and human services programs including the Texas Medicaid Program, SCHIP, and Medicaid waste, fraud, and abuse investigations. The agency also has oversight responsibilities for the four state Health and Human Services departments.

Out-stationed Eligibility Staff - HHSC outstations eligibility workers in clinics and hospitals. This staffs perform eligibility functions as well as screening functions for potential Medicaid and SCHIP eligibles. There is approximately 300 staff 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 inquires 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 programs and is updated as needed.

Worldwide Web Sites - HHSC maintains an agency home page that contains information about what types of benefits are available throughout the agency and also contains links to home pages for each of the HHSC regions. The regional home pages contain listings of local offices, and the services available at each of the local offices.

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

Temporary Assistance to Needy Families (TANF) - Individuals eligible for TANF are made Medicaid eligible by virtue of their certification for TANF. Those who apply and are determined ineligible for TANF are tested to determine their eligibility for Medicaid under other eligibility categories. Former TANF recipients receiving transitional Medicaid are sent an automated notice telling them to contact their local HHSC office if they wish to reapply for Medicaid when the transitional Medicaid ends.

Newborns of Medicaid Eligible Mothers - Enrollment in Medicaid is automatic for the majority of newborns of Medicaid-eligible mothers. When the medical facility notifies an HHSC centralized unit about the birth of the child to a Medicaid-eligible mother, the HHSC unit establishes eligibility for

the child. An automated system then notifies the child's mother, designated providers, and the child 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 SCHIP 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 eligible persons are automatically enrolled in Medicaid in Texas. The Texas Rehabilitation Commission Disability Determination Divisions make 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 Medically Needy and 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 mental retardation. 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 - Texas Health Steps 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 DSHS 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 DSHS 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.

Pursuant to SB 445, 76th Texas Legislature, Texas extends general revenue-funded SCHIP coverage to non-citizen children who would be SCHIP eligible but for their immigration status. In addition, state employee children who otherwise meet SCHIP eligibility criteria are eligible for enhanced state-funded subsidy of their coverage through the Uniform Group Insurance Program offered to state employees.

- 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 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 which 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 American Academy of Pediatrics 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 of mothers and children to health services. 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% of the federal poverty level.

- 2.3. Describe the procedures the state uses to accomplish coordination of SCHIP 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 with organizations such as insure-a-kid as well as contracts with 34 local, community-based organizations (CBOs). The CBOs were selected based on their local expertise and experience with low-income populations. SCHIP enrollment information is routinely shared with Texas' Title V agency in order to coordinate program benefits. Texas' SCHIP coordination efforts are ongoing, but appear successful, as Texas' SCHIP 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.

- 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 through managed care models, including an HMO model and an exclusive provider organization (EPO) model primarily in rural areas of the state. In the HMO & EPO models, the state contracts to deliver health care services, relying on managed care principles that will include a "manager of care" or "medical home" and utilization controls on inpatient hospital and certain other services in the case of the HMOs model and the latter only in the case of the EPO. The same requirements are applied to both HMOs and the EPO.

The SCHIP procurement of health plan services is aligned as closely as possible with other plans, such as Medicaid and the Title V 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 SCHIP health plans.

- 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.

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 states Medicaid plan, and continue on to Section 5.

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))

These standards are be used for Texas SCHIP:

- 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 gross family income is at or below 200% of the federal poverty level (FPL) will be eligible.
- 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% of the federal poverty level.

For children with gross family income above 150% of the federal poverty level, a family resource test is applied. For these families, the resource limit will be \$5,000 or less in countable liquid resources, combined with excess vehicle value. Up to \$15,000 of the fair market value of the family's highest valued vehicle will be exempted. For other countable vehicles, fair market value in excess of \$4,650 will be counted. Certain types of vehicles, such as income producing vehicles will be exempted.

Additionally, family resources are evaluated as part of the screening and enrollment process for Medicaid eligibility.

Unborn children to be delivered to families with income at or below 200% of the federal poverty level are exempt from family resource test requirements for eligibility determination.

- 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.
- 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 SCHIP. Unborn children with existing health insurance are denied eligibility for Texas SCHIP.

4.1.8. Duration of eligibility: Eligible children receive coverage for 6 continuous months. Eligible unborn children receive coverage for 12 continuous months.

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.

As referenced in Section 4.3, the state does require the child's social security number or proof of application for a social security number at the time of application.

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)) (42CFR 457.320(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)

The eligibility process for the Children's Health Insurance Program is easy to access, convenient for families and is identical to the Children's Medicaid eligibility process. A single application form is used for Medicaid & SCHIP. Families apply for children's health insurance by mail, by phone, through a web-assisted application or in person.

The application asks for the following information:

- Family's gross income and the names of employers
- Age, names, social security numbers, and insurance status of children
- Composition of the family
- Resource information
- Immigration/Citizenship Status

Information from the application is entered into the SCHIP eligibility system. This entry may occur through several means: data entry by a telephone operator who receives the information through a phone call; data entry by a clerk at a central processing unit who reads the information from the application; or direct data entry via the internet to the extent feasible.

All applicants are screened for Medicaid eligibility before being deemed eligible for SCHIP. Any application in which the family income and resources fall within

Medicaid eligibility is routed to a Medicaid worker. Data on that applicant is transferred, electronically and in hard copy, to the Medicaid system. Data on those applicants who are denied Medicaid by Medicaid eligibility staff are transmitted to the SCHIP system and those applicants are notified of their SCHIP eligibility and enrolled in SCHIP health plans.

Applicants applying via the Internet currently print out and sign applications, and mail them with necessary verifications to the central processing unit. Mail-in applications need to include the necessary verifications. In the case of phone applications, the data are printed out and sent to the family with a self-addressed envelope. The family returns the signed application with necessary verifications after reviewing the application for accuracy.

Based on the eligibility information and the receipt of necessary verifications, the system makes a determination of eligibility and sends written notification to the family.

If a child is determined SCHIP eligible, the administrative services contractor sends the family an enrollment packet, which provides information about their health plan choices and any applicable enrollment fee. The family returns to the administrative services contractor the completed enrollment forms and any applicable enrollment fee owed, and the administrative services contractor processes the forms and enrolls the child in a health plan.

For a child's initial enrollment in SCHIP, a three-month waiting period applies, unless the child qualifies for an exception to the waiting period. Following the waiting period (if applicable), a six month term of coverage begins on the first day of the following month or, if the waiting period does not apply, on the first day of the month following the month in which the enrollment process was completed (by the enrollment processing cut-off date).

Waiting period:

- If the child is found eligible for SCHIP on or before the 15th day of a month, then the waiting period begins on the first day of that same month.
- If the child is found eligible on or after the 16th day of a month, then the waiting period begins on the first day of the next month.

Exceptions to the waiting period:

A child is not subject to the waiting period if the family lost coverage for the child as a result of:

(A) termination of employment because of a layoff or business closing;

- (B) termination of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272);
- (C) change in marital status of a parent of the child;
- (D) termination of the child's Medicaid eligibility because the family's earnings or resources increased or the child reached an age at which Medicaid coverage is not available;
- (E) a similar circumstance resulting in the involuntary loss of coverage;
- (F) the family terminated health benefits plan coverage for the child because the cost to the child's family for the coverage exceeded 10 percent of the family's income;
- (G) the child has access to group-based health benefits plan coverage and will participate in a federally-approved SCHIP premium assistance program administered by HHSC; or
- (H) HHSC has determined that other grounds exist for a good cause exception.

Unborn children are exempt from the waiting period.

The enrollment fee amount, if applicable (See Section 8.2.3), must be paid and the health plan selection, if applicable, must be made in advance of the enrollment cutoff date. Two months before the end of the six-month term of coverage, families are sent a renewal notice informing them that they must renew the SCHIP coverage. For the CHIP Perinatal Program, two months before the end of the twelve-month term of coverage, families are sent a renewal notice informing them that they must renew the SCHIP coverage.

Upon implementation of the dental benefit, current enrollees will be placed in one of the following tiers based on the criteria below:

- Tier I: All new enrollees, with the exception of those listed in Tier II;
- Tier II: Children exempt from cost sharing (less than 133% FPL, Alaskan Natives and American Indians) and children deemed from Medicaid to SCHIP without a gap in coverage; and
- Tier III: No child would be placed in Tier III upon implementation.

As children are enrolled, they will be placed in the appropriate tier as follows:

- Tier I: All new enrollees, with the exception of those listed in Tier II;
- Tier II: Children exempt from cost sharing (less than 133% FPL, Alaskan Natives and American Indians), and children deemed from Medicaid to SCHIP without a gap in coverage; and
- Tier III: No child would be placed in Tier III at initial enrollment.

Members may move up a tier every other consecutive six-month enrollment coverage unless they are already at Tier III.

If there is more than a six-month gap in coverage, their Tier will be based on the criteria for initial enrollment. For the purpose of this policy, Medicaid coverage is not considered a gap in coverage.

Families currently enrolled in SCHIP will receive a packet from the dental contractor at least 30 days prior to implementation. The enrollment packet will contain a Member ID Card, a Provider Directory, a Member Handbook and a Certificate of Coverage. The Certificate of Coverage describes the covered benefits, the cap on preventive coverage, the cap on therapeutic coverage and the complaint and appeal process. The dental contractor will issue a new Certificate of Coverage any time there is a change to benefits.

The dental contractor will be responsible for providing the enrollment broker with a description of the dental benefit for the broker to use in explaining the benefit to enrollees. For specific questions regarding the benefit, the member will need to contact the dental contractor.

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.

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))

The SCHIP application asks whether applicant children are covered through existing health insurance. Children with health coverage are ineligible for SCHIP.

As described in Section 4.1 above, the application for Texas SCHIP and Medicaid screens for Medicaid eligibility. Applications for children eligible for Medicaid are processed by Medicaid workers and eligible children are enrolled in Medicaid. Data matches with Medicaid are also carried out to minimize the chances that children found eligible for Texas SCHIP are not already receiving health insurance.

Texas has two "state health benefits" plans: state employee health coverage under the state Employee Retirement System (ERS) and health coverage for active school district employees available through the Teachers Retirement System (TRS "Active Care"). State law treats these two groups differently, but children with access to either benefits plan are not eligible for SCHIP federal funding.

Children with access to TRS Active Care may be enrolled in Texas SCHIP program, but are identified and paid as state-funded members. Information

about the availability of employer-based insurance and the employer name is obtained during the application process. Additionally, electronic data matching is performed with both the ERS and TRS systems to identify children with access to those benefits.

- 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))

As described in Section 4.4.2 above, Medicaid workers complete the enrollment of these children into the program. The state tracks applications of children who are deemed Medicaid eligible to determine whether eligible applicants choose to enroll.

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

Children determined ineligible for Medicaid are automatically enrolled in SCHIP based on electronic data sharing between the Medicaid eligibility agency and the SCHIP administrative services contractor.

- 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))

4.4.4.1. Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution. Labor analyses show that Texas has a low percentage of jobs in the manufacturing industries where dependent insurance coverage is highest. Employment in Texas is concentrated in retail, services and small business, all of which have low rates of employee health benefits, particularly for lower-paying positions. Also, program design for Texas SCHIP, with such features as a commercially-based benefits package and cost-sharing provisions, are similar to private insurance and will thereby diminish the differences in consumers' minds between group health plans and SCHIP. Up to 150% FPL, crowd out is not anticipated to be a significant issue. The data are less clear at incomes between 150% and 200% FPL. Consequently, the program requires that applicants be uninsured for 90 days as a condition of eligibility. Provision is made to exempt families whose coverage has been discontinued through no fault of their own or who have discontinued coverage because the cost exceeded 10% of family income.

The application screens for whether the child has current insurance. If that is the case, eligibility for SCHIP is denied. If the application indicates that other insurance coverage was in effect during the previous 90 days, the applicant must indicate the date coverage ended, the reason, and the cost of the coverage. This information is used to determine if the children meet a good cause exception to the 90-day waiting period.

The State also monitors for substitution of coverage through SCHIP consumer surveys conducted by the External Quality Review Organization, evaluation of trends indicated by administrative data (e.g.: rates of "good cause" exceptions granted), and evaluation of statewide trends in insured/uninsured rates as indicated by the Current Population Survey (CPS) data.

4.4.4.2. Coverage provided to children in families over 200% and up to 250% 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% 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.

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))

Texas has three Native American tribes:

- The Alabama Coushatta, located in Livingston, has 800 members;
- The Ysleta Del Sur, located in El Paso, has 1500 members;
- The Kickapoo, located in Eagle Pass, has 750 members.

Before the implementation of Texas SCHIP in these areas, the state contacted the tribes to determine how best to ensure the continued participation of tribal

health clinics in the care of tribal members. Health plans are required to contract with or enter into special arrangement with tribal providers. These arrangements help ensure continuity of care for clients that choose to enroll in SCHIP.

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)

Outreach in the first two years of TexCare, which is the state's generic outreach campaign for Children's Medicaid and SCHIP, 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 contracted community-based organizations' (CBO) 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 has always been designed to outreach on behalf of both Children's Medicaid and SCHIP. However, because SCHIP 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 SCHIP "start-up" goal. Now that SCHIP 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 an application and enrollment process for Children's Medicaid-eligible families as seamless, simple and transparent as that enjoyed by SCHIP-eligible families.

Texas' call-to-action outreach efforts that have been so effective in the first two years of the program have not stopped. But, these activities needed to be diversified and made more strategic as Texas' focus shifted to include the permanent incorporation of TexCare information in systems (e.g., schools) in the community and the perpetuation and appropriate utilization of existing coverage.

In all aspects of implementing TexCare, 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 TexCare, 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 TexCare:

- 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 TexCare contracted CBOs and health plans shifting primary emphasis from a call-to-action to the idea that through TexCare, families can afford to keep their children healthy and protected in the event of illness;
- increased emphasis on activities by TexCare CBOs and stakeholders to place TexCare 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 TexCare CBOs and stakeholders to work within organizations that have regular contact with families, i.e., 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 TexCare; and
- continued activities to support enrollee families in successfully completing their annual renewal process, involving health plans, the administrative services contractor, and TexCare CBOs.

The CHIP Car Safety Seat Pilot was a collaborative effort between HHSC and the Texas Injury Prevention (TIP) Network. The pilot was conducted in Hidalgo and Starr counties. The purpose of the pilot was to encourage families to complete their CHIP renewal and increase the appropriate use of child safety seats through the distribution of and training in the proper use of safety seats. Families in the pilot area entering the renewal process were informed they could qualify to receive an age and weight appropriate car seat and safety training. Qualified families made an appointment to attend safety training and receive a car seat when they completed the CHIP renewal process. The TIP Center utilized the broadest possible community participation, including health plans, contracted CHIP community-based organizations, and local health departments. This event-based plan involved going directly into the communities to distribute the car seats as well as informing and assisting with renewal of children in CHIP. The pilot ran for 12 months.

As the TexCare campaign to insure Texas children prepares to enter its fifth year, the continued success of the campaign will require the commitment of entire communities across the state of Texas.

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 community-based organizations 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 community-based organizations 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

- 6.1.4.6. comprehensive state-based coverage
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 services are not a covered benefit for unborn children between 0 and 185 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 above 185 percent up to and including 200 percent of the FPL. Once the child is born, they will receive full CHIP benefits.

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 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 conformation.
- Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentesis, 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 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 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, Cordocentesis, 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 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 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 are limited to prenatal and postpartum 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 Amniocentesis, Cordocentesis, 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 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.

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 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 CHIP Perinatal Program are limited to: nonstress testing, contraction stress testing, hemoglobin or hematocrit, or complete blood count (CBC), urinalysis, 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 CHIP clients.

6.2.9.

Prenatal care and pre-pregnancy 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 pre-pregnancy 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 2 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 (urinalysis 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).

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.

Inpatient psychiatric services are included, up to a 12-month period limit, 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 binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.

Inpatient mental health services are for a 12-month benefit period, and are limited to a 45-day inpatient limit per 12-month period. Twenty-five (25) days of the inpatient benefit can be converted to residential treatment, therapeutic foster care or other 24-hour therapeutically planned and structured services or sub-acute outpatient (partial hospitalization or rehabilitative day treatment) mental health services on the basis of financial equivalence against the inpatient per diem cost. Twenty (20) of the inpatient days must be held in reserve for inpatient use only. Prior authorization may be required for non-emergency 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 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 and neuropsychological and psychological testing.

Includes outpatient psychiatric services, up to an annual limit, 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 binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.

Outpatient mental health services are for a 12-month benefit period and are limited to up to 60 outpatient visits per 12-month period. The visits can be furnished in a variety of community-based settings (including school and home-based settings) or in a state-operated facility. Medication management visits do not count against the outpatient visit limit. Outpatient rehabilitative day treatments are limited to up to 60 days per 12-month period.

Sixty (60) outpatient visits can be converted to skills training (psycho-educational skills development) or rehabilitative day treatment on the basis of financial equivalence against the outpatient visit cost. Sixty (60) rehabilitative day treatment days can be converted to outpatient visits on the basis of financial equivalence against the day treatment per diem cost. Inpatient days converted to sub-acute outpatient services are in addition to the outpatient limits and do not count towards those limits.

Partial hospitalization benefits are paid as described in the inpatient mental health benefits section. Prior authorization may be required; however, outpatient mental health 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 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 (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 ophthalmological disease; hearing aids; other artificial aides including surgical implants.

Durable medical equipment and other medically related or remedial devices are for a 12-month benefit period. Limitations include: \$20,000 per 12-month 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 durable medical equipment 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:

- Durable medical equipment or other medically related remedial devices are not a covered benefit for the unborn child.
- Upon delivery, coverage for the CHIP Perinatal newborn is the same as coverage for 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 \$10,000 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.
- Upon delivery, coverage for the CHIP Perinatal newborn is the same as coverage for 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.
- Upon delivery, coverage for the CHIP Perinatal newborn is the same as coverage for 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.
- Upon delivery, coverage for the CHIP Perinatal newborn is the same as coverage for 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 dental benefit consists of three tiers that cover the following services per 12-month coverage period:

Tier I covers preventive services up to \$250, and therapeutic services up to \$280;

Tier II covers preventive services up to \$250, and therapeutic services up to \$425; and

Tier III covers preventive services up to \$250, and therapeutic services up to \$565.

Preventive services include routine check-ups, x-rays, cleaning and sealants. Therapeutic services include such things as fillings, crowns, root canals and extractions.

A 12-month coverage period is defined as one 12-month enrollment period.

Limitations to dental services are that if services are all used within one 6-month enrollment period, these services are not available during the second 6-month enrollment period.

CHIP Perinatal Program:

- Dental services are not a covered benefit for the unborn child.
- Upon delivery, coverage for the CHIP Perinatal newborn is the same as coverage for CHIP clients.

- 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.

Inpatient substance abuse treatment services and residential substance abuse treatment services are for a 12-month benefit period. Limitations to inpatient and residential substance abuse treatment services are 14 days per 12-month period for detox/crisis stabilization services; 60 days per 12-month period for 24-hour residential rehabilitation programs, or equivalent (30 days must be held in reserve; however, 30 days may be converted to partial hospitalization or intensive outpatient rehabilitation on the basis of financial equivalence against the inpatient per diem cost).

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.
- Upon delivery, coverage for the CHIP Perinatal newborn is the same as coverage for 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.

Outpatient substance abuse treatment services are for a 12-month benefit period. Limitations to outpatient substance abuse treatment services are: up to 12 weeks per 12-month period for the intensive outpatient program; and up to six months per 12-month period for outpatient services. 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 primary care provider 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.
- Upon delivery, coverage for the CHIP Perinatal newborn is the same as coverage for 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 underserved 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 on the CHIP program.

CHIP Perinatal Program:

- Case management services are a covered benefit for the unborn child.
- Upon delivery, coverage for the CHIP Perinatal newborn is the same as coverage for 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.
- Upon delivery, coverage for the CHIP Perinatale newborn is the same as coverage for 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.
- Upon delivery, coverage for the CHIP Perinatal newborn is the same as coverage for 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 6-month benefit 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 services must waive their rights to treatment related to their terminal illnesses; however, they 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.
- Upon delivery, coverage for the CHIP Perinatal newborn is the same as coverage for 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 period. Coverage is limited to 60 days per 12-month 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.

- Upon delivery, coverage for the CHIP Perinatal newborn is the same as coverage for CHIP clients.

Emergency Services including Emergency Hospitals and Physician

Covered, medically necessary covered services include: emergency services based on prudent lay person definition of emergency health condition; hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers; medical screening examination; stabilization services; 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 are limited to those emergency services that directly relate to the delivery of the covered unborn child until birth.
- Coverage for the CHIP Perinatal newborn is the same as coverage for 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 period, without Health Plan authorization; and one pair of non-prosthetic eyewear per 12-month period. Vision services are for a 12-month benefit 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.
- Upon delivery, coverage for the CHIP Perinatal newborn is the same as coverage for 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.
- Upon delivery, coverage for the CHIP Perinatal newborn is the same as coverage for CHIP clients.

Tobacco Cessation Programs

A Health Plan approved tobacco cessation program is covered up to a \$100 limit per 12-month period. Tobacco cessation program services are for a 12-month benefit 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.
- Upon delivery, coverage for the CHIP Perinatal newborn is the same as coverage for CHIP clients.

Chiropractic Services

Medically necessary services are limited to spinal subluxation. Chiropractic services do not require physician prescription and are for a 12-month benefit period. These services are limited to 12 visits per 12-month 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.
- Upon delivery, coverage for the CHIP Perinatal newborn is the same as coverage for CHIP clients.

6.2.25. Premiums for private health care insurance coverage (Section 2110(a)(25)) (Note: HHSC is developing a premium assistance program through a HIFA waiver request.)

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.
- Upon delivery, coverage for the CHIP Perinate newborn is the same as coverage for 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))

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% limitation 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))

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 SCHIP 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 SCHIP 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 SCHIP 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 SCHIP 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 SCHIP 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 SCHIP 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 SCHIP 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 SCHIP beneficiaries and full-time board certified/board eligible pediatricians to SCHIP 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. No member is 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 SCHIP 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 SCHIP 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.

SCHIP 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? (42CFR 457.505)

8.1.1. YES

8.1.2. NO, skip to question 8.8.

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 and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums: See costing sharing table. Unborn children are exempt from cost-sharing through the duration of their 12-month eligibility.

8.2.2. Deductibles: None.

8.2.3. Coinsurance or co-payments: See costing sharing table. Unborn children are exempt from cost-sharing through the duration of their 12-month eligibility.

Cost Sharing	
Enrollment Fees (for 6-month enrollment period):	Charge
At or below 133% of FPL, American Indians and Alaska Natives	\$0
Above 133% up to and including 150% of FPL	0
Above 150% up to and including 185% of FPL	\$35
Above 185% up to and including 200% of FPL	\$50
Co-Pays (per visit):	Charge
At or below 100% of FPL	Charge
Office Visit	\$3
Non-Emergency ER	\$3
Generic Drug	\$0
Brand Drug	\$3
Cost Sharing Cap	1.25% (of family’s income)*
Facility Co-pay, Inpatient	\$10
Above 100% up to and including 150% of FPL	Charge
Office Visit	\$5
Non-Emergency ER	\$5
Generic Drug	\$0
Brand Drug	\$5
Cost Sharing Cap	1.25% (of family’s income)*
Facility Co-pay, Inpatient (per admission)	\$25

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Above 150% up to and including 185% of FPL	Charge
Office Visit	\$7
Non-Emergency ER	\$50
Generic Drug	\$5
Brand Drug	\$20
Cost Sharing Cap	2.5% (of family’s income)*
Facility Co-pay, Inpatient (per admission)	\$50
Above 185% up to and including 200% of FPL	Charge
Office Visit	\$10
Non-Emergency ER	\$50
Generic Drug	\$5
Brand Drug	\$20
Cost Sharing Cap	2.5% (of family’s income)*
Facility Co-pay, Inpatient (per admission)	\$100

*Per 6-month term of coverage

8.2.4. Other: None.

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)(B)) (42CFR 457.505(b))

Outreach materials reference cost sharing requirements. The administrative services contractor provides information to SCHIP families about the required enrollment fee and co-payments for services. Health plans also include information on co-payments in member handbooks sent to SCHIP beneficiaries once enrolled.

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)) (42CFR 457.530)

8.4.2. No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 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)) (42CFR 457.515(f))

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))

Families receive information during the enrollment process on how to track and report

their cost sharing expenditures. Texas uses a 1.25% aggregate cap per 6-month term of coverage for families at or below 150% of the FPL. For families at 151% to 200% of the FPL, a 2.5% aggregate cap applies per 6-month term of coverage (see section 8.2.3).

When a family is near their cap on out of pocket cost sharing, they submit a form to the SCHIP administrative services contractor, which in turn, notifies the member's HMO. The HMO sends the member a new membership card that indicates no cost sharing is required through the end of that member's enrollment period.

In addition to seeing the member's card (which would indicate no cost sharing required if cap has been reached), providers can also access a toll-free line operated by the SCHIP administrative services contractor that provides eligibility information.

- 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)) (42CFR 457.535)

American Indian and Alaska Native applicants identify themselves on the application. The administrative services contractor uses special identifying codes for American Indians and Alaska Natives. This code ensures that American Indians and Alaska Natives are not charged an enrollment fee. The American Indian and Alaska Native identifiers are transmitted electronically to the health plans. Under the state's contract, the health plans are prohibited from assessing co-payments for American Indians and Alaska Natives. Health plan Member ID cards for American Indians and Alaska Natives must show that they owe no co-payments for services. The health plan also is contractually required to educate providers about the cost-sharing waiver for American Indians and Alaska Natives.

- 8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(e))

New enrollees must pay the enrollment fee prior to enrollment in the program. Families renewing coverage have until cut-off of the first month of the new six-month coverage period to pay the enrollment fee. Cut-off is usually 10-15 days prior to the end of the month. As long as payment is received by the cut-off date, no lapse in coverage is experienced. If the family fails to pay the enrollment fee by cut-off of the first month of the new six-month coverage period, the family will be sent a disenrollment letter.

If the family wishes to request a review, the family must send a written request within 30 days from the date of denial. The review is processed within 10 business days. If the family is dissatisfied with the outcome of the review, the family may request an administrative review. The administrative review is performed by the state within 15 business days. The results of the administrative review are final.

Enrollees are not disenrolled for nonpayment of co-pays (payments that clients pay directly to providers).

- 8.7.1 Please provide an assurance that the following disenrollment protections are being applied:
- State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, co-payments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))
 - 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. (42CFR 457.570(b))
 - In the instance mentioned above, the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))
 - The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))
- 8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))
- 8.8.1 No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)
 - 8.8.2 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)
 - 8.8.3 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 the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))
 - 8.8.4 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))
 - 8.8.5 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.
 - 8.8.6 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 SCHIP-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 SCHIP-Enrolled Texas Children.

Strategic Objective 3: Provide Improved Health Outcomes for New SCHIP-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 SCHIP-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 SCHIP to the estimated number of potentially SCHIP 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 SCHIP-Enrolled Texas Children.

Performance Goal A: Track number and percentage of SCHIP-coverage children with completed immunizations at end of middle school (approximately 12-14 years of age).

Performance Goal B: Track number and percentage of SCHIP-coverage children receiving well child checkups by county, age, and racial/ethnic groups.

Strategic Objective 3: Provide Improved Health Outcomes for New SCHIP-Enrolled Texas Children through Appropriate Utilization of Health Care Resources.

Performance Goal A: Track number and percentage of SCHIP-coverage children receiving well child checkups by county, age,

and racial/ethnic groups.

Performance Goal B: Track number and percentage of SCHIP-coverage children receiving emergency services by county and age.

Performance Goal C: Track number and percentage of SCHIP-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 SCHIP program have been initiated for the first biennium based on the principal desire of the state to plan and implement a successful SCHIP 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 SCHIP 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 SCHIP 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 SCHIP. The Texas House Committee on Appropriations and the Texas House Committee on Public Health also participated in joint public hearings on SCHIP 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 SCHIP 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 SCHIP.

A number of advocacy groups in Texas formed the SCHIP Coalition in Spring 1998.

State representatives meet regularly with the SCHIP Coalition, making presentations on various aspects of the program design and seeking feedback throughout the development process. The state used the SCHIP Coalition to provide input and guidance on program components as Texas SCHIP was implemented. The state also meets with the Disability Policy Consortium, which represents statewide disability advocacy groups, to discuss developments in Texas SCHIP.

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 SCHIP.

Public involvement in implementation of Texas SCHIP 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 SCHIP 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 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 SCHIP 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.

- hearing was held on November 1, 2005.
- Public notice was also submitted to the *Texas Register*.

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.

SCHIP Budget Plan

	Federal Fiscal Year 2008 Costs
Enhanced FMAP rate (state share)	0.2761
Benefit Costs	
Managed Care Premiums	
Per member/per month rate times the number of eligibles	935,187,374
Fee for Service:	
Prescription Drugs	135,642,986
Total Benefit Costs	1,070,830,359
(Offsetting beneficiary cost sharing payments)	(10,936,980)
Net Benefit Costs	1,059,893,379
Administration Costs	
Eligibility Enrollment and Outreach	20,883,925
Other Administration	5,624,944
Subtotal	26,508,869
Total Administration Costs	26,508,869
10% Administrative Cost Ceiling (benefits-cost share)/9)	117,765,931
Federal Share (multiplied by EFMAP rate)	786,446,587
State Share	299,955,661
TOTAL PROGRAM COSTS	1,086,402,248

Notes: The Federal Fiscal Year (FFY) runs from October 1st through September 30th.
 Members per Month and PMPM assumptions are derived from the June Update 2007 forecast which includes HB 109.
 Client Service cost include Perinates, Vaccines, and Dental.

Model Application Template for the State Children's Health Insurance Program

Average Federally funded SCHIP Members per Month: FY 2008 - 335,969 (excludes Perinates).

The PMPM assumptions are \$103.06 for premiums, and \$0.49 for vaccines and \$25.36 for Prescription Drugs

Average Federally-funded SCHIP Perinate Members per Month: FY 2008 - 95,480

The PMPM assumptions are \$451.85 for premiums, and \$29.17 for Prescription Drugs

The State's funding sources include State Tobacco Funds, General Revenues, rebates, and cost sharing.

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.

Funding Sources

The funding source for the state share for state fiscal years 2002 and beyond includes appropriated state funds and may include other public funds certified or transferred from public agencies consistent with applicable federal law and regulations.

Sources of state share for state fiscal year 2002 and beyond also include bona-fide donations consistent with Section 2107(e)(1)(C) of the Social Security Act, Section 1903(w) of the Act, and other applicable federal law and regulations. The following provides background on the donors, donor sources of revenue and donor funding flow for the one project that involves bona-fide donations: the Community Health Workers Project (approved in correlation with the compliance SPA amendment). Documentation for additional donors will be submitted to CMS for approval. The State assures compliance with the definition of bona-fide donations described in 42CFR Section 433.54 for all donations.

Donor(s)

Community Health Workers Project

The donor(s) for the community health worker project are as follows:

Houston Endowment, Inc. – Jesse and Mary Gibbs Jones established the Houston Endowment, Inc. in 1937 to provide financial support for charitable and educational projects in the Houston community. The total award is \$173,000 over a three-year period.

Donor Sources of Revenue

Community Health Workers Project

According to Financial Statements for the Year ended December 31, 2002, it is assured that the Houston Endowment, Inc. receives no more than 25 percent of its annual revenues from health care related providers and does not provide medical or administrative related services under SCHIP.

Funding Flow

Community Health Workers Project

Donations will flow from the donor entity (the Houston Endowment, Inc.) to HHSC, which in turn will reflect the amount of those donations in its federal funds claims.

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.

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.

Both the TexCare review and the HHSC review processes described below are impartial reviews. The TexCare review is impartial because it is performed by a TexCare unit that is separate from the unit that originally made the determination. The HHSC review is impartial since HHSC does not do any direct determinations.

Eligibility and Enrollment Matters Review and Reconsideration Process

- 1) **Matters Subject to Review.** An applicant or member may request a review of an initial adverse determination made by the administrative contractor concerning the following:
 - a) denial of eligibility;
 - b) failure to make a timely determination of eligibility;
 - c) enrollment or disenrollment (disenrollment for failing to meet cost sharing obligations is not applicable);
- 2) **Matters Not Subject to Review.** The state is not required to provide an opportunity for review and reconsideration 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.
- 3) **Reconsideration by the Health and Human Services Commission.**

If TexCare's decision following its review is adverse to the applicant or member, he or she may request reconsideration by the Health and Human Services Commission.

Notice of Adverse Determinations

TexCare must 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 supporting it;
- 2) the individual's right to request review and reconsideration of the action or

determination;

- 3) the process for initiating a review or reconsideration;
- 4) the time frame that applies to the review or reconsideration; and
- 5) the circumstances under which enrollment, if applicable, may continue pending review and reconsideration.

Notification of Eligibility Denials

Within 5 business days of determining an eligibility denial, TexCare sends the applicant an eligibility denial notification letter explaining:

- 1) the reason for the denial;
- 2) the member's right to request review by TexCare of the decision and the time frames for the review process;
- 3) the member's right to request impartial reconsideration by HHSC, if he or she disagrees with TexCare's review decision, and the time frames for the reconsideration process; and how to request review and reconsideration

Notification of Disenrollment

Within ten calendar days of determining a member should be disenrolled, TexCare sends the applicant a disenrollment notification letter explaining:

- 1) the reason for disenrollment;
- 2) the effective date of the disenrollment;
- 3) the member's right to request review by the TexCare of the decision and the time frames for the review process;
- 4) the member's right to request impartial reconsideration by HHSC, if he or she disagrees with TexCare's review decision, and the time frames for the reconsideration process; and
- 5) how to request review and reconsideration.

Requesting a Review

The applicant or member must submit a 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, whether the appeal is conducted in person, in writing, or by telephone.

Disposition of the Review

Timely Review. TexCare must complete its decision on the review in a timely manner and furnish a copy of the decision to the applicant or member. The review decision must:

- 1) state whether the initial adverse action or determination was upheld or reversed and the reasons why; and
- 2) explain the individual's right to request a second reconsideration by the Health and Human Services Commission or its designee, of the initial adverse action or determination, and include instructions on requesting reconsideration.

Expedited Review. If TexCare and/or HHSC becomes aware that an enrollee's medical condition necessitates an expedited review, in accordance with 42 CFR 457.1160(b)(2), TexCare will grant a continuation of the enrollee's current enrollment pending the expedited review.

Reconsideration by the Health and Human Services Commission

- 1) An applicant or member must request reconsideration by HHSC in writing.
- 2) HHSC must complete its reconsideration of its final decision in a timely manner based upon receipt of the written request for reconsideration by HHSC.
- 3) The reconsideration decision must include the reasons for the decision.

Continuation of Enrollment Pending Disposition of Review and Reconsideration

TexCare will grant continuation of enrollment pending review and reconsideration of a disenrollment determination, including disenrollment for failure to pay cost sharing.

Timelines for Reviews

- (1) Families have 30 working days from date of notification letter to submit an appeal concerning TexCare's decision to deny eligibility or disenroll.
- (2) TexCare 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.
- (4) Within 5 working days of date of receipt, TexCare notifies HHSC of request for additional HHSC review.
- (5) HHSC has 15 working days to respond to family and notify TexCare of HHSC decision

Health Services Matters

- 12.2 Please describe the review process for **health services matters** that complies with 42 CFR §457.1120.

HHSC requires health insurers to comply with State-specific grievance and appeal requirements currently in effect in the State. State regulations concerning adverse determination are found in the Texas Insurance Code, Section 843.261, Atr.21.58A.

Health Services Matters are:

- 1) delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services; and
- 2) failure to approve, furnish or provide payment for health services in a timely manner.

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 Chapter 20A and article 21.58A, Insurance Code. Such a complaint may lead to review by an independent review organization formed pursuant to article 21.58C, 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.

Premium Assistance Programs

- 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.