Table of Contents

State/Territory Name: Texas

State Plan Amendment (SPA) #: 24-0006

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

November 22, 2024

Emily Zalkovsky
State Medicaid Director
Texas Health and Human Services Commission (HHSC)
P.O. Box 13247
Austin, TX 78711-3247

Re: Texas State Plan Amendment (SPA) – 24-0006

Dear Director Zalkovsky:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 24-0006. This amendment expands the types of providers who can provide case management for children and pregnant women (CPW) services. The two provider types are doulas and community health workers. Additionally, it modifies the eligible postpartum period to require continued medical assistance to eligible pregnant women for 12 months. The amendment includes conforming changes made by TX 23-0028. Other non-substantive updates have been done to formatting and language.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations. This letter informs you that Texas' Medicaid SPA TN 24-0006 was approved on November 22, 2024, with an effective date of September 1, 2024.

Enclosed are copies of Form CMS-179 and approved SPA pages to be incorporated into the Texas State Plan.

If you have any questions, please contact Ford Blunt at (214) 767-6381 or via email at Ford.Blunt@cms.hhs.gov.

Sincerely,

[redacted]

Digitally signed by James G. Scott -S
Date: 2024.11.22 16:49:07 -06'00'

James G. Scott, Director
Division of Program Operations

Enclosures

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24 - 0006

2. STATE: TX

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
09/01/2024

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR § 440.169 and 42 CFR § 441.18

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 0
b. FFY 2025 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Appendix 1 to Attachment 3.1-A and Appendix 1 to Attachment 3.1-B
Page 7m
Page 7m.1
Page 7m.2
Page 7m.3
Page 7m.4
Supplement 1 to Attachment 3.1-A and Supplement 1 to Attachment 3.1-B
Page 1D
Page 1D.1
Page 1D.2
Page 1D.2a
Page 1D.3

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Appendix 1 to Attachment 3.1-A and Appendix 1 to Attachment 3.1-B
Page 7m (TN 12-04)
Page 7m.1 (TN 12-04)
Page 7m.2 (TN 14-50)
Page 7m.3 (TN 12-04)
Page 7m.4 (new page)
Supplement 1 to Attachment 3.1-A and Supplement 1 to Attachment 3.1-B
Page 1D (TN 13-15)
Page 1D.1 (TN 07-16)
Page 1D.2 (TN 14-50)
Page 1D.2a (TN 14-50)
Page 1D.3 (TN 11-19)

9. SUBJECT OF AMENDMENT

The purpose of this amendment is to implement state statutory requirements in House Bill (H.B.) 1575, 88th Texas Legislature, Regular Session, 2023 related to expanding the types of providers who can provide case management for children and pregnant women (CPW) services. The two new provider types are doulas and community health workers.

Additionally, the 88th Legislature modified the eligible postpartum period in H.B. 12 to require continued medical assistance to eligible pregnant women for 12 months. This amendment includes conforming changes made by TN 23-0028 implementing H.B. 12. Other non-substantive updates have been done to formatting and language.

10. GOVERNOR'S REVIEW *(Check One)*

- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
- ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
- ☑ OTHER, AS SPECIFIED: Sent to Governor's Officethis date. Comments, if any, will be forwarded upon receipt.

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Emily Zalkovsky

13. TITLE
State Medicaid Director

14. DATE SUBMITTED
7/12/2024

15. RETURN TO

Emily Zalkovsky
State Medicaid Director
Post Office Box 13247, MC: H-100
Austin, Texas 78711

FOR CMS USE ONLY

16. DATE RECEIVED
7/12/2024

17. DATE APPROVED
November 22, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
9/01/2024

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]
Digitally signed by James G. Scott -S
Date: 2024.11.22 16:49:36 -06'00'

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

21. TITLE OF APPROVING OFFICIAL
Director, Division of Program Operations

22. REMARKS
Pen and ink change for box 8 to Appendix 1 to Attachment 3.1-A and Appendix 1 to Attachment 3.1-B as per e-mail dated 11/22/24.

4b. EPSDT Services (Continued)

1) EPSDT Case Management:

a) Children birth through age 20 with a health condition or health risk. This includes case management services for pregnant women under the age of 21 that have one or more high-risk medical and/or personal/psychosocial condition(s) during pregnancy and may occur through the end of the post-partum coverage period.

2) Areas of state in which services will be provided:

a) Entire State

3) Comparability of services:

a) Services are not comparable in amount duration and scope. Under section 1915(g) of the Social Security Act, a state may provide services without regard to the comparability requirements of section 1902(a)(10)(B) of the Act.

4) Definition of services:

a) Targeted case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Case Management includes the following assistance:

i) Comprehensive face-to-face assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social, or other services required to address short- and long-term health and well-being. All eligible clients are assessed at the initiation of services. If an individual later transitions to a new provider or has a major change in need or status, a second assessment may be necessary. These assessment activities include:

(1) taking an individual's history;
(2) identifying the individual's needs by assessing and providing referrals to address any medical, educational, social, or other health-related factors that impact health outcomes and completing related documentation; and
(3) Assessing and providing referrals to address any family issues that impact the individual's health condition, health risk, or high-risk pregnancy, and completing related documentation; and
(4) gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

ii) Development (and periodic revision) of a specific care plan that:

4b. EPSDT Services (Continued)

EPSDT Case Management (Continued)

(1) is based on the information collected through the face-to-face needs assessment. face-to-face follow-up contacts, or telephone follow up contacts;

(2) specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;

(3)includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and

(4) identifies a course of action to respond to the assessed needs of the eligible individual, including identifying the individual responsible for contacting the appropriate service providers; and designating the time frame within which the eligible individual should access services.

iii) Referral and related activities to help an eligible individual obtain needed services, including activities that help link an individual with:

(1) medical, social, and educational providers; and

(2) other programs and services that can provide needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

iv) Monitoring and follow-up activities:

(1) activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service provider, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring visit, to determine whether the following conditions are met:

(a) services are being furnished in accordance with the individual's care plan;

(b) services in the care plan are adequate; and

4b. EPSDT Services (Continued)

(c) changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers. Monitoring includes face-to-face follow-up visits and phone calls. The frequency of the follow up visits is based upon the complexity of the individual's need.

(2) Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e)).

b) Qualifications of providers:

A provider who is an agency or an individual approved by HHSC to provide case management services must ensure a case manager meets at least one of the following qualifications:

(1) an advanced practice registered nurse who holds a license, other than a provisional or temporary license, under Texas Occupations Code Chapter 301;
(2) Registered nurse (with a bachelor's or advanced degree), registered nurse (without a bachelor's or advanced degree and with two years of experience); or
(3) Social worker (with bachelor's or advanced degree), currently licensed by the respective Texas licensure board and whose license is not temporary, limited, or provisional in nature; or
(4) a community health worker, as defined by Texas Health and Safety Code §48.001, and be certified as a community health worker by the Department of State Health Services; or
(5) a doula who is certified in alignment with nationally recognized standards and as determined by HHSC, unless the doula qualifies as a certified community health worker.

5) Freedom of choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a) (23) of the Act.

a) Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
b) Eligible individuals have free choice of any qualified Medicaid providers of other medical care under the plan.

4b. EPSDT Services (Continued)

(__) Freedom of Choice Exception (§1915(9)(1) and 42 CFR 441.18(b)):

Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

6) Access to Services:

a) The State assures that case management services will be provided in a manner consistent with the best interest of the individual and will not be used to restrict an individual's access to other services under the plan.

b) The State assures that individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.

c) The State assures that providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

7) Payment (42 CFR 441.18(a)(4)):

Payment for targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

8) Case Records:

a) Providers maintain case records that document for all individuals receiving case management as follows:

i) The name of the individual;

ii) The dates of the case management services;

iii) The name of the provider agency (if relevant) and the person providing the case management service;

iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;

v) Whether the individual has declined services in the care plan;

vi) The need for, and occurrences of, coordination with other case managers;

vii) A timeline for obtaining needed services, and

viii) A timeline for reevaluation of the plan.

4b. EPSDT Services (Continued)

EPSDT Case Management (Continued)

9) Limitations:

a) Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

b) Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, education, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

c) FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

10) Other limitations:

a) The number of billable contacts is based on the individual's level of need, level of medical involvement, and complicating psychosocial factors.

4b. EPSDT Services (Continued)

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a) Children birth through age 20 with a health condition or health risk. This includes case management services for pregnant women under the age of 21 that have one or more high-risk medical and/or personal/psychosocial condition(s) during pregnancy and may occur through the end of the post-partum coverage period.

2) Areas of state in which services will be provided:

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3) Comparability of services:

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a) Targeted case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Case Management includes the following assistance:

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(1) taking an individual's history;
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(3) Assessing and providing referrals to address any family issues that impact the individual's health condition, health risk, or high-risk pregnancy, and completing related documentation; and
(4) gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

ii) Development (and periodic revision) of a specific care plan that:

4b. EPSDT Services (Continued)

EPSDT Case Management (Continued)

(1) is based on the information collected through the face-to-face needs assessment. face-to-face follow-up contacts, or telephone follow up contacts;

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(3)includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and

(4) identifies a course of action to respond to the assessed needs of the eligible individual, including identifying the individual responsible for contacting the appropriate service providers; and designating the time frame within which the eligible individual should access services.

iii) Referral and related activities to help an eligible individual obtain needed services, including activities that help link an individual with:

(1) medical, social, and educational providers; and

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4b. EPSDT Services (Continued)

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(2) Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e)).

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(5) a doula who is certified in alignment with nationally recognized standards and as determined by HHSC, unless the doula qualifies as a certified community health worker.

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The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a) (23) of the Act.

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vii) A timeline for obtaining needed services, and

viii) A timeline for reevaluation of the plan.

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EPSDT Case Management (Continued)

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b) Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, education, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

c) FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

10) Other limitations:

a) The number of billable contacts is based on the individual's level of need, level of medical involvement, and complicating psychosocial factors.

CASE MANAGEMENT SERVICES
High Risk Pregnant Women Aged 21
and Over

1) Target Group:

Women aged 21 and over who are pregnant and have one or more high-risk medical and/or personal/psychosocial condition(s) during pregnancy and through the end of the post-partum coverage period.

2) Areas of state in which services will be provided:

a) Entire State

3) Comparability of services:

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ii) Development (and periodic revision) of a specific care plan that:

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i) Comprehensive face-to-face assessment of individual needs to determine the need for any medical, educational, social, or other services required to address short- and long-term health and well-being. All eligible clients are assessed at the initiation of services. If an individual later transitions to a new provider or has a change in need or status, a second assessment may be necessary. These assessment activities include:

(1) taking an individual's history;

(2) identifying the individual's needs by assessing and providing referrals to address any medical, educational, social, or other health-related factors that impact health outcomes and completing related documentation.

(3) Assessing and providing referrals to address any family issues that impact the individual's health condition/risk or high-risk condition and completing related documentation; and

(4) gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

ii) Development (and periodic revision) of a specific care plan that:

(1) is based on the information collected through the face-to-face needs assessment, face-to-face follow up contacts, or telephone follow up contacts;

(2) specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;

(3) includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and

(4) identifies a course of action to respond to the assessed needs of the eligible individual, including identifying the individual responsible for contacting the appropriate service providers; and designating the time frame within which the eligible individual should access services.

iii) Referral and related activities to help an eligible individual obtain needed services, including activities that help link an individual with:

(1) medical, social, and educational providers, and

(2) other programs and services that can provide needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

iv) Monitoring and follow-up activities:

(1) activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual’s needs, and which may be with the individual, family members, service provider, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring visit, to determine whether the following conditions are met:

(a) services are being furnished in accordance with the individual’s care plan;

(b) services in the care plan are adequate; and

(c) changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers. Monitoring includes face-to-face follow-up visits and phone calls. The frequency of the follow-up visits is based upon the complexity of the individual’s needs.

(2) Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e)).

b) Qualifications of providers:

A provider who is an agency or an individual approved by HHSC to provide case management services must ensure a case manager meets at least one of the following qualifications:

(1) an advanced practice registered nurse who holds a license, other than a provisional or temporary license, under Texas Occupations Code Chapter 301;

(2) Registered nurse (with a bachelor's or advanced degree), registered nurse (without a bachelor's or advanced degree and with two years of experience); or

(3) Social worker (with bachelor's or advanced degree), currently licensed by the respective Texas licensure board and whose license is not temporary, limited, or provisional in nature; or

(4) a community health worker, as defined by Texas Health and Safety Code §48.001, and be certified as a community health worker by the Department of State Health Services; or

(5) a doula who is certified in alignment with nationally recognized standards and as determined by HHSC, unless the doula qualifies as a certified community health worker.

5) Freedom of choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

a) Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.

b) Eligible individuals have free choice of any qualified providers of other medical care under the plan.

(__) Freedom of Choice Exception (§1915(9)(1) and 42 CFR 441.18(b)):

Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

6) Access to Services:

a) The State assures that case management services will be provided in a manner consistent with the best interest of the individual and will not be used to restrict an individual's access to other services under the plan.

b) The State assures that individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.

c) The State assures that providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

7) Payment (42 CFR 441.18(a)(4)):

Payment for targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

8) Case Records

a) Providers maintain case records that document for all individuals receiving case management as follows:

i) The name of the individual;

ii) The dates of the case management services;

iii) The name of the provider agency (if relevant) and the person providing the case management service;

iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;

v) Whether the individual has declined services in the care plan;

vi) The need for, and occurrences of, coordination with other case managers;

vii) A timeline for obtaining needed services, and

viii) A timeline for reevaluation of the plan.

9) Limitations:

a) Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

b) Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, education, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

c) FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

10) Other Limitations:

a) The number of billable contacts is based on the individual's level of need, level of medical involvement, and complicating psychosocial factors.