

**Department of State Health Services
Council Agenda Memo for State Health Services Council
January 22, 2010**

Agenda Item Title: Amendments to rules, repeal of a rule, and new rules concerning the Children with Special Health Care Needs Services Program

Agenda Number: 5j

Recommended Council Action:

For Discussion Only

For Discussion and Action by the Council

Background: The Children with Special Health Care Needs (CSHCN) Services Program, in the Family and Community Health Services Division, Specialized Health Services Section, Purchased Health Services Unit, provides services to children younger than 21 years of age who have a chronic physical or developmental condition or to eligible clients with cystic fibrosis, regardless of age. The program's health care benefits include payments for medical care, family support services, and related services not covered by Medicaid, Children's Health Insurance Program (CHIP), private insurance, or other third party payers. The program contracts with agencies throughout the state to provide an array of clinical and support services to children with special health care needs and their families. The program also assists children and their families by supporting case management at DSHS regional offices throughout Texas.

As of August 31, 2009, there were 2,568 clients eligible to receive health care benefits, and there were 838 clients on the waiting list. The CSHCN Services Program reports annually to the federal government on six national Title V performance measures and additional state program performance measures. The CSHCN Services Program Fiscal Year 2010 budget is \$43,471,343, from Federal Title V Block Grant and state funds.

Summary: The purpose of the amendments, repeal, and new rules is to strengthen and clarify the rule language, correct the grammar to improve the flow, accuracy, and consistency of the rules, and comply with the four-year review of agency rules required by Government Code, Section 2001.039.

The rules will update names and addresses, revise definitions, clarify requirements of the program, and add procedures for third party recovery.

The expected outcomes of the proposed rules are to enhance the understanding of program policy for CSHCN Services Program applicants, clients, and providers; increase readability of the rules; and accurately reflect program information for better interpretation of the rules by the public.

Summary of Input from Stakeholder Groups: Recommendations were solicited via the CSHCN Services Program website, email, and regular mail on May 13, 2009, from 7,158 CSHCN Services Program contracted providers and 43 advocacy groups.

Comments were received from 24 stakeholders representing community clinics, hospitals, home health organizations, a county indigent program, private practitioners, Advocacy Inc., the Office of the Medical Director for Medicaid/CHIP, the Texas Nurses Association, and members of the public.

Recommendations included in the rules are to correct formatting; add a definition of "subrogation;" and clarify covered services for clients who need physical therapy, occupational therapy, and speech-language therapy.

Suggestions and comments not included in the rules because they are addressed in the current statute, rules, or policy are to:

- Communicate electronically for cost savings purposes.
- Clarify the benefit for inpatient hospital stays.
- Renew eligibility annually instead of semiannually.
- Establish a consistent process for dental reimbursements.
- Establish a voucher program for dental care.
- Authorize a pediatric healthcare provider or the primary healthcare provider, such as an advanced practice registered nurse or physician's assistant, to sign the Physician/Dentist Assessment Form (PAF).
- Renew the PAF every three years for chronic diagnoses.
- Add benefits for adults over the age of 21 with a diagnosis of congenital heart disease (CHD).
- Add benefits for adults over the age of 21 with a diagnosis of sickle cell disease.
- Clarify the provider enrollment process.

Suggestions and comments not included in the rules because they are out of scope of the rules are to simplify the quick reference guide for program providers; increase the accessibility of enrollment applications for applicants; expedite the authorization approval process; and establish an online or phone authorization process.

A recommendation not included in the rules because it is outside the scope of the program is to improve the quality of state-approved group homes.

The following recommendations were not included in the rules due to budgetary restrictions.

- Increase the reimbursement rate for physicians for case management in primary and specialty care offices.
- Increase the benefits and simplify the transition from pediatric to adult-based care.
- Add benefits for premature infants.
- Add benefits for an evaluation of a living kidney donor.
- Increase the maximum number of allowable inpatient hospital days.
- Clarify covered services for renal transplants and include other organ transplants.
- Increase funding.
- Increase benefits for clients' behavioral needs.
- Add behavioral analysts as a payable provider type for the CSHCN Services Program.
- Allow reimbursement for special testing on the same date as the original appointment.
- Increase reimbursement rates for providers.
- Decrease the waiting list and simplify the application process.
- Evaluate the limits on outpatient mental health treatment and ensure consistency with health care parity rules.

Proposed Motion: Motion to recommend HHSC approval for publication of rules contained in agenda item #5j

Approved by Assistant Commissioner/Director: Evelyn Delgado	Date: 1-5-10	
Presenter: Jann Melton-Kissel	Program: Specialized Health Services Section	Phone No.: (512) 458-7111 ext. 2002
Approved by CPCPI: Carolyn Bivens	Date: 1-4-10	

Title 25. HEALTH SERVICES
Part I. DEPARTMENT OF STATE HEALTH SERVICES
Chapter 38. Children with Special Health Care Needs Services Program
Amendments §§38.1 - 38.12, 38.14, and 38.16
New §§38.13 and 38.15
Repeal §38.13

PROPOSED PREAMBLE

The Executive Commissioner of the Health and Human Services Commission, on behalf of the Department of State Health Services (department), proposes amendments to §§38.1 - 38.12, 38.14, and 38.16, repeal of §38.13, and new §§38.13 and 38.15 concerning the Children with Special Health Care Needs (CSHCN) Services Program.

BACKGROUND AND PURPOSE

As authorized by Health and Safety Code, Chapter 35, the CSHCN Services Program provides services to children younger than 21 years of age who have a chronic physical or developmental condition, or to eligible clients with cystic fibrosis regardless of age.

The amendments, repeal, and new rules will strengthen and update information, revise and delete language, and make grammatical corrections to improve flow, accuracy, and consistency in the rules.

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

SECTION-BY-SECTION SUMMARY

The following changes to names and addresses have been made throughout §§38.1 - 38.12, 38.14, and 38.16. References to the department's name have been changed from "Texas Department of Health" to "Department of State Health Services," and the address for all correspondence has been changed from "1100 West 49th Street, Austin, Texas 78756" to "MC 1938, P. O. Box 149347, Austin, Texas 78714-9347."

The proposed amendments to §§38.1, 38.5, 38.11, 38.12, 38.14, and 38.16, the repeal of §38.13, and new §38.13 revise the name of the program as currently used, clarify existing language, and increase readability.

Proposed amendments to §38.2 add new definitions, delete one definition, and update the definitions of other terms used within the rules. The paragraphs have been renumbered accordingly.

Proposed amendments to §38.3 clarify the CSHCN Services Program eligibility requirements.

Proposed amendments to §38.4 modify and update language concerning benefits and limitations and revise references to reimbursements for services.

Proposed amendments to §38.6 revise general requirements for program participation, actions affecting provider enrollment, provider types, requirements for specialty centers, and out-of-state coverage.

Proposed amendments to §38.7 clarify that all freestanding ambulatory surgical centers must apply for program approval and must comply with state licensure requirements and Medicare certification standards.

Proposed amendments to §38.8 revise criteria for approval of inpatient rehabilitation centers.

Proposed amendments to §38.9 clarify existing language, increase readability, and revise the section title concerning cleft-craniofacial services.

Proposed amendments to §38.10 modify existing language and revise specific reimbursement amounts for payment of services.

New §38.15 authorizes the program or the program's designee to recover the cost of services provided to a client from a person who does not pay or from any third party who has a legal obligation to pay other benefits. New §38.15 limits the program's right of recovery to the cost of the covered services provided to treat the client's specific condition or injury that was caused by a liable third party and also authorizes the program or the program's designee to waive all or part of the program's right to recover from a liable third party in certain specific circumstances.

FISCAL NOTE

Jann Melton-Kissel, RN, MBA, Director, Specialized Health Services Section, has determined that for each year of the first five-year period that the sections will be in effect, there will be no fiscal impact to state or local governments as a result of enforcing and administering the sections as proposed. The amendments, repeal, and new sections are intended to clarify, update, and strengthen the chapter and are not anticipated to be controversial or have significant fiscal impact on the department or local governments.

MICRO-BUSINESS AND SMALL BUSINESS ECONOMIC IMPACT ANALYSIS

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

PUBLIC BENEFIT

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

REGULATORY ANALYSIS

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

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Comments on the proposal may be submitted by mail to Sandra Owen, RN, MN, Policy Formulation and Health Benefit Team Lead, Purchased Health Services Unit, MC 1938, Department of State Health Services, P.O. Box 149347, Austin, Texas 78714-9347; by telephone at (512) 458-7111, extension 3007; or by email to sandra.owen@dshs.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Lisa Hernandez, certifies that the proposed rules have been reviewed by legal counsel and found to be within the state agencies' authority to adopt.

STATUTORY AUTHORITY

The amendments, repeal, and new rules are authorized by Government Code, §531.0055(e), and Health and Safety Code, §§35.003, 35.004, 35.005, 35.006, and §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. Review of the sections implements Government Code, §2001.039.

The amendments, repeal, and new rules affect Government Code, Chapter 531, and Health and Safety Code, Chapters 35 and 1001.

Section for repeal.

§38.13. Right of Appeal.

Legend: (Proposed Amendments and New Rules)

Single Underline = Proposed new language

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

Regular Print = Current language

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

§38.1. Purpose and Common Name.

(a) Purpose. The purpose of this chapter is to implement the **[Services Program for]** Children with Special Health Care Needs Services Program (CSHCN) that is authorized by Health and Safety Code, Chapter 35₂, to provide the following services to eligible children:

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

(b) (No change.)

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

(1) (No change.)

(2) Advanced practice registered nurse--A registered nurse approved by the Texas Board of Nursing **[Nurse Examiners]** to practice as an advanced practice registered nurse, including₂, but not limited to₂, a nurse practitioner, nurse anesthetist, or clinical nurse specialist.

(3) (No change.)

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

[(A) is physically present within the geographic boundaries of the state;]

[(B) has an intent to remain within the state;]

[(C) maintains an abode within the state (i.e., house or apartment, not merely a post office box);]

[(D) has not come to Texas from another country for the purpose of obtaining medical care, with the intent to return to the person's native country;]

[(E) does not claim residency in any other state or country; and]

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

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

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

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

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

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

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

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

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

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

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

(7)[(8)] Chronic developmental condition--A disability manifested during the developmental period for a child with special health care needs which results in impaired intellectual functioning or deficiencies in essential skills, which is expected to continue for a period longer than one year, and which causes a person to need assistance in the major activities of daily living or **[and/or]** in meeting personal care needs. For the purpose of this chapter, a chronic developmental condition must include physical manifestations and may not be solely a delay in intellectual, mental, behavioral, or **[and/or]** emotional development.

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

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

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

(A) New client:

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

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

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

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

(11) CMS--The Centers for Medicare and Medicaid Services.

(12) (No change.)

(13) Commissioner--The Commissioner of the Department of State Health Services.
[The Commissioner of Health.]

(14) (No change.)

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

(16) - (20) (No change.)

(21) Diagnosis and evaluation services--The process of performing specialized examinations, tests, or ~~and/or~~ procedures to determine whether a CSHCN Services Program applicant for health care benefits has a chronic physical or developmental condition as

determined by a physician or dentist participating in the CSHCN Services Program or [and/or] to help determine whether a waiting list client has an "urgent need for health care benefits"[,] according to the criteria and protocol described in §38.16(e) of this title (relating to Procedures to Address CSHCN Services Program Budget Alignment).

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

(A) The effective date of eligibility for newborns who are not born prematurely will be the date of birth. Newborn means a child 28 [30] days old or younger.

(B) The effective date of eligibility for an applicant who is born prematurely shall [following traumatic injury will] be the day after the applicant has been out of the hospital for 14 consecutive days [the acute phase of treatment ends], but no earlier than 15 days prior to the date of receipt of the application.

(C) The effective date of eligibility following traumatic injury shall [for an applicant that is born prematurely will] be the day after the acute phase of treatment ends [the applicant has been out of the hospital for 14 consecutive days], but no earlier than 15 days prior to the date of receipt of the application.

(D) (No change.)

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

(23) - (24) (No change.)

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

(26) Family--For the purpose of determining family income for program eligibility [this chapter], the family includes the following persons who live in the same residence:

(A) (No change.)

(B) those related to the applicant as a parent, stepparent [**step-parent**], or spouse who have a legal responsibility to support the applicant, or guardians or managing [**guardians/managing**] conservators who have a duty to provide food, shelter, education, and medical care for the applicant;

(C) (No change.)

(D) children of a parent, stepparent [**step-parent**], or spouse.

(27) (No change.)

(28) Federal Poverty Level (FPL)--The minimum income needed by a family for food, clothing, transportation, shelter, and other necessities in the United States, according to the United States Department of Health and Human Services, or its successor agency or agencies. The FPL varies according to family size and after adjustment for inflation, is published annually in the *Federal Register*.

(29) Federally qualified health center (FQHC)--A federally qualified health center is designated by CMS to provide core medical services to a Medically Underserved Population (MUP).

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

(31) Guardian--A statutory officer appointed under the Texas Probate Code who has a duty to provide food, shelter, education, and medical care for his or her ward.

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

(33)[(30)] Health insurance and health benefits plan [**Health insurance/health benefits plan**]--A policy or plan, individual, group, or government-sponsored, that an individual purchases or in which an individual participates that provides benefits when medical or [**and/or**] dental costs are or would be incurred. Sources of health insurance include, but are not limited to, health insurance policies, buy-in programs, health maintenance organizations, preferred provider organizations, employee health welfare plans, union health welfare plans, medical expense reimbursement plans, United States Department of Defense or Department of Veterans Affairs benefit plans, Medicaid, CHIP [**the Children's Health Insurance Program (CHIP)**], and Medicare. Benefits may be in any form, including, but not limited to, reimbursement based upon cost, cash payment based upon a schedule, or access without charge or at minimal charge to providers of medical or [**and/or**] dental care. Benefits from a municipal or county hospital, joint

municipal-county hospital, county hospital authority, hospital district, county indigent health care programs, or the facilities of a publicly supported medical school shall not constitute health insurance for purposes of this chapter.

(34)[(31)] Household--For the purpose of determining spenddown medical expenses, the [The] living unit in which the applicant resides and which also may include one or more of the following:

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

(35) Managing conservator--A person designated by a court to have daily legal responsibility for a child.

(36) Medicaid--A program of medical care authorized by Title XIX of the Social Security Act and the Human Resources Code.

(37)[(32)] Medical home--A respectful partnership between a client, the client's family as appropriate, and the client's primary health care setting. A medical home is family centered health care that is accessible, continuous, comprehensive, coordinated, compassionate, and culturally competent. A medical home provides primary care that includes [a licensed medical professional who accepts responsibility for the provision and/or coordination of primary,] preventive[,] care, care coordination, and appropriate referral and collaboration with specialist and other service providers as required [and/or specialty care for a client, and coordination of care with other community services providers].

(38) Medicare--A federal program that provides medical care for people age 65 or older and the disabled as authorized by Title XVIII of the Social Security Act.

(39)[(33)] Natural home--The home in which a person lives that is either the residence of his or her [his/her] parent(s), foster parent(s) or guardian [guardian(s)], or extended family

member(s), or the home in the community where the person has chosen to live, alone or with other persons. A natural home may utilize natural support systems such as family, friends, co-workers, and services available to the general population as they are available.

(40)~~[(34)]~~ Other benefit--A benefit, other than a benefit provided under this chapter, to which a person is entitled for payment of the costs of services included in the scope of coverage of the CSHCN Services Program including, but not limited to, benefits available from:

- (A) an insurance policy, group health plan, health maintenance organization, or prepaid medical or dental care plan;
- (B) home, auto, or other liability insurance;
- (C) Title XVIII, Title XIX, or Title XXI of the Social Security Act (42 U.S.C. §§1395 *et seq.*, 1396 *et seq.*, and 1397aa *et seq.*)~~;~~ as amended;
- (D) the United States Department of Veterans Affairs;
- (E) the United States Department of Defense;
- (F) workers' compensation or any other compulsory employers' insurance program;
- (G) a public program created by federal or state law or under the authority of a municipality or other political subdivision of the state, excluding benefits created by the establishment of a municipal or county hospital, a joint municipal-county hospital, a county hospital authority, a hospital district, a county indigent health care program, or the facilities of a publicly supported medical school; or
- (H) a cause of action for the cost of care, including medical care, dental care, facility care, and medical supplies, required for a person applying for or receiving services from the department~~;~~ or a settlement or judgment based on the cause of action~~;~~ if the expenses are related to the need for services provided under this chapter.

(41) Otologist--A physician whose specialty is diseases of the ear.

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

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

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

(45) Physician assistant--A person licensed as a physician assistant by the Texas Physician Assistant Board.

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

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

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

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

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

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

(C) other services specified in this chapter.

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

(51) Rural health clinic--A rural health clinic is designated by CMS to provide core medical services in a Medically Underserved Area (MUA).

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

(53)[(44)] Services--The care, activities, and supplies provided under the Act, including but not limited to, both acute and chronic or rehabilitative **[chronic/rehabilitative]** medical care, dental care, facility care, medications, durable medical equipment, medical supplies,

occupational, physical, and speech therapies, family support services, case management services, and other care specified by program rules.

~~(54)~~**(45)** Social service organization--For purposes of this chapter, a for-profit or nonprofit corporation or other entity, not including individual persons, that provides funds for travel, meal, lodging, and family supports expenses in advance to enable CSHCN Services Program clients to obtain program services.

~~(55)~~**(46)** Specialty center--A facility and staff that meet the CSHCN Services Program minimum standards established in this chapter and are designated for use by CSHCN Services Program clients as part of the comprehensive services for a specific medical condition.

~~(56)~~**(47)** Spenddown--Financial eligibility achieved when household income exceeds 200% of the FPL [**federal poverty level,**] if the applicant's family can document its responsibility for household medical bills that are equal to or greater than the amount in excess of the 200% level.

~~(57)~~**(48)** State--The State of Texas.

~~(58)~~ Subrogation--Assumption by third party, such as a second creditor or an insurance company, of another person's legal right to collect a debt or damages.

~~(59)~~**(49)** Supplemental Security Income Program (SSI)--Title XVI of the Social Security Act which provides for payments to individuals (including children under age 18) who are disabled and have limited income and resources.

~~(60)~~**(50)** Support--The contribution of money or services necessary for a person's maintenance, including, but not limited to, food, clothing, shelter, transportation, and health care.

~~(61)~~ Texas resident--A person who:

~~(A)~~ is physically present within the geographic boundaries of the state;

~~(B)~~ has an intent to remain within the state;

~~(C)~~ maintains an abode within the state (i.e., house or apartment, not merely a post office box);

~~(D)~~ has not come to Texas from another country for the purpose of obtaining medical care with the intent to return to the person's native country;

~~(E)~~ does not claim residency in any other state or country; and

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

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

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

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

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

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

(65) Ward--An individual placed under the protection of a guardian, or a person who by reason of incapacity is under the protection of a court either directly or through a guardian appointed by the court.

§38.3. Eligibility for Services.

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

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

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

(2) Financial criteria. Financial criteria are determined every six months [,] or as directed by statutory requirements. Financial criteria are based upon the same determinations of income, family size, and disregards as the CHIP. Premiums paid for health insurance may be included as a disregard. All families must verify their income and disregards, if applicable.

(A) (No change.)

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

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

(ii) The program [CSHCN Services **Program**] also may require an ongoing client for whom actual or projected expenditures exceed \$2,000 per year to apply for the SSI program[,], and, if eligible, to participate in that program in order to remain eligible for further program [CSHCN Services **Program**] benefits. Within 60 days of the date of the notification letter, the client must submit to the program [CSHCN Services **Program**] verification of a timely and complete application to SSI. During this 60-day period, program [CSHCN Services **Program**] coverage will continue. If the client does not provide this verification within the 60-day time limit, program [CSHCN Services **Program**] coverage may be terminated. With verification of an application to SSI, the program may continue coverage[,], pending receipt of an SSI eligibility determination.

(3) Health insurance.

(A) All health insurance coverage insuring the applicant and [**and/or**] family must be listed on the application. If insurance coverage was effective prior to program [CSHCN Services **Program**] eligibility, such coverage must be kept in force. Noncompliance with this requirement may result in the termination of program [CSHCN Services **Program**]

benefits. If insurance cannot be maintained, the applicant or parent, guardian, or managing conservator [**parent/guardian/managing conservator**] must, upon request, provide to the program [**CSHCN Services Program**] proof of:

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

(iii) exhaustion of the right to continue group insurance coverage as provided under federal or [**and/or**] state law; or

(iv) (No change.)

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

(C) The program [**CSHCN Services Program**] will assist in determining possible eligibility for insurance and may provide program [**CSHCN Services Program**] benefits for ongoing clients during insurance application, enrollment, or [**and/or**] limited or excluded coverage periods.

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

(4) (No change.)

(5) Residency. The applicant must be a Texas resident. [**bona fide resident of the State of Texas.**]

(6) Application.

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

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

- (i) denied[,] if eligibility requirements are not met;
- (ii) incomplete [,] if required information that includes a CHIP, Medicaid, or SSI determination or any other data and document(s) [**data/document**] needed to process the application is not provided[,] or if an outdated form is submitted; or
- (iii) approved[,] if all criteria are met.

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

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

(7) Verification of information.

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

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

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

(8) Determination of continuing eligibility for health care benefits. Financial criteria for eligibility for health care benefits must be re-established every six months[,] or as directed by statutory requirements. Medical criteria must be re-established at least annually (i.e., within 365 days from the first day of the client's current eligibility period[,] or within 366 days during a leap year). Ongoing clients for health care benefits will be notified of program [CSHCN Services Program] deadlines for re-establishment of eligibility. If an ongoing client for health care benefits does not meet program [CSHCN Services Program] deadlines for submitting information required for the determination of continuing eligibility, the client's eligibility for health care benefits will end. If the then former client re-applies to the program [CSHCN Services Program] after such lapse in eligibility and is determined eligible for health care benefits, the former client will be considered a new client. If the program [CSHCN Services Program] has a waiting list for health care benefits, the new client will be placed on the waiting list in order according to the date and time [date/time] the client is determined eligible for health care benefits.

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

§38.4. Covered Services.

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

(b) Types of service.

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

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

(B) - (C) (No change.)

(D) integration with programs which screen for or provide treatment of newborn congenital anomalies or **[and/or]** other specialty care; and

(E) links with community, regional, or **[and/or]** school-based clinics to identify, assess needs, and provide appropriate resources for children with special health care needs.

(2) Diagnosis and evaluation services. These services may **[May]** be covered for the purpose of determining whether an **[a CSHCN Services Program]** applicant **[for health care benefits]** meets the program **[CSHCN Services Program]** definition of a child with special health care needs in order to receive health care benefits. Diagnosis and evaluation services must be prior authorized and coverage is limited in duration. If a physician or dentist requests coverage of diagnosis and evaluation services to determine if the applicant **[child/applicant]** meets the definition of a "child with special health care needs[,]" and the applicant meets all other eligibility criteria, then the applicant may be given up to 60 days of program coverage for diagnosis and evaluation services only. The program medical director or other designated medical staff may prior authorize limited coverage of diagnosis and evaluation services for waiting list clients if needed to help determine "urgent need for health care benefits" as described in §38.16(e) of this title (relating to Procedures to Address **[CSHCN Services]** Program Budget Alignment). Only program **[CSHCN Services Program participating]** providers may be reimbursed for diagnosis and evaluation services.

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

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

(B) Outpatient mental health services. Outpatient mental health services are limited to no more than 30 encounters in a calendar year by all professionals licensed to provide mental or behavioral **[mental/behavioral]** health services[,] including psychiatrists, psychologists, licensed clinical social workers (LCSW), licensed marriage and family therapists, and licensed professional counselors[,] per eligible client per calendar year.

Coverage includes, but is not limited to psychological or neuropsychological testing, psychotherapy, and [psychoanalysis,] counseling[, and narcosynthesis].

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

(D) Podiatric services. Podiatric services must be provided by licensed podiatrists enrolled to participate in the program [CSHCN Services Program]. Coverage is limited to the medically necessary treatment of foot and ankle conditions and follows the Texas Medicaid program guidelines. Supportive devices, such as molds, inlays, shoes, or supports, must comply with coverage limitations for foot orthoses.

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

(i) Inpatient hospital care, coverage limitations, and inpatient psychiatric care.

(I) Inpatient hospital care. Coverage [**is limited to 60 days per calendar year for medically necessary care and**] excludes the following:

(-a-) - (-b-) (No change.)

(-c-) private duty nursing or attendant [**nursing/attendant**] care.

(II) Coverage limitations. Coverage is limited to 60 days per calendar year except for stem cell transplantation, for which coverage is available for 120 days per calendar year.

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

(ii) Inpatient rehabilitation care. Medically necessary inpatient rehabilitation care is limited to an initial admission not to exceed 30 days[,] based on the

functional status and potential of the client as certified by a physician participating in the program [CSHCN Services Program]. Services beyond the initial 30 days may be approved by the program [CSHCN Services Program] based upon the client's medical condition, plan of treatment, and progress. Payment for inpatient rehabilitation care is limited to 90 days during a calendar year.

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

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

(v) Care for renal disease. Renal dialysis is limited to the treatment of acute renal disease or chronic (end stage) renal disease through a renal dialysis facility and includes, but is not limited to dialysis, laboratory services, drugs and supplies, declotting shunts, on-site physician services, and appropriate access surgery. Renal transplants may be covered in approved renal transplant centers if the projected cost of the transplant and follow-up care is less than that of continuing renal dialysis. Estimated cost of the renal transplant over a one-year period versus the cost of renal dialysis for one year at their facility must be documented. For each client 18 years of age and older, the transplant team must also provide a plan of care to be implemented after the client reaches 21 years of age and is no longer eligible for program services. Renal transplants must be prior authorized, and approval is subject to the availability of funds.

(F) (No change.)

(G) Medications. Outpatient medications available through pharmacy providers, including over-the-counter products, must be prescribed by practitioners licensed to do so. **[Payment shall be made only after delivery of the medications.]**

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

(i) (No change.)

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

(I) Hyperalimentation and Total Parenteral Nutrition (TPN) Services. **[Hyperalimentation/Total Parenteral Nutrition (TPN) services. A package of medically necessary services provided on a daily basis when oral intake cannot maintain adequate nutrition.]** Services [TPN services] include, but are not limited to solutions and additives, supplies and equipment, customary and routine laboratory work, enteral supplies, and nursing visits. These services may be provided on a daily basis when oral intake cannot maintain adequate nutrition. Covered services must be reasonable, medically necessary, appropriate, and prescribed by a practitioner licensed to do so.

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

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

(L) – (M) (No change.)

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

(O) Hearing services include, but are not limited to, hearing screening, audiological assessment, otological examination, hearing aid evaluation, hearing aid devices, hearing aid fitting and repair, hearing aid batteries and supplies, and ear molds. **[Audiological testing, hearing exams, and amplification devices. Services for clients under 21 years of age are coordinated through the Program for Amplification for Children of Texas (PACT). For clients 21 years of age and older and those ineligible for the PACT, covered services are the same as those available through the PACT.]**

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

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

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

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

(4) Care management.

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

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

(I) provision of preventive care, including but not limited to, immunizations,_{1[;]} growth and development assessments,_{1[;]} appropriate screening health care supervision,_{1[;]} client and parental counseling about health care supervision,_{1[;]} and client and parental counseling about health and psychological issues;

(II) - (IV) (No change.)

(V) interaction with school and community agencies to assure that the special health needs of the client are addressed; **[and]**

(VI) guidance and assistance needed to make the transition to all aspects of adult life, including adult health care, work, and independence; and

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

(ii) (No change.)

(B) Case management. Case management services may be made available to program clients through public health regional offices or other resources to assist clients and their families in obtaining adequate and appropriate services to meet the client's health and related services needs. The program will make available case management as needed or desired [**needed/desired**] to all clients who are eligible for health care benefits (includes clients who are on the waiting list for health care benefits). The program also may make available case management services to clients who are not eligible for the program's health care benefits.

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

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

(i) the client is not receiving services from a Medicaid [**home and community-based**] waiver program, and the family support needs cannot be met by services [**requested service does not duplicate services received**] from other family support programs, such as the Department of Aging and Disability Services or the In-Home and Family Support Program; [**program, the Primary Home Care Program, or the Medically Dependent Children's Program;**] and

(ii) (No change.)

(B) Processing and evaluation of requests.

(i) Families of clients indicate their need for family support services by completing and signing an approved request form.

(ii) Requests [**In each public health region or other designated subdivision of the state, requests**] for family support services are processed in chronological order by the date of the request.

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

(iv) While there is a waiting list for health care benefits, limitations in reimbursement or [and/or] prior authorization may be instituted as provided in §38.16 of this title (relating to Procedures to Address Program Budget Alignment).

(v) Some services or items may require a written statement from a physician, physical therapist, occupational therapist, or [and/or] other healthcare professional to establish the disability-related nature of the request.

(vi) (No change.)

(vii) Persons requesting assistance are responsible for collaborating with their case managers to obtain information as necessary so that an accurate determination can be made in a timely manner.

(viii) Families shall be notified in writing of the outcome of their requests for family support services.

(ix) Families have the right to appeal a denial or partial approval [decision] as described in §38.13 of this title (relating to Right of Appeal).

(C) Service plan and cost allowances.

(i) The case manager and the client or family must develop a family assessment and service plan and complete a Family Support Services request packet to request a prior authorization for family support services

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

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

(I) lifetime benefit [one-time assistance] of up to \$3,600 per eligible client for minor home modifications [remodeling]; and

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

(-a-) The annual benefit may increase to no more than \$7,200 per eligible client for the purchase of vehicle lifts and modifications;

(-b-) The lifetime benefit for minor home modifications and the annual benefit may be used in the same calendar year.

(iii) (No change.)

(iv) Reimbursement **[Disbursement of assistance]:**

(I) may be made to the family or to the vendor enrolled as a program provider; and **[in a lump sum or on a periodic basis;]**

(II) may be reduced by the amount of a cost-sharing requirement, if applicable. **[made to the family or to the vendor enrolled as a CSHCN Services Program provider; and]**

[(III) may be reduced by the amount of a cost-sharing requirement, if applicable.]

(v) Reimbursement rates for respite providers are established by the client or family **[client/family]** and the selected provider in collaboration with the case manager.

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

(D) Allowable services.

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

(I) - (II) (No change.)

(III) directly support the client's living in his or her **[his/her]** natural home and participating in family life and community activities.

(ii) (No change.)

(iii) Allowable services include:

(I) (No change.)

(II) specialized child care costs for a client that are expenses directly related to the client's disability and special needs that are beyond the scope of community-based child care centers **[in excess of the prevailing rate for routine child care],** including specialized training for the child care provider;

(III) counseling, **[or]** training programs, or conferences to obtain specific skills or knowledge related to the client's care that assists family members or caregiver(s) in maintaining the client in their home and to increase their knowledge and ability to care for the client **[services that assist the client/family, including parent or family stipends to attend education or training conferences];**

(IV) minor home modifications such as **[remodeling, limited to the purchase and]** installation of a ramp **[ramps]**, widening of doorways, bathroom modifications **[the modification of bathroom facilities, kitchen modifications]**, and other home modifications to increase accessibility and safety;

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

(VI) specialized equipment, including porch or stair **[porch/stair]** lifts, air purification systems or air conditioners, positioning equipment, bath aids, supplies prescribed by licensed practitioners that are not covered through other systems, and other non-medical disability-related equipment that assists with family activities, promotes the client's self-reliance, or otherwise supports the family;

(VII) other disability-related services that support permanency planning, independence, **or** **[and/or]** participation in family life and integrated or inclusive **[integrated/inclusive]** community activities.

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

- (i) (No change.)
- (ii) purchase or lease of vehicles[,], or vehicle maintenance and repair;
- (iii) home mortgage or rent expenses[,], or basic home maintenance and repair;
- (iv) - (xi) (No change.)

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

(xiii) - (xiv) (No change.)

(xv) school tuition or fees, or equipment, items, or services [equipment/items/services] that should be provided through the public school system;

(xvi) - (xvii) (No change.)

(xviii) computers and software[,] unless for use as an assistive technology device or necessary to perform a critical or essential function, such as environmental control[,] or written or oral communication, which the client is unable to perform without the computer;

(xix) services provided by an individual under the age of 18 years or by the client's parent(s), guardian, [parent(s)/guardian(s)] or other member of the client's household;

(xx) (No change.)

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

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

(ii) (No change.)

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

(iv) - (vii) (No change.)

(viii) the client's designated case manager is unable to locate the client and family [client/family]; or

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

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

(A) Ambulance services. Emergency ground, non-emergency ground and air ambulance services are covered for the medically necessary transportation of a client. Non-emergency ambulance transport is covered if the client cannot be transported by any other means without endangering the health or safety of the client[,] and when there is a scheduled medical appointment for medically necessary care at the nearest appropriate facility. Transportation by air ambulance is limited to instances when the client's pickup point is inaccessible by land[,] or when great distance interferes with immediate admission to the nearest appropriate medical treatment facility. Transports to out-of-locality providers are covered if a local facility is not adequately equipped to treat the client. Out-of-locality refers to one-way transfers 50 miles or more from point of pickup to point of destination.

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

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

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

(i) transportation cost for the remains of a client who expires in a program-approved [**CSHCN Services Program approved**] facility while receiving program [**CSHCN Services Program**] health care benefits, if the client was not in the family's city of residence in Texas, and the transportation cost of a parent or other person accompanying the remains[,] from the facility to the place of burial in Texas that is designated by the parent or other person legally responsible for interment;

(ii) embalming of the deceased[,] if required by law for transportation;

(iii) a coffin meeting minimum requirements[,] if required by law for transportation; and

(iv) (No change.)

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

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

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

(8) services provided by a nursing home or facility **[nursing home/facility];**
and

(9) services provided while the client is in the custody of or incarcerated by any municipal, county, state, or federal governmental entity. Case management or prior approved family support services not provided by the governmental entity[,] that are needed during the time when a client is transitioning from custody or incarceration into a community living setting[,] may be covered.

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

(1) Provider's responsibility. A program **[CSHCN Services Program]** provider must request services in specific terms on department-prepared forms so that an authorization may be issued and sufficient monies encumbered to cover the cost of the service. If a service is authorized, payment may be made to the provider as long as the service is not covered by a third party resource[,] and all billing requirements are met. Program authorization should not be considered an absolute guarantee of payment. Once a service is delivered and if the service requires authorization for payment, the authorization request for that service must be submitted within 95 days of the date of service.

(2) Required prior authorization for selected services. At the program's **[CSHCN Services Program's]** option, selected services may require authorization prior to the

delivery of services in order for payment to be made. Prior authorization requests must be submitted prior to the date of service.

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

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

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

§38.5. Rights and Responsibilities of a Client's Parents, Foster Parents, Guardian, or Managing Conservator **[Parents/Foster Parents/Guardian/Managing Conservator]**, or an **[the]** Adult Client.

(a) Rights. A client's parents, foster parents, guardian, or managing conservator **[The parent/foster parent/guardian/managing conservator]**, or an **[the]** adult client shall have the right to:

(1) (No change.)

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

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

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

(6) (No change.)

(b) Responsibilities. A client's parents, foster parents, guardian, or managing conservator **[The parent/foster parent/guardian/managing conservator]**, or an adult client shall have the responsibility to:

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

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

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

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

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

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

(7) utilize health insurance (following all plan guidelines and paying required co-payments), other benefits, and assets[,] and to inform service providers of same;

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

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

(c) Nondiscrimination. The department operates in compliance with Title VI, Civil Rights Act of 1964 (Public Law 88-352) and 45 Code of Federal Regulations, Part 80, so that no person will be excluded from participation in[,] or otherwise subjected to discrimination on the grounds of race, color, or national origin.

§38.6. Providers.

(a) General requirements for participation. The Children with Special Health Care Needs Services (CSHCN) Act, Health and Safety Code, §35.004, requires that [authorizes the

approval of] physicians, dentists, [**podiatrists,**] licensed dietitians, facilities, specialty centers, and other providers be approved to participate in the program [**CSHCN Services Program**] according to program [**its**] criteria and procedures.

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

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

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

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

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

(6) All approved providers must agree to the following:

(A) maintain and retain all necessary records and claims to fully document the services and supplies provided to a client for full disclosure to the program or its designee;

(B) retain these records and claims for a period of five years from the date of service, until the client's 21st birthday, or until all audit questions, appeal hearings, investigations, litigation, or court cases are resolved, whichever occurs last;

(C) provide unconditionally upon request, free copies of and access to all records pertaining to the services for which claims are submitted to the program or its designees; and

(D) allow the department, the Office of Inspector General (OIG), HHSC, or designees of these organizations access to its premises; and cooperate and assist with any audit or investigation.

(7)[(6)] All program [CSHCN Services Program] providers of services also covered by Medicaid must enroll and remain enrolled as Title XIX Medicaid providers. In order to be reimbursed by Medicaid as the primary payer, a provider must be enrolled on the date of service. The program [CSHCN Services Program] will not reimburse an enrolled provider for any service covered under Medicaid that was provided to a program [CSHCN Services Program] client eligible for Medicaid at the time of service. If a service covered by the program [CSHCN Services Program] is not covered by Medicaid, the provider of that service is not required to enroll as a Medicaid provider. Any provider excluded by Medicaid for any reason shall be excluded by the program [CSHCN Services Program].

(8) Providers must comply with applicable Medicare standards.

(9)[(7)] If a license or certification is required by law to practice in the State of Texas, the provider must maintain the required license or certification.

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

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

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

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

(A) (No change.)

(B) submitting false information on the enrollment application;

(C)[(B)] failing to provide and maintain quality services or medically acceptable standards;

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

(E) conviction of any felony;

(F) conviction of any misdemeanor involving moral turpitude;

(G)~~(D)~~ disenrollment as a Medicaid provider; **[or]**

(H)~~(E)~~ violation of the standards of this chapter;

(I) failure to submit a claim for reimbursement for an extended period of time, as specified by program policy; or

(J) disciplinary action taken against the provider by the licensing authority under which the provider practices in the State of Texas or by the Texas Medicaid Program.

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

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

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

(1) advanced practice registered nurses **[physicians];**

(2) ambulance providers **[dentists];**

(3) ambulatory surgical centers **[advanced practice nurses];**

(4) certified home and community support services agencies **[mental/behavioral health professionals, including psychiatrists, licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, and licensed professional counselors];**

(5) certified respiratory care practitioners **[podiatrists];**

(6) dentists **[hospitals];**

- (7) dietitians [**inpatient rehabilitation centers**];
- (8) family support services providers [**ambulatory surgical centers**];
- (9) federally qualified health centers [**renal dialysis centers**];
- (10) genetic counselors [**orthotists and prosthetists**];
- (11) hearing service professionals [**pharmacies**];
- (12) hospice care providers [**dietitians**];
- (13) hospitals [**medical supply and/or equipment companies**];
- (14) inpatient rehabilitation centers [**optometrists and opticians**];
- (15) licensed speech-language pathologists [**and audiologists**];
- (16) lodging facilities [**hearing aid professionals (limited to physicians and those audiologists who are fitters and dispensers and enrolled as Program for Amplification for Children of Texas providers)**];
- (17) medical supply and equipment companies [**occupational therapists and physical therapists**];
- (18) mental and behavioral health professionals including, but not limited to, psychiatrists, licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, and licensed professional counselors [**certified respiratory care practitioners**];
- (19) occupational therapists and physical therapists [**certified home and community support services agencies**];
- (20) optometrists and opticians [**hospice care providers**];
- (21) orthotists and prosthetists [**ambulance providers**];
- (22) pharmacies [**transportation companies or providers**];
- (23) physicians [**meal and lodging facilities; and**];
- (24) physicians assistants [**funeral homes**];
- (25) podiatrists;

- (26) renal dialysis centers;
- (27) rural health clinics; and
- (28) transportation companies or providers.

(d) Requirements for specialty centers.

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

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

(e) Out-of-state coverage.

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

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

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

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

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

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

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

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

§38.7. Ambulatory Surgical Care Facilities.

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

[**(1) State licensure requirements. Facilities must comply with state licensure requirements for ambulatory surgical centers at §§135.1 - 135.27 of this title (relating to Operating Requirements for Ambulatory Surgical Centers).**]

[**(2) Medicare certification. Facilities must comply with Medicare standards concerning ambulatory surgical services at 42 Code of Federal Regulations, Parts 405 and 416.**]

[**(3) Pediatric equipment. Pediatric facilities must maintain all necessary pediatric equipment including operating room, surgical tools, resuscitation apparatus, pharmaceutical services, beds, and other supplies that are appropriate for children.**]

[**(4) Staff requirements.**]

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

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

[(C) A registered nurse with documented clinical pediatric experience must be on the premises at all times the client is in the facility.]

[(5) Risk management principles. The facility must apply risk management principles to all client care.]

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

(b) Freestanding ambulatory surgical care (ASC) facilities, even if governed by or affiliated with a hospital participating in the program, must apply for program approval. The program may contract with a limited number of facilities to contain costs. For approval to participate in the program, a freestanding ASC facility must meet the following criteria:

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

(1) State licensure requirements. Facilities must comply with state licensure requirements for ambulatory surgical centers at §§135.1 - 135.29 of this title (relating to Operating Requirements for Ambulatory Surgical Centers).

(2) Medicare certification. Facilities must comply with Medicare standards concerning ambulatory surgical services at 42 Code of Federal Regulations, Parts 405 and 416.

(c) The program [CSHCN Services Program] reimbursement for care at freestanding ASC facilities shall be limited to Levels I and II surgical procedures so designated by the American Society of Anesthesiologists.[:]

[(1) children 24 months of age or older; and]

[(2) Levels I and II surgical procedures so designated by the American Society of Anesthesiologists.]

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

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

[(A) all parts of the application form have been completed, including a signature and date;]

[(B) all criteria for program participation have been met; and]

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

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

[(3) Any ASC facility which disagrees with the result of the application review may appeal the decision in accordance with §38.13 of this title (relating to Right of Appeal).]

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

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

[(A) current address, telephone number, state comptroller's vendor identification number, and administrator;]

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

[(C) current listing of qualified staff or facilities available; and]

[(D) Medicare certification status.]

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

§38.8. Inpatient Rehabilitation Centers.

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

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

(1) The center shall have current accreditation by either the Joint Commission **[on Accreditation of Health Care Organizations]** as a comprehensive physical rehabilitation program or the Commission on Accreditation of Rehabilitation Facilities as a comprehensive inpatient rehabilitation program.

(2) (No change.)

(3) The center shall be located within 50 miles of the Texas border **[agree to allow on-site visits and/or audit privileges to the CSHCN Services Program staff].**

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

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

[(6) When pediatric clients are receiving inpatient rehabilitation treatment, the center shall have at least one registered nurse with pediatric training or experience available to the center at all times.]

[(7) A center which serves pediatric clients shall have a licensed dietitian, preferably with experience in evaluation and counseling children with chronic illness on staff or available for consultation to provide nutrition services.]

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

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

[(10) The center shall arrange for provision of appropriate educational services for children in the rehabilitation center.]

§38.9. Cleft-Craniofacial Services **[Cleft/Craniofacial Center Teams]**. To assure that clients with cleft lip, cleft palate, or other craniofacial anomalies[, **including cleft lip and/or cleft palate,**] receive quality, comprehensive services, cleft-craniofacial teams **[cleft/craniofacial**

(C/C) teams] requesting approval from the program must [CSHCN Services Program shall] comply with the following standards:

(1) All cleft-craniofacial surgical procedures are provided within the context and consultation of a coordinated, comprehensive, interdisciplinary cleft-craniofacial team and must be prior authorized. Team composition is consistent with current basic standards of the American Cleft Palate-Craniofacial Association (ACPA).

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

(2) The comprehensive cleft-craniofacial team will include an operating surgeon, orthodontist, speech-language pathologist, and at least one additional specialist from otolaryngology, audiology, pediatrics, genetics, social work, psychology, and general pediatric or prosthetic dentistry. Adjunct participants may be added as determined by the cleft-craniofacial team to meet the needs of individual clients.

[(2) C/C team administrator responsibility.]

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

[(B) The C/C team's administrator shall recognize clients' rights. All members of the C/C team shall:]

[(i) give parents/guardians or adult clients complete information concerning diagnosis, treatment, and prognosis; and]

[(ii) involve parents/guardians or adult clients in decisions concerning the client's care, including development of the treatment plan.]

(3) The cleft-craniofacial surgical procedures and related cleft-craniofacial team services are provided in accordance with a client and family-oriented comprehensive treatment plan jointly developed by the client or family and the cleft-craniofacial team.

[(3) Composition of a comprehensive C/C team. Several health care providers in the same category may be designated as C/C team participants (e.g. more than one plastic surgeon or more than one C/C team case manager). C/C team members responsible for monitoring and coordinating the client's treatment plan and follow-up should interact consistently with the client.]

(A) A copy of the comprehensive treatment plan will be given to the family (prior to the surgical procedures), the local or referring primary care physician, and other collaborative providers, e.g. local dentist, local speech therapist, case manager, etc. who will be providing services to the client.

[(A) The comprehensive C/C team shall be composed of the following participants:]

[(i) a plastic surgeon and/or an oral surgeon;]

[(ii) an otolaryngologist;]

[(iii) a primary care physician;]

[(iv) an orthodontist and/or a pediatric dentist;]

[(v) a licensed speech language pathologist (master's level);]

[(vi) a C/C team care coordinator who is capable of performing the responsibilities specified in paragraph (4) of this section; and]

[(vii) a client educator.]

(B) The plan will include specific services to be provided by the members of the cleft-craniofacial team, action steps, persons responsible, and timeframes.

[(B) Adjunct participants may be added as determined by the C/C team to meet the needs of individual clients.]

[(4) Care coordination. The C/C team care coordinator will be responsible for the coordination of services for each client. Each client should have only one C/C team care coordinator who will assure that the focus of the service is client and family oriented and that a comprehensive treatment plan is jointly developed by the client/family and C/C team. A copy of the plan shall be given to the family, the local and/or referring physician, other appropriate agencies, including a local care coordinator designated by the family, and the department's regional social worker upon request. The plan should include specific treatments and time frames for all disciplines and agencies involved. The C/C team care coordinator must assure that the client is seen by only one C/C team.]

[(5) Affiliated providers.]

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

[(B) An affiliated provider shall consult with and coordinate the development of a treatment plan with a comprehensive C/C team(s) according to each individual client's needs.]

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

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

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

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

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

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

(ii) Denied claims may be corrected and resubmitted for reconsideration if received within 120 days of the last denial or [of and/or] adjustment to the original claim. If the results of the reconsideration process are unsatisfactory, denied claims may be appealed according to §38.13 of this title (relating to Right of Appeal).

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

(A) Health insurance denial or nonresponse. If a claim is denied by health insurance, the provider may bill the program [CSHCN Services Program,] if the letter of denial also is submitted with the claim form. If the denial letter is not available, the provider must include on the claim form the date the claim was filed with the insurance company, the reason for the denial, name and telephone number of the insurance company, the policy number, the name of the policy holder and identification numbers for each policy covering the client, the name of the insurance company employee who provided the information on the denial of benefits, and the date of the contact. If more than 110 days have elapsed from the date a claim was filed with the third party resource and no response has been received, the claim may be submitted to the program [CSHCN Services Program] for consideration of payment. Claims must be submitted with documentation indicating the third party resource has not responded.

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

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

(D) Deductibles and coinsurance. If the client has other third party coverage, the program [CSHCN Services Program] may pay a deductible or coinsurance for the client as

long as the total amount paid to the provider does not exceed the allowable amount [**maximum allowed**] for the covered service[,] and conforms with current program [**CSHCN Services Program**] policies regarding third party resources, deductible, and coinsurance.

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

(A) damage to or destruction of the provider's business office or records by a catastrophic event or natural disaster[,] including, but not limited to fire, flood, hurricane, or earthquake[,] that substantially interferes with normal business operations of the provider;

(B) damage to or destruction of the provider's business office or records caused by the intentional acts of an employee or agent of the provider[,] only if:

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

(C) delay₂ [**or**] error₂ or constraint imposed by the program in the eligibility determination of a client or [**and/or**] in claims processing, or delay due to erroneous written information from the program or its designee, or another state agency; or

(D) (No change.)

(4) Exception requests. Providers requesting an exception under paragraph (3)(A) - (D) of this section must submit an affidavit or statement from a person with personal knowledge of the facts detailing the exception being requested,[,] the cause for the delay,[,] verification that the delay was not caused by neglect, indifference, or lack of diligence of the provider or the provider's employee or agent,[,]and any additional information requested by the program. All claims for which the provider requests an exception must accompany the request. The program will consider only the claim(s) attached to the request, and the exception request must be received by the program within 18 months from the date of service.

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

(C) For exception requests under paragraph (3)(C) of this section, the provider must submit written documentation from the program, its designee, or another state agency containing the erroneous information or explanation of the delay, error, or [**and/or**] constraint.

(D) For exception requests under paragraph (3)(D) of this section, the provider must submit the following:

(i) a written repair statement or invoice,[,] a computer or modem generated error report indicating attempts to transmit the data failed for reasons outside the

control of the provider, [;] or an explanation for the system implementation or other claim submission problems;

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

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

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

(D) the exception request includes an affidavit or statement from a representative of an original payer, a third party payer, or [**and/or**] a person who has personal knowledge of the facts, stating the exception being requested, documenting the cause for the delay, and providing verification that the delay was caused by another entity and not the neglect, indifference, or lack of diligence of the provider or the provider's employee(s) or agent(s).

(6) Program fees [**CSHCN Services Program fee schedules**]. Subject to any reductions or limitations authorized by §38.16(b)(2)(E) of this title (relating to Procedures to Address Program Budget Alignment), the program [**CSHCN Services Program**] or its designee shall reimburse claims for covered medical, dental, and other services according to the following [**fee schedules**]:

(A) meals, lodging, and transportation:

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

(iii) transportation:

(I) - (II) (No change.)

(III) air fare--the ticket price reflecting the state discount if ordered by MTP[,], or the billed amount[,], if MTP had no opportunity to coordinate transportation in an emergency; and

(IV) cab fare--the billed amount[,], if other transportation is unavailable[,], or the MTP is unable to coordinate transportation;

(B) (No change.)

(C) ambulance service--the lower of the billed amount or the amount [**maximum charge**] allowed by the Texas Medicaid Program;

(D) transportation of remains:

- (i) first call--\$150 [**\$75**];
- (ii) (No change.)
- (iii) container--\$150 [**\$75**];
- (iv) - (v) (No change.)

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

(F) nutritional services--the lower of the billed amount or the amount [**maximum charge**] allowed by the Texas Medicaid Program;

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

(H) out-patient medications:

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

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

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

(I) expendable medical supplies--the lower of the billed amount or the [**maximum**] amount allowed by the Texas Medicaid Program;

(J) durable medical equipment--provided by enrolled home health agencies and durable medical equipment providers, the lower of the billed amount or the amount allowed by the [**maximum allowable fee for durable medical equipment established**] Texas Medicaid Program. If the Texas Medicaid Program [**program**] has not established an allowable amount [**a maximum fee**], then reimbursement will be the least of the following:

(i) (No change.)

(ii) the Medicare fee schedule as defined in 1 [25] Texas Administrative Code, §354.1031(b)(9) [\$29.301]; or

(iii) (No change.)

(K) (No change.)

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

(M) home health nursing services (provided only through participating program [CSHCN Services Program participating] home and community support service agencies)--reimbursement for a maximum of 200 hours per client per calendar year, with an additional 200 hours per client per calendar year available[,] if justification of need and cost effectiveness are documented;

(i) services provided by a registered nurse--the lower of the billed amount or the amount allowed by the Texas Medicaid Program [\$36 per hour];

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

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

(N) outpatient physical therapy, occupational therapy, speech-language pathology, and respiratory therapy (provided by physicians or by therapists other than physicians)--the lower of the billed amount or the amount allowed by the Texas Medicaid Program;[:]

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

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

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

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

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

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

(S) (No change.)

(T) care for renal disease--

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

(ii) (No change.)

(U) - (V) (No change.)

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

(X) independent laboratory--the lower of the billed amount or the [**maximum**] amount allowed by the Texas Medicaid Program;

(Y) - (Z) (No change.)

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

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

(8) Overpayments.

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

(i) - (v) (No change.)

(B) Overpayments made to providers must be reimbursed to the department by lump sum payment or, at the department's discretion, offset against current payments [**claims**] due to the provider for services to other clients. The department also shall require reimbursement of overpayments from any person or persons who have a legal obligation to support the client

and have received payments from a payer of other benefits. Providers, clients, and person(s) responsible for clients may appeal proposed recoupment of overpayments by the department according to §38.13 of this title (relating to Right of Appeal).

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

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

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

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

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

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

(1) (No change.)

(2) the applicant or family [applicant/family] does not meet financial eligibility requirements;

(3) the person does not meet Texas residency requirements;

[(3) the person is not a bona fide resident of Texas;]

(4) (No change.)

(5) **[the applicant has a]** behavioral or emotional condition(s) exist, but no physical or developmental condition(s);

(6) a client [person who] has received third party or liability payments and has failed to reimburse the department for services provided to the client;

(7) the client [person] attains the age of 21, except for adults with cystic fibrosis;

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

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

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

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

§38.13. Right of Appeal.

(a) Administrative review.

(1) If the program denies eligibility to a program applicant, the program shall give the applicant written notice of the denial and the applicant's right to request an administrative review of the denial within 30 days of the date of the notification.

(2) If the program proposes to modify, suspend, or terminate a client's eligibility for health care benefits (unless such program actions are authorized by §38.16 of this title (relating to Procedures to Address Program Budget Alignment)), the program shall give the client written notice of the proposed action and the client's right to request an administrative review of the proposed action within 30 days of the date of notification.

(3) If the program denies a prior-authorization or authorization request for program services, the program shall give the client and provider written notice of the denial and the right of the client or provider to request an administrative review of the denial within 30 days of the date of notification.

(4) A client, family, or provider may not request administrative review of the program's denial of a prior-authorization or authorization request for program services or reduced provider reimbursement amounts that are authorized by §38.16 of this title.

(5) If the program denies a provider's claim that has been corrected and resubmitted for reconsideration according to §38.10(1)(B)(ii) of this title (relating to Payment of Services), the program shall give the provider written notice of the denial. The provider has the right to request an administrative review of the denial within 30 days of the date of notification.

(6) If the program denies or proposes to modify, suspend, or terminate an individual provider's participation in the program, the program shall give the provider written notice of the proposed action and the provider's right to request an administrative review of the proposed action within 30 days of the date of notification.

(7) If the applicant, client, family, or provider requests an administrative review in writing within 30 days of the date of the notification, the program shall conduct an administrative review of the circumstances surrounding the proposed action. The program shall give the applicant, client, family, or provider written notice of the program decision and the supporting reasons for the decision within 30 days of receipt of the request for administrative review.

(8) If the applicant, client, family, or provider does not respond in writing within the 30-day period, the applicant, client, family, or provider is presumed to have waived the administrative review as well as access to a fair hearing, and the program's action is final.

(b) Fair hearing. If the applicant, client, family, or provider is dissatisfied with the program's decision and supporting reasons following the administrative review, the applicant, client, family, or provider may request a fair hearing in writing addressed to the Children with Special Health Care Needs Services Program, Purchased Health Services Unit, MC 1938, Department of State Health Services, P.O. Box 149347, Austin, Texas 78714-9347 within 20 days of receipt of the administrative review decision notice. If the applicant, client, family, or provider fails to request a fair hearing within the 20-day period, the applicant, client, family, or provider is presumed to have waived the request for a fair hearing, and the program may take final action. A fair hearing requested by an applicant, client, family, or provider shall be conducted in accordance with §§1.51 - 1.55 of this title (relating to Fair Hearing Procedures).

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

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

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

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

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

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

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

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

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

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

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

[(A)] Population-based systems development activities include, but are not limited to the development and maintenance of community-based systems such as case management, parent case management, parent networks, parent resource centers, parent or provider [parent/provider] training, voucher programs, wellness centers, permanency planning, or other systems that may directly or indirectly support any family in Texas with the program [CSHCN].

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

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

[(ii) Services provided in community-based wellness centers may include, but are not limited to:]

- [(I) case management or social services;]**
- [(II) psychological services, particularly for child or family groups;]**
- [(III) sibling support;]**
- [(IV) dietary counseling;]**
- [(V) recreation or fitness programs and physical conditioning;]**
- [(VI) a meeting place for family or child groups school liaison support;]**
- [(VII) a parent/family information or resource center;]**
- [(VIII) parent to parent referrals and/or networking;]**
- [(IX) health promotion education and/or training; and]**
- [(X) family or individual health planning, including permanency planning.]**

[(iii) Wellness center services may include direct services as well as population-based services.]

§38.15. Third Party Recovery.

(a) The program or the program's designee may recover the cost of services provided to a client from a person who does not pay or reimburse the department as required by Health and Safety Code, §35.007.

(b) The program or the program's designee may recover the cost of services provided to a client from any third party who has a legal obligation to pay for the services provided.

(c) The program's right of recovery against a third party liable for the client's condition or injury is limited to the amount paid by the program for all claims submitted by program providers for covered services to treat the client's condition or injury.

(d) The program or the program's designee may agree to waive all or part of the program's right to recover from a liable third party if;

(1) the total of all claims from providers for the cost of services provided to the client exceeds the amount of the available recovery or settlement;

(2) the program or the program's designee finds that enforcement of the program's right of recovery of the cost of services provided would adversely affect the client's long-term health and welfare; or

(3) the program or the program's designee finds that the cost of recovery could exceed the cost of services provided by the program.

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

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

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

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

(1) give clients and providers who will be directly affected written notice of any reductions or limitations of services, coverage, or [and/or] reimbursements;

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

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

(B) (No change.)

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

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

(ii) (No change.)

(iii) allow limited prior authorization of diagnosis and evaluation services on a short-term basis[,], only when such information is needed to assess whether clients on the waiting list have "urgent need for health care benefits" as described in subsection (e) of this section and only with prior authorization and approval by the medical director or other designated medical staff.

(D) place new applicants or re-applicants with lapsed eligibility who are determined eligible for program health care benefits (new clients for health care benefits) on the waiting list. These clients will be ordered on the waiting list according to the date and time [date/time] the client is determined eligible for program health care benefits;

(E) reduce or limit [reduce/limit] reimbursements for contractual service providers[,], while avoiding changes which may jeopardize the integrity of the contractor base and thereby decrease client access to services;

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

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

(ii) ongoing clients for health care benefits in the following order by age groups: 21 years of age or older₁[;] 20 years of age₁[;] 19 years of age₁[;] 18 years of age; and

(iii) (No change.)

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

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

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

(A) give clients and providers who will be directly affected written notice of any reductions or limitations of services, coverage, or [**and/or**] reimbursements;

(B) reduce or limit [**reduce/limit**] reimbursements for contractual service providers[,] while avoiding changes which may jeopardize the integrity of the contractor base and thereby decrease client access to services; and

(C) (No change.)

(2) utilize cost savings generated to remove as many clients with urgent need for health care benefits as possible from the waiting list and provide health care benefits to those clients. Clients with urgent need for health care benefits will [**shall**] be removed from the waiting list according to the original date and time [**date/time**] that starts the client's latest uninterrupted sequence of eligibility for program health care benefits and in the following group order:

(A) clients who are less than 21 years old and who have an urgent need for health care benefits[,] as described in subsection (e) of this section;

(B) clients who are 21 years of age or older and who have an urgent need for health care benefits[,] as described in subsection (e) of this section;

(3) (No change.)

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

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

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

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

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

(i) clients who are less than 21 years old and who have an urgent need for health care benefits[,] as described in subsection (e) of this section;

(ii) clients who are 21 years of age or older and who have an urgent need for health care benefits[,] as described in subsection (e) of this section;

(iii) - (iv) (No change.)

(B) (No change.)

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

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

(D) if the program [**CSHCN Services Program**] projects that the amount of funds to be expended by the program in the fiscal year will be less than the program's appropriated funds and other available resources after no clients eligible for program [**CSHCN**

Services Program] health care benefits remain on the waiting list, the program may take the following actions in the following order:

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

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

(iv) remove any reductions or limitations **[reductions/limitations]** to contractor reimbursements that have been implemented; and

(v) (No change.)

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

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

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

(B) (No change.)

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

(D) (No change.)

(E) remove any reductions or limitations **[reductions/limitations]** to contractor reimbursements that have been implemented.

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

(1) the physician or dentist who signs the client's application or **[and/or]** the treating physician or dentist **[physician/dentist]** attests or **[and/or]** documents the physician's or dentist's **[physician/dentist's]** determination that delay in receiving health care benefits could result in loss of life, permanent increase in disability, or intense pain and suffering **[pain/suffering]**;

(2) the client or family **[client/family]** states that no other source of health insurance coverage is available to the client;

(3) information on the application for health care benefits indicates the complexity of the client's condition or **[and/or]** need for care;

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

(5) (No change.)

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

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

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

(2) (No change.)

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

(4) The program will offer case management services as needed or desired **[needed/desired]** to all clients who are eligible for health care benefits[,] including those on the waiting list for health care benefits.

Proposed repealed text
~~Strikethrough=repealed text~~

~~§38.13. Right of Appeal.~~

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

~~—(1) Administrative review.~~

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

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

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

~~—(D) The commission establishes provider reimbursement and the program's budget alignment methodologies by rule. Families and/or providers may not request administrative review and may not appeal service authorization decisions and/or provider reimbursement amounts that are in accordance with the reimbursement and budget alignment methodologies as stated in CSHCN Services Program rules.~~

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

~~(b) Appeal procedures for applicants/clients.~~

~~—(1) Administrative review.~~

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

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

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

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