



TO: Medical Care Advisory Committee
DATE: February 11, 2021
FROM: Meghan Young, Manager, Policy and Program Development, HHSC Medicaid and CHIP Services Department

SUBJECT: Continuity of Care for Certain Children Formerly in Foster Care

Agenda Item No.: 9

Amendments to: Texas Administrative Code, Title 1, Chapter 353, Medicaid Managed Care, §§353.2, 353.702, and 353.1203 relating to the State of Texas Access Reform (STAR) Health and STAR Kids programs

BACKGROUND: Federal Requirement Legislative Requirement Other: Program Initiative

The proposed amendments are in response to Texas Government Code §533.00531, concerning Medicaid benefits for certain children formerly in foster care, which was added by House Bill (H.B.) 72, 86th Legislature, Regular Session, 2019. Section 533.00531 requires HHSC to allow the adoptive parent or permanent managing conservator of a child who participates in the Adoption Assistance (AA) Program or Permanency Care Assistance (PCA) Program operated by the Texas Department of Family and Protective Services, and is receiving Supplemental Security Income (SSI) or was receiving SSI before enrolling in the AA Program or PCA Program, to choose for the child to receive Medicaid benefits through the STAR Health program or the STAR Kids program, instead of being required to receive benefits through STAR Kids.

The proposed amendments make changes to the eligibility criteria for the STAR Health and STAR Kids programs to implement the requirements of §533.00531. In addition, the proposed amendments allow children and young adults who participate in the AA Program or PCA Program and are enrolled in a Medicaid 1915(c) waiver or Medicare, to choose to receive benefits through the STAR Health program or the STAR Kids program, unless they are in a category that is specifically excluded from the STAR Kids program.

ISSUES AND ALTERNATIVES:

There are no anticipated issues or concerns related to this amendment. The amendment is a result of legislative direction and provides continuity of care for certain children formerly in foster care. No alternatives were considered or proposed by stakeholders.

STAKEHOLDER INVOLVEMENT:

HHSC posted the draft amendments for informal external stakeholder review and comment from June 29 - July 13, 2020 and received no comments.

FISCAL IMPACT:

Yes

	SFY21	SFY22	SFY23	SFY24	SFY25
State	\$678,981	(\$272,278)	(\$276,855)	(\$291,143)	(\$300,391)
Federal	\$747,535	(\$458,638)	(\$471,306)	(\$486,330)	(\$501,835)
Total	\$1,426,516	(\$730,916)	(\$748,161)	(\$777,473)	(\$802,226)

RULE DEVELOPMENT SCHEDULE:

February 11, 2021 Present to the Medical Care Advisory Committee
February 18, 2021 Present to HHSC Executive Council
March 2021 Publish proposed rules in *Texas Register*
July 2021 Publish adopted rules in the *Texas Register*
July 2021 Effective Date

REQUESTED ACTION: (Check appropriate box)

The MCAC recommends approval of the proposed rules for publication.

Information Only

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 353 MEDICAID MANAGED CARE

PROPOSED PREAMBLE

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes amendments to §353.2, concerning Definitions; §353.702, concerning Member Participation; and §353.1203, concerning Member Participation.

BACKGROUND AND PURPOSE

The proposed amendments are in response to Texas Government Code §533.00531, concerning Medicaid benefits for certain children formerly in foster care, which was added by House Bill (H.B.) 72, 86th Legislature, Regular Session, 2019. Section 533.00531 requires HHSC to allow the adoptive parent or permanent managing conservator of a child who participates in the Adoption Assistance (AA) Program or Permanency Care Assistance (PCA) Program operated by the Texas Department of Family and Protective Services, and is receiving Supplemental Security Income (SSI) or was receiving SSI before enrolling in the AA program or PCA program, to choose for the child to receive Medicaid benefits through the STAR Health program or the STAR Kids program, instead of being required to receive benefits through STAR Kids.

The proposed amendments make changes to the eligibility criteria for the STAR Health and STAR Kids programs to implement the requirements of §533.00531. In addition, the proposed amendments allow children and young adults who participate in the AA Program or PCA Program and are enrolled in a Medicaid 1915(c) waiver or Medicare, to choose to receive benefits through the STAR Health program or the STAR Kids program, unless they are in a category that is specifically excluded from the STAR Kids program.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §353.2 adds definitions of "Adoption Assistance Program" and "Permanency Care Assistance Program" because these terms are used in the proposed amendments to §353.702 and §353.1203. The proposed amendment also adds a definition of "DFPS." The agency is referenced in the new definitions of "Adoption Assistance Program" and "Permanency Care Assistance Program;" in the current definitions of "Former Foster Care Children Program," "Medicaid for transitioning foster care youth program," and "STAR Health;" and in §353.702(a)(1) and §353.1203(d)(5). The acronym improves the readability of those provisions.

The proposed amendment to §353.702 adds certain children and young adults, from birth through the month of their 21st birthday, who are enrolled in the AA

program or the PCA program to the categories of persons eligible for the STAR Health program. Specifically, the proposed amendment makes such a child or young adult eligible for the STAR Health program if the child or young adult is receiving SSI; was receiving SSI before becoming eligible for the AA program or the PCA program; is enrolled in a Medicaid 1915(c) waiver; or is enrolled in Medicare. Subsection (c)(5), which currently excludes children and youth who are receiving Medicaid benefits through the AA program from the STAR Health program, has been deleted because the proposed amendment to this section makes some of those children and young adults eligible for STAR Health. The proposed amendment also makes minor changes to subsection (a)(2) and (3) to clarify the age ranges of children and young adults who are eligible for the STAR Health program. The proposed amendment changes "and" to "or" in subsection (b) to clarify that a young adult must only be described in subsection (a)(2) or (3), not both, to be able to choose to transfer from the STAR Health program to the STAR program or STAR Kids program.

The proposed amendment to §353.1203 adds the same categories of children and young adults to the eligibility categories for STAR Kids as the categories being added to §353.702 for STAR Health in new subsection (i). Subsection (h), which currently requires children and youth who are receiving Medicaid benefits through the AA program or the PCA program to enroll in STAR Kids if they meet the criteria described in subsections (a), (b), (c), or (e), has been deleted because the proposed new subsection (i) allows these children and young adults to have a choice of receiving benefits from the STAR Kids program or the STAR Health program. In addition, the proposed amendment changes the term "STAR Kids Medicaid client" to "STAR Kids member" in re-lettered subsection (h) because "member" refers to a person who is enrolled in a managed care program, which is appropriate in this context. The proposed amendment also makes minor changes to subsections (a), (b), (c), (f), and (g) to clarify the age ranges of children and young adults who are eligible for the STAR Kids program.

FISCAL NOTE

Trey Wood, HHSC Chief Financial Officer, has determined that for each year of the first five years that the rules will be in effect, there will be an estimated additional cost to the state as a result of enforcing and administering the rules as proposed. Enforcing or administering the rules does not have foreseeable implications relating to costs or revenues of local government.

The effect on state government for each year of the first five years the proposed rules are in effect is an estimated net cost of \$678,981 General Revenue (GR) (\$747,535 Federal Funds (FF), \$1,426,516 All Funds (AF)) for State Fiscal Year (SFY) 2021 and estimated net savings of \$272,278 GR (\$458,638 FF, \$730,916 AF) for SFY 2022; \$276,855 GR (\$471,306 FF, \$748,161 AF) for SFY 2023, \$291,143 GR (\$486,330 FF, \$777,473 AF) for SFY 2024; and \$300,391 GR (\$501,835 FF, \$802,226 AF) for SFY 2025.

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years that the rules will be in effect:

- (1) the proposed rules will not create or eliminate a government program;
- (2) implementation of the proposed rules will not affect the number of HHSC employee positions;
- (3) implementation of the proposed rules will require an increase in future legislative appropriations;
- (4) the proposed rules will not affect fees paid to HHSC;
- (5) the proposed rules will not create new rules;
- (6) the proposed rules will not expand existing rules; and
- (7) the proposed rules will not change the number of individuals subject to the rules.
- (8) the proposed rules will not affect the state's economy.

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT ANALYSIS

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities. The rules do not impose any additional costs on small businesses, micro businesses, or rural communities that are required to comply with the rules.

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because the rules do not impose a cost on regulated persons.

PUBLIC BENEFIT AND COSTS

Stephanie Stephens, State Medicaid Director, has determined that for each year of the first five years the rules are in effect, the public benefit will be improved continuity of care for children and young adults formerly in foster care by allowing them to obtain services more efficiently.

Trey Wood has also determined that for the first five years the rules are in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rules because the proposed amendments do not impose any new costs or fees on those required to comply.

TAKINGS IMPACT ASSESSMENT

HHSC 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 Texas Government Code §2007.043.

PUBLIC COMMENT

Written comments on the proposal may be submitted to Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin, Texas 78711-3247, or street address 4900 North Lamar Boulevard, Austin, Texas 78751; or emailed to HHSRulesCoordinationOffice@hhs.texas.gov.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register*. Comments must be: (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 20R037 in the subject line.

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.00531, which requires the Executive Commissioner to adopt rules necessary to implement requirements relating to Medicaid benefits for certain children formerly in foster care; §531.0055, which requires the Executive Commissioner of HHSC to adopt rules for the operation and provision of services by the health and human services agencies; §531.021(a), which authorizes HHSC to administer the federal medical assistance (Medicaid) program; §531.033, which directs the Executive Commissioner of HHSC to adopt rules as necessary to carry out the commission's duties; and Texas Human Resources Code §32.021(c), which requires the Executive Commissioner of HHSC to adopt necessary rules for the proper and efficient operation of the Medicaid program.

The amendments affect Texas Government Code §§531.021, 531.033, 531.0055, and 531.00531; and Texas Human Resources Code §32.021.

This agency hereby certifies that this proposal has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

ADDITIONAL INFORMATION

For further information, please call: (512) 438-3360.

Legend:

Single Underline = Proposed new language

~~[Strikethrough and brackets]~~ = Current language proposed for deletion

Regular print = Current language

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

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 353 MEDICAID MANAGED CARE
SUBCHAPTER A GENERAL PROVISIONS

§353.2. Definitions.

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

(1) Action--

(A) An action is defined as:

(i) the denial or limited authorization of a requested Medicaid service, including the type or level of service;

(ii) the reduction, suspension, or termination of a previously authorized service;

(iii) the failure to provide services in a timely manner;

(iv) the denial in whole or in part of payment for a service; or

(v) the failure of a managed care organization (MCO) to act within the timeframes set forth by the Texas Health and Human Services Commission (HHSC) and state and federal law.

(B) "Action" does not include expiration of a time-limited service.

(2) Acute care--Preventive care, primary care, and other medical or behavioral health care provided by the provider or under the direction of a provider for a condition having a relatively short duration.

(3) Acute care hospital--A hospital that provides acute care services.

(4) Adoption Assistance Program--The program administered by DFPS in accordance with 40 TAC Chapter 700, Subchapter H (relating to Adoption Assistance Program).

(5) ~~[(4)]~~ Agreement or Contract--The formal, written, and legally enforceable contract and amendments thereto between HHSC and an MCO.

(6) ~~[(5)]~~ Allowable revenue--All managed care revenue received by the MCO pursuant to the contract during the contract period, including retroactive

adjustments made by HHSC. This would include any revenue earned on Medicaid managed care funds such as investment income, earned interest, or third party administrator earnings from services to delegated networks.

(7) [~~(6)~~] Appeal--The formal process by which a member or his or her representative requests a review of the MCO's action.

(8) [~~(7)~~] Applicant Provider--A physician or other health care provider applying for expedited credentialing as defined in Texas Government Code §533.0064.

(9) [~~(8)~~] Behavioral health service--A covered service for the treatment of mental, emotional, or substance use disorders.

(10) [~~(9)~~] Capitated service--A benefit available to members under the Texas Medicaid program for which an MCO is responsible for payment.

(11) [~~(10)~~] Capitation rate--A fixed predetermined fee paid by HHSC to the MCO each month, in accordance with the contract, for each enrolled member in exchange for which the MCO arranges for or provides a defined set of covered services to the member, regardless of the amount of covered services used by the enrolled member.

(12) [~~(11)~~] CFR--Code of Federal Regulations.

(13) [~~(12)~~] Children's Medicaid Dental Services--The dental services provided through a dental MCO to a client birth through age 20.

(14) [~~(13)~~] Clean claim--A claim submitted by a physician or provider for health care services rendered to a member, with the data necessary for the MCO or subcontracted claims processor to adjudicate and accurately report the claim. A clean claim must meet all requirements for accurate and complete data as further defined under the terms of the contract executed between the MCO and HHSC.

(15) [~~(14)~~] Client--Any Medicaid-eligible recipient.

(16) [~~(15)~~] CMS--The Centers for Medicare & Medicaid Services, which is the federal agency responsible for administering Medicare and overseeing state administration of Medicaid.

(17) [~~(16)~~] Complainant--A member, or a treating provider or other individual designated to act on behalf of the member, who files a complaint.

(18) [~~(17)~~] Complaint--Any dissatisfaction expressed by a complainant, orally or in writing, to the MCO about any matter related to the MCO other than an action. Subjects for complaints may include:

(A) the quality of care of services provided;

(B) aspects of interpersonal relationships such as rudeness of a provider or employee; and

(C) failure to respect the member's rights.

(19) [~~(18)~~] Consumer Directed Services (CDS) option--A service delivery option (also known as self-directed model with service budget) in which an individual or legally authorized representative employs and retains service providers and directs the delivery of certain program services.

(20) [~~(19)~~] Covered services--Unless a service or item is specifically excluded under the terms of the state plan, a federal waiver, a managed care services contract, or an amendment to any of these, the phrase "covered services" means all health care, long term services and supports, or dental services or items that the MCO must arrange to provide and pay for on a member's behalf under the terms of the contract executed between the MCO and HHSC, including:

(A) all services or items comprising "medical assistance" as defined in §32.003 of the Human Resources Code; and

(B) all value-added services under such contract.

(21) [~~(20)~~] Credentialing--The process through which an MCO collects, assesses, and validates qualifications and other relevant information pertaining to a Medicaid enrolled health care provider to determine whether the provider may be contracted to deliver covered services as part of the network of the managed care organization.

(22) [~~(21)~~] Cultural competency--The ability of individuals and systems to provide services effectively to people of various disabilities, cultures, races, ethnic backgrounds, and religions in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves their dignity.

(23) [~~(22)~~] Day--A calendar day, unless specified otherwise.

(24) [~~(23)~~] Default enrollment--The process established by HHSC to assign a Medicaid managed care enrollee to an MCO when the enrollee has not selected an MCO.

(25) [~~(24)~~] Dental contractor--A dental MCO that is under contract with HHSC for the delivery of dental services.

(26) [~~(25)~~] Dental home--A provider who has contracted with a dental MCO to serve as a dental home to a member and who is responsible for providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care to patients, maintaining the continuity of patient care, and initiating referral for care. Provider types that can serve as dental homes are federally qualified health centers and individuals who are general dentists or pediatric dentists.

(27) [~~(26)~~] Dental managed care organization (dental MCO)--A dental indemnity insurance provider or dental health maintenance organization licensed or approved by the Texas Department of Insurance.

(28) [~~(27)~~] Dental service--The routine preventive, diagnostic, urgent, therapeutic, initial, and primary care provided to a member and included within the scope of HHSC's agreement with a dental contractor. For purposes of this chapter,

"dental service" does not include dental devices for craniofacial anomalies; treatment rendered in a hospital, urgent care center, or ambulatory surgical center setting for craniofacial anomalies; or emergency services provided in a hospital, urgent care center, or ambulatory surgical center setting involving dental trauma. These types of services are treated as health care services in this chapter.

(29) DFPS--The Texas Department of Family and Protective Services.

(30) [~~(28)~~] Disability--A physical or mental impairment that substantially limits one or more of an individual's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, socializing, or working.

(31) [~~(29)~~] Disproportionate Share Hospital (DSH)--A hospital that serves a higher than average number of Medicaid and other low-income patients and receives additional reimbursement from the State.

(32) [~~(30)~~] Dual eligible--A Medicaid recipient who is also eligible for Medicare.

(33) [~~(31)~~] Elective enrollment--Selection of a primary care provider (PCP) and MCO by a client during the enrollment period established by HHSC.

(34) [~~(32)~~] Emergency behavioral health condition--Any condition, without regard to the nature or cause of the condition, that in the opinion of a prudent layperson possessing an average knowledge of health and medicine:

(A) requires immediate intervention and/or medical attention without which the client would present an immediate danger to themselves or others; or

(B) renders the client incapable of controlling, knowing, or understanding the consequences of his or her actions.

(35) [~~(33)~~] Emergency medical condition--A medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care to result in:

(A) placing the patient's health in serious jeopardy;

(B) serious impairment to bodily functions;

(C) serious dysfunction of any bodily organ or part;

(D) serious disfigurement; or

(E) serious jeopardy to the health of a pregnant woman or her unborn child.

(36) [~~(34)~~] Emergency service--A covered inpatient and outpatient service, furnished by a network provider or out-of-network provider that is qualified to furnish such service, that is needed to evaluate or stabilize an emergency medical condition and/or an emergency behavioral health condition. For health care MCOs,

the term "emergency service" includes post-stabilization care services.

(37) [~~(35)~~] Encounter--A covered service or group of covered services delivered by a provider to a member during a visit between the member and provider. This also includes value-added services.

(38) [~~(36)~~] Enrollment--The process by which an individual determined to be eligible for Medicaid is enrolled in a Medicaid MCO serving the service area in which the individual resides.

(39) [~~(37)~~] EPSDT--The federally mandated Early and Periodic Screening, Diagnosis, and Treatment program defined in 25 TAC Chapter 33 (relating to Early and Periodic Screening, Diagnosis, and Treatment). The State of Texas has adopted the name Texas Health Steps (THSteps) for its EPSDT program.

(40) [~~(38)~~] EPSDT-CCP--The Early and Periodic Screening, Diagnosis, and Treatment-Comprehensive Care Program described in Chapter 363 of this title (relating to Texas Health Steps Comprehensive Care Program).

(41) [~~(39)~~] Exclusive provider benefit plan (EPBP)--An MCO that complies with 28 TAC §§3.9201 - 3.9212, relating to the Texas Department of Insurance's requirements for EPBPs, and contracts with HHSC to provide Medicaid coverage.

(42) [~~(40)~~] Expedited Credentialing--The process under Texas Government Code §533.0064 in which an MCO allows an applicant provider to provide Medicaid services to members on a provisional basis pending completion of the credentialing process.

(43) [~~(41)~~] Experience rebate--The portion of the MCO's net income before taxes that is returned to the State in accordance with the MCO's contract with HHSC.

(44) [~~(42)~~] Fair hearing--The process adopted and implemented by HHSC in Chapter 357, Subchapter A of this title (relating to Uniform Fair Hearing Rules) in compliance with federal regulations and state rules relating to Medicaid fair hearings.

(45) [~~(43)~~] Federal Poverty Level (FPL)--The household income guidelines issued annually and published in the *Federal Register* by the United States Department of Health and Human Services under the authority of 42 U.S.C. §9902(2) and as in effect for the applicable budget period determined in accordance with 42 C.F.R. §435.603(h). HHSC uses the FPL to determine an individual's eligibility for Medicaid.

(46) [~~(44)~~] Federal waiver--Any waiver permitted under federal law and approved by CMS that allows states to implement Medicaid managed care.

(47) [~~(45)~~] Federally Qualified Health Center (FQHC)--An entity that is certified by CMS to meet the requirements of 42 U.S.C. §1395x(aa)(3) as a Federally Qualified Health Center and is enrolled as a provider in the Texas Medicaid program.

(48) [(46)] Former Foster Care Children (FFCC) program--The Medicaid program for young adults who aged out of the conservatorship of DFPS [~~Texas Department of Family and Protective Services (DFPS)~~], administered in accordance with Chapter 366, Subchapter J of this title (relating to Former Foster Care Children's Program).

(49) [(47)] Functional necessity--A member's need for services and supports with activities of daily living or instrumental activities of daily living to be healthy and safe in the most integrated setting possible. This determination is based on the results of a functional assessment.

(50) [(48)] Habilitation--Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks based on the individual's person-centered service plan.

(51) [(49)] Health and Human Services Commission (HHSC)--The single state agency charged with administration and oversight of the Texas Medicaid program or its designee.

(52) [(50)] Health care managed care organization (health care MCO)--An entity that is licensed or approved by the Texas Department of Insurance to operate as a health maintenance organization or to issue an EPBP.

(53) [(51)] Health care provider group--A legal entity, such as a partnership, corporation, limited liability company, or professional association, enrolled in Medicaid, under which certified or licensed individual health care providers provide health care items or services.

(54) [(52)] Health care services--The acute care, behavioral health care, and health-related services that an enrolled population might reasonably require in order to be maintained in good health, including, at a minimum, emergency services and inpatient and outpatient services.

(55) [(53)] Health maintenance organization (HMO)--An organization that holds a certificate of authority from the Texas Department of Insurance to operate as an HMO under Chapter 843 of the Texas Insurance Code, or a certified Approved Non-Profit Health Corporation formed in compliance with Chapter 844 of the Texas Insurance Code.

(56) [(54)] Hospital--A licensed public or private institution as defined in the Texas Health and Safety Code at Chapter 241, relating to hospitals, or Chapter 261, relating to municipal hospitals.

(57) [(55)] Intermediate care facility for individuals with an intellectual disability or related condition (ICF-IID)--A facility providing care and services to individuals with intellectual disabilities or related conditions as defined in §1905(d) of the Social Security Act (42 U.S.C. 1396(d)).

(58) [(56)] Legally authorized representative (LAR)--A person authorized by law to act on behalf of an individual with regard to a matter described in this chapter, and may, depending on the circumstances, include a parent, guardian, or managing

conservator of a minor, or the guardian of an adult, or a representative designated pursuant to 42 C.F.R. 435.923.

(59) [(57)] Long term service and support (LTSS)--A service provided to a qualified member in his or her home or other community-based setting necessary to allow the member to remain in the most integrated setting possible. LTSS includes services provided under the Texas State Plan as well as services available to persons who qualify for STAR+PLUS Home and Community-Based Program services or Medicaid 1915(c) waiver services. LTSS available through an MCO in STAR+PLUS, STAR Health, and STAR Kids varies by program model.

(60) [(58)] Main dental home provider--See definition of "dental home" in this section.

(61) [(59)] Main dentist--See definition of "dental home" in this section.

(62) [(60)] Managed care--A health care delivery system or dental services delivery system in which the overall care of a patient is coordinated by or through a single provider or organization.

(63) [(61)] Managed care organization (MCO)--A dental MCO or a health care MCO.

(64) [(62)] Marketing--Any communication from an MCO to a client who is not enrolled with the MCO that can reasonably be interpreted as intended to influence the client's decision to enroll, not to enroll, or to disenroll from a particular MCO.

(65) [(63)] Marketing materials--Materials that are produced in any medium by or on behalf of the MCO that can reasonably be interpreted as intending to market to potential members. Materials relating to the prevention, diagnosis, or treatment of a medical or dental condition are not marketing materials.

(66) [(64)] MDCP--Medically Dependent Children Program. A §1915(c) waiver program that provides community-based services to assist Medicaid beneficiaries under age 21 to live in the community and avoid institutionalization.

(67) [(65)] Medicaid--The medical assistance program authorized and funded pursuant to Title XIX of the Social Security Act (42 U.S.C. §1396 et seq) and administered by HHSC.

(68) [(66)] Medicaid for transitioning foster care youth (MTFCY) program--The Medicaid program for young adults who aged out of the conservatorship of DFPS [~~Texas Department of Family and Protective Services (DFPS)~~], administered in accordance with Chapter 366, Subchapter F of this title (relating to Medicaid for Transitioning Foster Care Youth).

(69) [(67)] Medical Assistance Only (MAO)--A person who qualifies financially and functionally for Medicaid assistance but does not receive Supplemental Security Income (SSI) benefits, as defined in Chapters 358, 360, and 361, of this title (relating to Medicaid Eligibility for the Elderly and People with Disabilities, Medicaid Buy-In Program and Medicaid Buy-In for Children Program).

(70) [~~(68)~~] Medical home--A PCP or specialty care provider who has accepted the responsibility for providing accessible, continuous, comprehensive, and coordinated care to members participating in an MCO contracted with HHSC.

(71) [~~(69)~~] Medically necessary--

(A) For Medicaid members birth through age 20, the following Texas Health Steps services:

(i) screening, vision, dental, and hearing services; and

(ii) other health care services or dental services that are necessary to correct or ameliorate a defect or physical or mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition:

(I) must comply with the requirements of a final court order that applies to the Texas Medicaid program or the Texas Medicaid managed care program as a whole; and

(II) may include consideration of other relevant factors, such as the criteria described in subparagraphs (B)(ii) - (vii) and (C)(ii) - (vii) of this paragraph.

(B) For Medicaid members over age 20, non-behavioral health services that are:

(i) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member, or endanger life;

(ii) provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions;

(iii) consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;

(iv) consistent with the member's medical need;

(v) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;

(vi) not experimental or investigative; and

(vii) not primarily for the convenience of the member or provider.

(C) For Medicaid members over age 20, behavioral health services that:

(i) are reasonable and necessary for the diagnosis or treatment of a mental health or substance use disorder, or to improve, maintain, or prevent

deterioration of functioning resulting from such a disorder;

(ii) are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;

(iii) are furnished in the most appropriate and least restrictive setting in which services can be safely provided;

(iv) are the most appropriate level or supply of service that can safely be provided;

(v) could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered;

(vi) are not experimental or investigative; and

(vii) are not primarily for the convenience of the member or provider.

(72) [~~(70)~~] Member--A person who is eligible for benefits under Title XIX of the Social Security Act and Medicaid, is in a Medicaid eligibility category included in the Medicaid managed care program, and is enrolled in a Medicaid MCO.

(73) [~~(71)~~] Member education program--A planned program of education:

(A) concerning access to health care services or dental services through the MCO and about specific health or dental topics;

(B) that is approved by HHSC; and

(C) that is provided to members through a variety of mechanisms that must include, at a minimum, written materials and face-to-face or audiovisual communications.

(74) [~~(72)~~] Member materials--All written materials produced or authorized by the MCO and distributed to members or potential members containing information concerning the managed care program. Member materials include member ID cards, member handbooks, provider directories, and marketing materials.

(75) [~~(73)~~] Non-capitated service--A benefit available to members under the Texas Medicaid program for which an MCO is not responsible for payment.

(76) [~~(74)~~] Outside regular business hours--As applied to FQHCs and rural health clinics (RHCs), means before 8 a.m. and after 5 p.m. Monday through Friday, weekends, and federal holidays.

(77) [~~(75)~~] Participating MCO--An MCO that has a contract with HHSC to provide services to members.

(78) Permanency Care Assistance Program--The program administered by DFPS in accordance with 40 TAC Chapter 700, Subchapter J, Division 2 (relating to Permanency Care Assistance Program).

(79) [(76)] Person-centered care--An approach to care that focuses on members as individuals and supports caregivers working most closely with them. It involves a continual process of listening, testing new approaches, and changing routines and organizational approaches in an effort to individualize and de-institutionalize the care environment.

(80) [(77)] Person-centered planning--A documented service planning process that includes people chosen by the individual, is directed by the individual to the maximum extent possible, enables the individual to make choices and decisions, is timely and occurs at times and locations convenient to the individual, reflects cultural considerations of the individual, includes strategies for solving conflict or disagreement within the process, offers choices to the individual regarding the services and supports they receive and from whom, includes a method for the individual to require updates to the plan, and records alternative settings that were considered by the individual.

(81) [(78)] Post-stabilization care service--A covered service, related to an emergency medical condition, that is provided after a Medicaid member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 C.F.R. §438.114(b) and (e) and 42 C.F.R. §422.113(c)(iii) to improve or resolve the Medicaid member's condition.

(82) [(79)] Primary care provider (PCP)--A physician or other provider who has agreed with the health care MCO to provide a medical home to members and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

(83) [(80)] Provider--A credentialed and licensed individual, facility, agency, institution, organization, or other entity, and its employees and subcontractors, that has a contract with the MCO for the delivery of covered services to the MCO's members.

(84) [(81)] Provider education program--Program of education about the Medicaid managed care program and about specific health or dental care issues presented by the MCO to its providers through written materials and training events.

(85) [(82)] Provider network or Network--All providers that have contracted with the MCO for the applicable managed care program.

(86) [(83)] Quality improvement--A system to continuously examine, monitor, and revise processes and systems that support and improve administrative and clinical functions.

(87) [(84)] Rural Health Clinic (RHC)--An entity that meets all of the requirements for designation as a rural health clinic under §1861(aa)(1) of the Social Security Act (42 U.S.C. §1395x(aa)(1)) and is approved for participation in the Texas Medicaid program.

(88) [(85)] Service area--The counties included in any HHSC-defined service

area as applicable to each MCO.

(89) [(86)] Significant traditional provider (STP)--A provider identified by HHSC as having provided a significant level of care to the target population, including a DSH.

(90) [(87)] STAR--The State of Texas Access Reform (STAR) managed care program that operates under a federal waiver and primarily provides, arranges for, and coordinates preventive, primary, acute care, and pharmacy services for low-income families, children, and pregnant women.

(91) [(88)] STAR Health--The managed care program that operates under the Medicaid state plan and primarily serves:

(A) children and youth in DFPS [~~Texas Department of Family and Protective Services (DFPS)~~] conservatorship;

(B) young adults who voluntarily agree to continue in a foster care placement (if the state as conservator elects to place the child in managed care); and

(C) young adults who are eligible for Medicaid as a result of their former foster care status through the month of their 21st birthday.

(92) [(89)] STAR Kids--The program that operates under a federal waiver and primarily provides, arranges, and coordinates preventative, primary, acute care, and long-term services and supports to persons with disabilities under the age of 21 who qualify for Medicaid.

(93) [(90)] STAR+PLUS--The managed care program that operates under a federal waiver and primarily provides, arranges, and coordinates preventive, primary, acute care, and long-term services and supports to persons with disabilities and elderly persons age 65 and over who qualify for Medicaid by virtue of their SSI or MAO status.

(94) [(91)] STAR+PLUS Home and Community-Based Services Program--The program that provides person-centered care services that are delivered in the home or in a community setting, as authorized through a federal waiver under §1115 of the Social Security Act, to qualified Medicaid-eligible clients who are age 21 or older, as cost-effective alternatives to institutional care in nursing facilities.

(95) [(92)] State plan--The agreement between the CMS and HHSC regarding the operation of the Texas Medicaid program, in accordance with the requirements of Title XIX of the Social Security Act.

(96) [(93)] Supplemental Security Income (SSI)--The federal cash assistance program of direct financial payments to people who are 65 years of age or older, are blind, or have a disability administered by the Social Security Administration (SSA) under Title XVI of the Social Security Act. All persons who are certified as eligible for SSI in Texas are eligible for Medicaid. Local SSA claims representatives make SSI eligibility determinations. The transactions are forwarded to the SSA in Baltimore, which then notifies the states through the State Data Exchange (SDX).

(97) [~~(94)~~] Texas Health Steps (THSteps)--The name adopted by the State of Texas for the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, described at 42 U.S.C. §1396d(r) and 42 CFR §440.40 and §§441.40 - 441.62.

(98) [~~(95)~~] Value-added service--A service provided by an MCO that is not "medical assistance," as defined by §32.003 of the Texas Human Resources Code.

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 353 MEDICAID MANAGED CARE
SUBCHAPTER H STAR HEALTH

§353.702. Member Participation.

(a) Children and young adults in the following categories are eligible to participate in the STAR Health program:

(1) a child in the conservatorship of DFPS [~~the Texas Department of Family and Protective Services (DFPS)~~], if the state as conservator elects to place the child in the STAR Health program;

(2) a young adult, from [age] 18 years of age through the month of his or her 22nd birthday, who voluntarily agrees to continue in foster care placement, if the state as conservator elects to place the child in the STAR Health program; [~~and~~]

(3) a young adult, from [age] 18 years of age through the month of his or her 21st birthday, who is an FFCC member or participating in the MTFCY Program; and [-]

(4) a child or young adult, from birth through the month of his or her 21st birthday, who is enrolled in the Adoption Assistance Program or the Permanency Care Assistance Program and who:

(A) receives Social Security Income (SSI);

(B) received SSI before becoming eligible for the Adoption Assistance Program or the Permanency Care Assistance Program;

(C) is enrolled in a Medicaid 1915(c) waiver; or

(D) is enrolled in Medicare.

(b) A young adult described in subsection (a)(2) or [~~and~~] (3) of this section may choose to transfer from the STAR Health program to the STAR program or STAR Kids program, if the young adult meets [~~they meet~~] the member participation requirements in §353.802 of this chapter (relating to Member Participation) or §353.1203 of this chapter (relating to Member Participation).

(c) The following Medicaid recipients cannot participate in the STAR Health program:

(1) Children and youth who have been adjudicated and placed with the Texas Juvenile Justice Department (TJJD);

(2) Children and youth from other states who are placed in Texas through the Interstate Compact Placement Commission (ICPC) as defined by DFPS in 40 TAC Chapter 700, Subchapter S (relating to Interstate Placement of Children);

(3) Children and youth in Medicaid-paid facilities such as nursing facilities or state supported living centers;

(4) Children and youth who are in the conservatorship of DFPS who are placed outside of Texas; and

~~[(5) Children and youth who are receiving adoption assistance Medicaid as defined by DFPS in 40 TAC Chapter 700, Subchapter H (relating to Adoption Assistance Program); and]~~

(5) ~~[(6)]~~ Children who are declared manifestly dangerous as defined by the Texas Department of Health Services in accordance with 25 TAC Chapter 415, Subchapter G (relating to Determination of Manifest Dangerousness).

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 353 MEDICAID MANAGED CARE
SUBCHAPTER N STAR KIDS

§353.1203. Member Participation.

(a) Except as provided in subsection (b) of this section, enrollment in the STAR Kids program is *mandatory* for a Medicaid client who is younger than ~~[under the age of]~~ 21 years of age and meets one or both of the following criteria:

(1) has a physical or mental disability and qualifies for Supplemental Security Income (SSI) or SSI-related Medicaid; or

(2) is enrolled in the Medically Dependent Children Program (MDCP) waiver.

(b) Clients younger than 21 years of age ~~[birth through age 20]~~ residing in a community-based ICF-IID or nursing facility or receiving services under the following Medicaid 1915(c) waivers must enroll in STAR Kids to receive acute care services and non-facility based state plan services:

(1) Home and Community-based Services (HCS);

(2) Community Living Assistance and Support Services (CLASS);

(3) Texas Home Living (TxHmL); or

(4) Deaf Blind with Multiple Disabilities (DBMD).

(c) Clients younger than 21 years of age ~~[birth through age 20]~~ receiving services under the Youth Empowerment Services (YES) Medicaid 1915(c) waiver must enroll in STAR Kids to receive acute care services and non-facility based state plan services other than Community First Choice state plan services.

(d) The following Medicaid clients cannot participate in the STAR Kids program:

(1) clients residing in the Truman W. Smith Children's Care Center;

(2) residents of state supported living centers;

(3) residents of state veterans' homes;

(4) persons not eligible for full Medicaid benefits; and

(5) children in the conservatorship of DFPS ~~[the Texas Department of Family and Protective Services]~~.

(e) Dual eligible clients.

(1) Enrollment in Medicare does not affect eligibility for the STAR Kids program.

(2) Dual eligible clients who participate in the STAR Kids program receive most acute care services through their Medicare provider, and long term services and supports through the STAR Kids MCO. Participation in the STAR Kids program does not change the way dual eligible clients receive Medicare services.

(f) Individuals younger than 21 years of age [~~birth through 20~~] who participate in the Medicaid Buy-In for Children Program or the Medicaid Buy-In Program must enroll in STAR Kids.

(g) FFCC members at least [~~ages~~] 18 years of age but younger than 21 years of age [~~through 20~~] may choose to transfer from STAR Health to STAR Kids if they meet the criteria in subsections (b), (c), (e), or (f) of this section.

~~[(h) Except as provided in subsection (d), children receiving medical assistance through the Texas Department of Family and Protective Services Adoption Assistance Program, as described under Title 40 of the Texas Administrative Code, Chapter 700, Subchapter H (relating to Adoption Assistance Program); or Permanency Care Assistance Program, as described under Title 40 of the Texas Administrative Code, Chapter 700, Subchapter J, Division 2 (relating to Permanency Care Assistance Program) must enroll in STAR Kids if they meet one or more of the criteria in subsections (a), (b), (c), or (e) of this section.]~~

(h) [~~(i)~~] A STAR Kids member has [~~Medicaid clients have~~] a choice among at least two MCOs.

(i) Except as provided in subsection (d), a child or young adult, from birth through the month of his or her 21st birthday, who is enrolled in the Adoption Assistance Program or the Permanency Care Assistance Program and who meets one or more of the following criteria is eligible to participate in the STAR Kids program:

(1) receives Social Security Income (SSI);

(2) received SSI before becoming eligible for the Adoption Assistance Program or the Permanency Care Assistance Program;

(3) is enrolled in a Medicaid 1915(c) waiver; or

(4) is enrolled in Medicare.