DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DEC 31 2008

Mr. Chris Traylor
State Medicaid Director
Texas Health and Human Services Commission
P.O. Box 13247
Austin, TX 78751

Dear Mr. Traylor:

We are pleased to inform you that Texas' request to amend the Texas Women's Health Waiver section 1115 demonstration has been approved in accordance with section 1115(a) of the Social Security Act, and is effective as of the date of this approval letter through December 31, 2012. Specifically, you requested to modify the demonstration by adding Current Procedural Terminology (CPT) codes to the list of services provided through this demonstration. Specifically, the new codes are:

99201 New Client Office Visit
76856 Ultrasound, pelvic (nonobstretic), real time with image documentation, complete
76857 Ultrasound, pelvic (nonobstretic), real time with image documentation, Complete, limited or follow-up (e.g., for follicles)
76880 Ultrasound, extremity, nonvascular, real time with image documentation
J7307 Implantable contraceptive rod device
11975 Insertion, implantable contraceptive capsules
11976 Removal, implantable contraceptive capsules
11977 Removal with reinsertion, implantable contraceptive capsules
84443 Thyroid stimulating hormone test
86695 Herpes simplex type 1
86696 Herpes simplex type 2
87252 Tissue culture inoculation, observation, and presumptive identification by cytopathic effect
58565 Hysteroscopy, surgical, with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants
74740 Hysterosalpingography, radiological supervision and interpretation
E1399 Occlusive sterilization device
58340 Catheterization and introduction of saline or contrast material for saline infusion sonohysterography or hysterosalpingography

In addition, Attachment A (formerly Attachment B) to the enclosed Special Terms and Conditions (STCs) has been updated to reflect additional approved services and the

corresponding Federal Medical Assistance Percentage rate at which these services will be reimbursed.

Please be aware that by including those individuals who are eligible for family planning services under this waiver, the State is expanding the number of instances in which pharmacists, physicians, and other health care professionals would be protected by 42 U.S.C. section 300a-7(d) which provides:

> No individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions.

Our approval of this demonstration project amendment is subject to the limitations specified in the expenditure authorities. The State may deviate from Medicaid State plan requirements to the extent those requirements have been listed as inapplicable to expenditures for the demonstration population.

The approval is also conditioned upon continued compliance with the enclosed STCs, defining the nature, character, and extent of anticipated Federal participation in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of the STCs and expenditure authorities within 30 days of the date of this letter.

Your contact for this demonstration is Lane Terwilliger, Esquire, who may be reached at (410) 786-2059. Ms. Terwilliger is available to answer any questions concerning the scope and implementation of your demonstration project. Communications regarding the program matters and official correspondence concerning the demonstration should be submitted to her at the following address:

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
7500 Security Boulevard
Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Facsimile: 410-786-8534
E-mail: Lane.Terwilliger@cms.hhs.gov

Official communications regarding program matters should be submitted simultaneously to Ms. Terwilliger and to Mr. Bill Brooks, Acting Associate Regional Administrator, in the Dallas Regional Office. Mr. Brooks' address is:

Centers for Medicare & Medicaid Services
Office of the Regional Administrator
1301 Young Street, Room 833
Dallas, TX 75202

We extend our congratulations to you on this award and look forward to working with you during the course of the demonstration.

Sincerely,

Kerry Weems
Acting Administrator

Enclosures

cc:

Bill Brooks, Acting ARA, Dallas Regional Office

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00232/6**

TITLE: **Texas Women's Health Waiver**

AWARDEE: **Texas Health and Human Services Commission**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Texas for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this Demonstration, be regarded as expenditures under the State's title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditure authorities (including adherence to income and eligibility system verification requirements under section 1137(d) of the Act), except those specified below as not applicable to these expenditure authorities.

The following expenditure authority shall enable Texas to operate its section 1115 Medicaid "Texas Women's Health Waiver" demonstration. The demonstration extends Medicaid eligibility for family planning services to women from the ages of 18 to 44 with a net family income up to 185 percent of the Federal poverty level who are not otherwise eligible for Medicaid, the State Children's Health Insurance Program, Medicare, or have creditable health insurance coverage.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

1. **Amount, Duration, and Scope of Services (Comparability)-Section 1902(a)(10)(B)**

   To the extent necessary to allow the State to offer the demonstration population a benefit package consisting only of approved family planning services.

2. **Early and Periodic Screening, Diagnostic, and Treatment -Section 1902(a)(43)(A) (EPSDT)**

   The State will not furnish or arrange for EPSDT services to the demonstration population.

3. **Retroactive Coverage-Section 1902(a)(34)**

   Individuals enrolled in the family planning demonstration will not be retroactively eligible.

4. Prospective Payment for Federally Qualified Health Centers and Rural Health Centers and Rural Health Clinics – Section 1902(a)(15)

The State will establish reimbursement levels to these clinics that would compensate them solely for family planning services.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS
(Amendment Effective Date: XX XX, 2008)

NUMBER: **11-W-00232/6**

TITLE: **Texas Women's Health Waiver**

AWARDEE: **Texas Health and Human Services Commission**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Texas Women's Health Waiver Program section 1115(a) Medicaid Demonstration (hereinafter "Demonstration"). The parties to this agreement are the Texas Health and Human Services Commission (State), and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The STCs are effective the date of approval, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration is approved through December 31, 2011.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility; Benefits and Delivery Systems; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Evaluation of the Demonstration; and the Service Code List, Attachment A.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Texas Women's Health Waiver section 1115(a) Medicaid Demonstration expands the provision of family planning services to women of childbearing age with a net family income up to 185 percent of the Federal poverty level (FPL), who do not have creditable coverage for family planning services, and who are not otherwise eligible for Medicaid, or the State Children's Health Insurance Program (SCHIP). The objective of the program is to decrease the number of Medicaid paid deliveries, which will result in a decrease in annual Medicaid expenditures for prenatal, delivery, newborn and infant care, and increase the proportion of clients who receive assistance with accessing primary care services and comprehensive health coverage.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State agrees that it must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid programs expressed in law, regulation, court order, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents of which these terms and conditions are part, must apply to the Demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, court order, or policy directive, come into compliance with any changes in Federal law, regulation, court order, or policy affecting the Medicaid programs that occur during this Demonstration approval period, unless the provision being changed is explicitly waived under the STCs herein governing the Demonstration.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**

   a) To the extent that a change in Federal law, regulation, final court order, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change.

   b) If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **Changes Subject to the Amendment Process.** Demonstration provisions related to eligibility, enrollment, benefits, delivery systems, and cost sharing covered under this Demonstration; evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements in these STCs must be submitted to CMS as amendments to the Demonstration. Changes to the Service Code List, Attachment A, also require an amendment. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 6 below. The State will notify CMS of proposed Demonstration changes at the quarterly monitoring call, as well as in the written quarterly report, to determine if a formal amendment is necessary.

6. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must be reviewed by the Federal Review Team and must include, but are not limited to, the following:

   a) An explanation of the public process used by the State consistent with the requirements of paragraph 14 to reach a decision regarding the requested amendment;

b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis must include current "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;

c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

d) If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.

7. **Extension of the Demonstration**. States that intend to request demonstration extensions must submit to CMS a complete application at least **6 months prior** to the expiration of the current section 1115(a) extension period. Upon submission, the State will work with CMS to identify specific updates necessary to the submission based on significant programmatic changes (such as changes in State law, population demographics, or expenditures).

8. **Demonstration Phase Out.** The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Nothing herein should be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP must be limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

9. **Enrollment Limitation During Demonstration Phase-Out**. If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 8, during the last 6 months of the Demonstration, individuals who would not be eligible for Medicaid under the current Medicaid State plan must not be enrolled unless the Demonstration is extended by CMS. Enrollment may be suspended if CMS notifies the State in writing that the Demonstration will not be renewed.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration, in whole or in part, at any time before the date of expiration, whenever it determines following a hearing that the State has materially failed to comply with the terms of the project. CMS must promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS' finding that the State materially failed to comply.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waiver or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS must promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and must afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The State will ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements to the extent they apply; and reporting on financial and other Demonstration components.

14. **Public Notice and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) when any program changes to the Demonstration, including, but not limited to, those referenced in paragraph 6 are proposed by the State.

15. **FFP.** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

16. **Citizenship and Identity Documentation Requirements.** The State shall only enroll individuals into the Texas Women's Health Waiver that meet Medicaid citizenship and identity documentation requirements set forth at 42 CFR section 435.407.

IV. ELIGIBILITY

17. **Eligibility Requirements.** The State shall enroll only individuals meeting all of the following eligibility criteria in this Demonstration.

    - Individuals who do not have creditable coverage for family planning services;
    - Individuals who are ages 18 to 44;
    - Individuals who have net family incomes up to 185 percent of the FPL; and
    - Individuals who have not been sterilized.

18. **Implementation Plan.** Within 30 days from the date of approval of a demonstration amendment, the State shall submit an implementation plan. To the extent that an amendment affects the evaluation design, the State must also submit a revised evaluation plan.

19. **Redeterminations.** The State will ensure that redeterminations of eligibility for the demonstration are conducted at least every 12 months. The process for eligibility redetermination shall not be passive in nature, but will require that an action be taken by the recipient. Texas may satisfy this requirement by having the recipient sign and return a renewal form to verify the current accuracy of the information previously reported to the State.

20. **Integrity.** Within 60 days of approval of the demonstration renewal, the State will provide to CMS for approval, an appropriate methodology for ensuring the integrity of initial eligibility determinations and redeterminations of individuals covered under the family planning program.

    - The State will use this methodology to conduct reviews of the eligibility determination process on at least an annual basis.
    - As part of the submission, the State will also develop an eligibility determination error rate computation methodology.
    - The State's error rate will be included in the annual report as specified in paragraph 31.
    - If the error rate is beyond the State established threshold, the State will develop a corrective action plan for CMS approval.

21. **Disenrollment.** A woman who loses family planning eligibility due to pregnancy or due to sterilization shall be disenrolled effective the first of the month following confirmation of the condition. A woman who is enrolled in another Medical Assistance eligibility category will be disenrolled on the day prior to the date of enrollment in another eligibility category for the subsequent month.

22. **Primary Care Referral.** The State assures CMS that providers of family planning services will make appropriate referrals to primary care providers as medically indicated. The State also assures that individuals enrolled in this Demonstration receive materials about how to access primary care services. The State must evaluate the impact of providing such referrals for primary care services in the evaluation referenced in paragraph 44.

V. BENEFITS AND DELIVERY SYSTEMS

23. **Benefits.** Family planning services are medically necessary services and supplies related to birth control, pregnancy prevention, and preventive services listed in Attachment A, including:

    - Approved methods of contraception;
    - Drugs, supplies, or devices related to women's health services described above that are prescribed by a physician or advanced practice nurse (subject to the national drug rebate program requirements);
    - Contraceptive management, patient education and counseling; and
    - Primary care referrals to other social service and health care providers as medically indicated, however the costs of those primary care services are not covered for enrollees of this Demonstration.

24. **Services.** Services provided through this Demonstration are paid on a fee-for-service (FFS) basis.

VI. GENERAL REPORTING REQUIREMENTS

25. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX of the Social Security Act, as set forth in section VII.

26. **Reporting Requirements Relating to Budget Neutrality.** The State shall comply with all reporting requirements for monitoring budget neutrality, as set forth in section VIII.

27. **Annual Submission of Service Code Listing.** Texas will provide to CMS an updated list of Current Procedural Terminology (CPT) and Healthcare Common Procedural Coding Systems (HCPCS) codes covered under the Demonstration on January 31 of each Demonstration year (DY). The revised code list should reflect only changes due to updates in service codes for those services for which the State has already received approval and submitted on a template provided by CMS.

28. **Monitoring Calls.** CMS shall schedule quarterly conference calls with the State following the receipt of the quarterly reports unless CMS determines that more frequent calls are necessary to adequately monitor the Demonstration. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, health care delivery, enrollment, quality of care, access, benefits, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, State legislative developments, and any Demonstration amendments the State is considering submitting. The State and CMS shall discuss quarterly expenditure reports submitted by the State for purposes of monitoring budget neutrality. CMS shall update the State on any amendments under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

29. **Quarterly Operational Reports.** The State must submit progress reports no later than 30 days following the end of each quarter.

    The intent of these reports is to present the State's data along with an analysis of the status of the various operational areas under the demonstration. These quarterly reports must include, but are not limited to:

    a) Expenditures including administrative costs.

    b) The number of demonstration participants disenrolled because of pregnancy or sterilization. (Participants include all individuals who obtain one or more covered family planning services through the demonstration.)

    c) Events occurring during the quarter, or anticipated to occur in the near future that affect health care delivery, benefits, enrollment, grievances, quality of care, access, pertinent legislative activity, eligibility verification activities, and other operational issues;

    d) Action plans for addressing any policy and administrative issues identified; and

    e) Evaluation activities and interim findings.

30. **Annual Report.** The annual report is due 90 days following the end of the fourth quarter of each demonstration year and must include:

a) In each annual report the State shall report the average total Medicaid expenditures for a Medicaid-funded birth each year. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth up to age 1. (The services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants.)

b) In each annual report the State shall report the number of actual births that occur to family planning demonstration participants. (Participants include all individuals who obtain one or more covered medical family planning service through the family planning program each year.)

c) The eligibility error rate data referenced in paragraph 21.

d) At the end of each DY, a DY fertility rate will be determined for Demonstration participants during that DY.

The base-year fertility rate and the DY fertility rate will be used to calculate a measure of births averted through the Demonstration using the following formula:

> Births Averted = (base-year fertility rate) – (fertility rate of Demonstration participants during DY) X (number of Demonstration participants during DY)

The intent of the family planning program is to promote better birth outcomes for enrollees and avert unintended pregnancies for Demonstration participants.

31. **Final Report.** No later than 180 days prior to the end of the demonstration award period, Texas shall submit a draft final report to CMS for comments. The final report will incorporate all CMS comments and evaluation findings. The final report shall also contain a disclaimer that the opinions expressed are those of the State and do not necessarily reflect the opinions of CMS. The final report is due 90 days after the end of the demonstration award period.

VII. GENERAL FINANCIAL REQUIREMENTS

32. **Reporting Expenditures Under the Demonstration.** In order to track expenditures under this Demonstration, Texas must report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program (SCHIP) Budget and Expenditure System (MBES/CBES); following routine CMS-64 reporting instructions outlined in section 2500 and section 2115 of the State Medicaid Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). The State should report Demonstration expenditures on Forms CMS-64.9 Waiver and/or 64.9P Waiver as follows:

a) Allowable family planning expenditures eligible for reimbursement at the State's Federal medical assistance percentage (FMAP) rate should be entered in Column (B) on the appropriate waiver sheets.

b) Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate should be entered in Column (D) on the appropriate waiver sheets.

33. **Extent of FFP for the Demonstration.** CMS shall provide FFP for CMS-approved services (including prescriptions) provided to women at the following rates and as described in Attachment A.

a) For procedures or services clearly provided or performed for the primary purpose of family planning (i.e., contraceptive initiation, periodic or inter-periodic contraceptive management and sterilizations) and which are provided in a family planning setting, FFP will be available at the 90 percent Federal matching rate. Reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service. Note: The laboratory tests done during an initial family planning visit for contraception include a PAP smear, blood count and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program, or provider. Additional laboratory tests may be needed to address a family planning problem or needed during an inter-periodic family planning visit for contraception.

b) In order for family planning-related services to be reimbursed at the enhanced FMAP rate they must be defined as those services generally performed as part of, or as follow-up to, a family planning service for contraception. Such services are provided because a "family planning-related" problem was identified/diagnosed during a routine/periodic family planning visit. Three kinds of family planning related services are recognized:

- A colposcopy (and procedures done with/during a colposcopy) performed as a follow-up to an abnormal PAP smear which is done as part of a routine/periodic family planning visit. Only those colposcopies which can generally be performed in the office or clinic setting are covered as a family planning-related service under this Demonstration. No services/surgeries that are generally provided in an ambulatory surgery center/facility (except tubal ligations performed in an ambulatory surgery center/facility), a special procedure room/suite, an emergency room, an urgent care center or a hospital are covered under this demonstration as "family planning-related services."

- Treatment/drugs for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders in women, and urinary tract infections, where these conditions are identified/diagnosed during a routing/periodic family planning visit. Note: a follow-up visit/encounter for the treatment/drugs is not covered.

- Treatment for disorders/conditions such as hypertension, hypercholesterolemia, diabetes, or upper genital tract disorders are not covered under this demonstration because they are not considered "family planning-related," even though they may be identified/diagnosed as a result of a family planning visit/encounter.

c) FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them.

d) CMS will provide FFP at the appropriate 50 percent administrative match rate for general administration costs, such as, but not limited to, claims processing, eligibility assistance and determinations, outreach, program development, and program monitoring and reporting.

34. **Expenditures Subject to the Budget Agreement.** For purposes of this section, the term "expenditures subject to the budget neutrality agreement" must include all title XIX expenditures provided to individuals who are enrolled in this Demonstration. Participation in the Demonstration is described in paragraph 17 and expenditures are described in paragraph 33. All expenditures that are subject to the budget neutrality agreement are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.

35. **Administrative Costs.** Administrative costs will not be included in the budget neutrality agreement, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs must be identified on the Forms CMS-64.10.

36. **Claiming Period.** All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. All claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

37. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each Federal fiscal year (FFY) on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

38. **Sources of Non-Federal Share.** The State certifies that matching the non-Federal share of funds for the Demonstration are State/local monies. The State further certifies that such funds shall not be used to match any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

    a) CMS shall review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

    b) Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

39. **State Certification of Funding Conditions.** The State must certify that the following conditions for non-Federal share of Demonstration expenditures are met:

    a) Units of government, including governmentally-operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration.

    b) To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

    c) To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy Demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for Federal match.

    d) The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally-operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, the State must certify that no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes (including health care provider-related taxes), fees, business relationships with governmental entities that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

40. **Monitoring the Demonstration.** The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

VIII. MONITORING BUDGET NEUTRALITY

41. The following is the method by which budget neutrality will be monitored for the Texas section 1115 Family Planning Demonstration.

a) Texas will be subject to a limit on the amount of Federal title XIX funding it will receive for extending Medicaid eligibility for family planning services during the demonstration extension period. This limit will be determined using a pre/post comparison of fertility rates for demonstration participants. Thus, Texas will be at risk for the cost of family planning services (including traditional family planning services at the enhanced match rate and ancillary services at the FMAP rate described in the STCs) that are not offset by the demonstration intervention.

b) The demonstration will provide family planning services to uninsured women from the ages of 18-44 with a net family income up to 185 percent of the FPL who are not otherwise eligible for Medicaid, the State Children's Health Insurance Program, Medicare, or have creditable health insurance coverage. The demonstration will not change the current division of Federal and State responsibility for costs of the current Medicaid program. CMS will confirm that the demonstration expenditures do not exceed the levels of expenditures that would have occurred in the absence of the demonstration.

c) Annual Budget Limits
To calculate the overall expenditure limit for the demonstration, separate budget limits will be calculated for each year, and will be on a DY basis. These annual estimates will then be added to obtain an expenditure estimate over the entire demonstration period. The Federal share of the estimate will represent the maximum amount of FFP that the State can receive during the expanded family planning services demonstration. For each DY, the Federal share will be calculated using the FMAP rate(s) for that 12-month period.

d) The intent of the demonstration is to offset the cost of family planning services for demonstration participants in order to avert unintended pregnancies. During each year of the demonstration, the number of births averted (BA) will be estimated by the following equation:

- BA = (base year fertility rate - fertility rate of demonstration participants during DY) x (number of female demonstration participants during DY), where fertility rates will be measured per thousand. The base year fertility rate will be adjusted for age groupings, using the age distribution of the actual demonstration participants and predetermined age-specific fertility rates. Participants are all women who obtain one or more covered medical family planning service(s) through the demonstration. At its option, the State may also adjust the fertility rates for ethnicity.

- The base-year fertility rate must reflect fertility rates during 2003 for individuals in families with income up to 185 percent of the FPL and ineligible for Medicaid except for pregnancy. The fertility rates will include births paid for by Medicaid.

e) Application of the Budget Limit The budget limit calculated above will apply to demonstration expenditures, as reported by the State on the CMS-64 forms. If at the end of the Demonstration period, the costs of the Demonstration services exceed the budget limit, the excess Federal funds will be returned to CMS.

f) Base-Year Fertility Rate
The State will submit to CMS base-year fertility rates and a methodology for calculating the fertility rates. Preliminary base-year fertility rates must be submitted for approval within the first operational year of the demonstration and conform to the following requirements:

- They must reflect fertility rates during the Base Year, for women in families with income up to 185 percent of the FPL, and ineligible for Medicaid except for pregnancy.

- They must be adjusted for the age of all potential demonstration participants.

- The fertility rates will include births paid by Medicaid.

- The State will be allowed up to 6 months after the end of the first demonstration year to finalize these preliminary rates. Following the conclusion of each year of the demonstration, a demonstration year fertility rate will be determined by computing an age-weighted average fertility rate during the DY, unless the State demonstrates that the age distribution is consistent with the prior demonstration year(s). The annual age distribution categories will correspond with the base-year age-specific fertility rates. At its option, the State may also adjust the fertility rates for ethnicity.

g) Expenditure Review CMS will enforce budget neutrality over the life of the demonstration, rather than annually. However, no later than 6 months after the end of each DY or as soon thereafter as the data are available, the State will calculate annual expenditure targets for the completed year. This amount will be compared with the actual claimed FFP for Medicaid. Using the schedule below as a guide, if the State exceeds these targets, it will submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

Year	Cumulative Target Expenditures	Percentage
Year 1	Year 1 budget limit amount	+16 percent
Year 2	Years 1 and 2 combined budget limit amount	+8 percent
Year 3	Years 1 through 3 combined budget limit amount	+4 percent
Year 4	Years 1 through 4 combined budget limit amount	+2 percent
Year 5	Years 1 through 5 combined budget limit amount	+0 percent

h) Failure to meet budget Neutrality Goals The State, whenever it determines that the demonstration is not budget neutral or is informed by CMS that the demonstration is not budget neutral, shall immediately collaborate with CMS on corrective actions, which shall include submitting a corrective action plan to CMS within 21 days of the date the State is informed of the problem. While CMS will pursue corrective actions with the State, CMS will work with the State to set reasonable goals that will ensure that the State is in compliance.

i) Definition of With and Without Waiver Demonstration Costs The "with" and "without" demonstration costs (Federal share) follow. The "without" demonstration costs are estimates of the costs of births that would occur in the absence of the demonstration. The "with" demonstration costs are estimates of family planning services provided with the demonstration in effect.

Total Costs:

YEAR	WITHOUT DEMONSTRATION	WITH DEMONSTRATION	TOTAL SAVINGS
2007	**$1,315,825,939**	**$1,330,982,043**	**($15,156,104)**
2008	**$1,465,744,832**	**$1,443,804,930**	**$21,939,902**
2009	**$1,632,520,080**	**$1,576,049,380**	**$56,470,700**
2010	**$1,818,611,506**	**$1,758,178,388**	**$60,433,119**
2011	**$2,025,933,509**	**$1,960,870,461**	**$65,063,048**
TOTAL	**$8,258,635,866**	**$8,069,885,202**	**$188,750,665**

IX. PRIMARY CARE REFERRAL AND EVALUATION

42. **Access to Primary Care Services.** The State shall facilitate access to primary care services for enrollees in the Demonstration. The State shall assure CMS that written materials concerning access to primary care services are distributed to the Demonstration participants. The written materials must explain to the participants how they can access primary care services. In addition, the State must evaluate the impact of providing referrals for primary care services, as described in the State's demonstration evaluation design.

43. **Independent Evaluation**. Should CMS conduct an independent evaluation of the section 1115 family planning demonstration the State will cooperate fully with CMS or the independent evaluator selected by CMS, to assess the impact of the Medicaid demonstrations and/or to examine the appropriateness of the averted birth budget neutrality methodology. The State will submit the required data to CMS or its contractor.

44. **Final Evaluation Design.** A final evaluation design report must be submitted to CMS for approval within 30 days from the award of the demonstration extension. At a minimum, the evaluation design should include a detailed analysis plan that describes how the effects of the demonstration will be isolated from those of other initiatives occurring in the State. The report should also include an integrated presentation and discussion of the specific hypotheses (including those that focus specifically on the target population for the demonstration) that are being tested. The report will also discuss the outcome measures that will be used in evaluating the impact of the demonstration, particularly among the target population. It will also discuss the data sources and sampling methodology for assessing these outcomes. Finally, it will discuss how the referral process for primary care will be evaluated. The State must submit primary care materials to CMS with an evaluation of the effectiveness of those materials. The State must implement the evaluation design and report its progress in each of the demonstration's quarterly reports.

45. **Monitoring the Rate of Expenditure Growth.** Family planning expenditures under the Medicaid program have increased in recent years and CMS is interested in monitoring these expenditures. Thus, as part of the overall monitoring of the demonstration, CMS will also be monitoring the rate in expenditure growth for family planning services. This monitoring will be done on a per capita basis, using total expenditures recorded during the first year of the demonstration as a baseline. As a frame of reference the annual rate of growth of actual expenditures will be compared with the baseline amount trended forward using Consumer Price Index (CPI) Medical. The comparison of actual per capita expenditures over the life of the demonstration and per capita expenditures trended using CPI Medical will be considered if the State should seek an extension of their family planning demonstration.

46. **Federally Contracted Evaluation**. In addition, a federally-contracted evaluation will examine the appropriateness of the budget neutrality methodology of these demonstrations by assessing the births that have been averted as a result of the demonstrations, the data sources currently used to assess averted births and budget neutrality, and expenditures overall. Based on the evaluation findings and other information, CMS reserves the right to negotiate a new budget neutrality methodology, if CMS deems appropriate. Such a methodology change could range from a change in data sources used to determine budget neutrality, to a total change in methodology, such as incorporating a per capita cap like the one described above. Any and all changes to the budget will be made in full consultation with the State, including expenditure data used in the methodology.

47. **Interim Evaluation Reports.** In the event the State requests to extend the Demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.

48. **Final Evaluation Plan and Implementation.**

    a) CMS shall provide comments on the draft designs within 60 days of receipt, and the State must submit a final plan for the overall evaluation of the Demonstration described in paragraph 45, within 60 days of receipt of CMS comments.

b) The State must implement the evaluation designs and report its progress on each in the quarterly reports.

c) The State must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS comments.

49. **Cooperation with CMS Evaluators.** Should CMS conduct an independent evaluation of any component of the Demonstration; the State will cooperate fully with CMS or the independent evaluator selected by CMS. The State will submit the required data to the contractor or CMS.

Attachment A

State	Code	Description	90 % FFP	90% FFP with V25 or FP	FMAP	Approved
TX	99202	OFFICE/OUTPATIENT VISIT, NEW		X		X
TX	99203	OFFICE/OUTPATIENT VISIT, NEW		X		X
TX	99204	OFFICE/OUTPATIENT VISIT, NEW		X		X
TX	99205	OFFICE/OUTPATIENT VISIT, NEW		X		X
TX	99211	OFFICE/OUTPATIENT VISIT, EST		X		X
TX	99212	OFFICE/OUTPATIENT VISIT, EST		X		X
TX	99213	OFFICE/OUTPATIENT VISIT, EST		X		X
TX	99214	OFFICE/OUTPATIENT VISIT, EST		X		X
TX	99215	OFFICE/OUTPATIENT VISIT, EST		X		X
TX	99243	OFFICE CONSULTATION		X		X
TX	99401	PREVENTIVE COUNSELING, INDIV (METHOD SPECIFIC)		X		X
TX	99402	PREVENTIVE COUNSELING, INDIV (PROBLEM COUNSELING)		X		X
TX	99429	UNLISTED PREVENTIVE SERVICE (INITIAL PATIENT EDUCATION)		X		X
TX	H1010	NONMED FAMILY PLANNING ED (INSTRUCTION FOR NATURAL FAMILY PLANNING)	X			X
TX	00851	ANESTH, TUBAL LIGATION	X			X
TX	57170	DIAPHRAGM OR CERVICAL CAP FITTING WITH INSTRUCTIONS	X			X
TX	58300	INSERT INTRAUTERINE DEVICE	X			X
TX	58301	REMOVE INTRAUTERINE DEVICE	X			X
TX	58600	DIVISION OF FALLOPIAN TUBE	X			X
TX	58611	LIGATE OVIDUCT(S) ADD-ON	X			X
TX	58615	OCCLUDE FALLOPIAN TUBE(S)	X			X
TX	58670	LAPAROSCOPY, TUBAL CAUTERY	X			X
TX	58671	LAPAROSCOPY, TUBAL BLOCK	X			X
TX	76830	ECHO EXAM, TRANSVAGINAL		X		X
TX	99000	SPECIMEN HANDLING		X		X
TX	99001	SPECIMEN HANDLING		X		X
TX	A4261	CERVICAL CAP	X			X
TX	A4266	DIAPHRAGM	X			X
TX	A4267	MALE CONDOM	X			X
TX	A4268	FEMALE CONDOM	X			X
TX	A4269	SPERMICIDE	X			X
TX	J1055	MEDRXYPROGESTER ACETATE INJ	X			X
TX	J7300	INTRAUT COPPER CONTRACEPTIVE	X			X
TX	J7302	LEVONORGESTREL IU CONTRACEPT	X			X
TX	J7304	CONTRACEPTIVE HORMONE PATCH	X			X
TX	J7303	VAGINAL RING	X			X
TX	Q0111	WET MOUNTS/ W PREPARATIONS		X		X
TX	S4993	CONTRACEPTIVE PILLS FOR BC	X			X
TX	81000	URINALYSIS, NONAUTO W/SCOPE		X		X
TX	81001	URINALYSIS, AUTO W/SCOPE		X		X
TX	81002	URINALYSIS NONAUTO W/O SCOPE		X		X
TX	81003	URINALYSIS, AUTO, W/O SCOPE		X		X
TX	81015	MICROSCOPIC EXAM OF URINE		X		X
TX	81025	URINE PREGNANCY TEST		X		X
TX	82947	ASSAY, GLUCOSE, BLOOD QUANT		X		X
TX	82948	REAGENT STRIP/BLOOD GLUCOSE		X		X
TX	84702	CHORIONIC GONADOTROPIN TEST		X		X
TX	84703	CHORIONIC GONADOTROPIN ASSAY		X		X
TX	85013	HEMATOCRIT		X		X
TX	85014	HEMATOCRIT		X		X
TX	85018	HEMOGLOBIN		X		X
TX	85025	AUTOMATED HEMOGRAM		X		X
TX	85027	AUTOMATED HEMOGRAM		X		X
TX	86318	IMMUNOASSAY,INFECTIOUS AGENT		X		X
TX	86701	HIV-1		X		X
TX	86703	HIV-1/HIV-2, SINGLE ASSAY		X		X
TX	86762	RUBELLA ANTIBODY		X		X
TX	86803	HEPATITIS C AB TEST		X		X
TX	86900	BLOOD TYPING, ABO		X		X
TX	86901	BLOOD TYPING, RH (D)		X		X
TX	87070	CULTURE, BACTERIA, OTHER		X		X
TX	87086	URINE CULTURE/COLONY COUNT		X		X
TX	87088	URINE BACTERIA CULTURE		X		X
TX	87102	FUNGUS ISOLATION CULTURE		X		X
TX	87110	CHLAMYDIA CULTURE		X		X
TX	87205	SMEAR, GRAM STAIN		X		X
TX	87210	SMEAR, WET MOUNT, SALINE/INK		X		X
TX	87220	TISSUE EXAM FOR FUNGI		X		X
TX	87340	HEPATITIS B SURFACE AG, EIA		X		X
TX	87480	CANDIDA, DNA, DIR PROBE		X		X
TX	87490	CHYLMD TRACH, DNA, DIR PROBE		X		X
TX	87491	CHYLMD TRACH, DNA, AMP PROBE		X		X

TX	87510	GARDNER VAG, DNA, DIR PROBE		X		X
TX	87590	N.GONORRHOEAE, DNA, DIR PROB		X		X
TX	87591	N.GONORRHOEAE, DNA, AMP PROB		X		X
TX	87621	HPV, DNA, AMP PROBE		X		X
TX	87660	TRICHOMONAS VAGIN, DIR PROBE		X		X
TX	87797	DETECT AGENT NOS, DNA, DIR		X		X
TX	87800	DETECT AGNT MULT, DNA, DIREC		X		X
TX	87810	CHYLMD TRACH ASSAY W/OPTIC		X		X
TX	87850	N. GONORRHOEAE ASSAY W/OPTIC		X		X
TX	88141	CYTOPATH, C/V, INTERPRET		X		X
TX	88142	CYTOPATH, C/V, THIN LAYER		X		X
TX	88150	CYTOPATH, C/V, MANUAL		X		X
TX	88164	CYTOPATH TBS, C/V, MANUAL		X		X
TX	88175	CYTOPATH C/V AUTO FLUID REDO		X		X
TX	80061	LIPID PANEL		X		X
TX	86580	TB TEST		X		X
TX	86689	HIV CONFIRMATORY TEST		X		X
TX	86592	SYPHILIS TEST		X		X
TX	74000	X-RAY, ABDOMEN, SINGLE A/P VIEW		X		X
TX	74010	X-RAY, ABDOMEN, A/p AND ADDITIONAL VIEWS		X		X
TX	99201	OFFICE/OUTPATIENT VISIT, NEW		X		
TX	76856	ULTRASOUND EXAM OF THE ABDOMEN RELATED TO AN INTRAUTERINE DEVICE		X		
TX	76857	ULTRASOUND EXAM OF THE ABDOMEN RELATED TO AN INTRAUTERINE DEVICE		X		
TX	76880	ULTRASOUND EXAM OF EXTREMITY RELATED TO AN IMPLANTABLE CONTRACEPTIVE ROD		X		
TX	J7307	IMPLANTABLE CONTRACEPTIVE ROD DEVICE	X			
TX	11975	INSERTION OF AN IMPLANTABLE CONTRACEPTIVE ROD DEVICE	X			
TX	11976	REMOVAL OF AN IMPLANTABLE CONTRACEPTIVE ROD DEVICE	X			
TX	11977	REMOVAL WITH REINSERTION OF AN IMPLANTABLE CONTRACEPTIVE ROD DEVICE	X			
TX	84443	THYROID STIMULATING HORMONE TEST		X		
TX	86695	SCREENING OF HERPES SIMPLEX 1		X		
TX	86696	SCREENING OF HERPES SIMPLEX 2		X		
TX	87252	TISSUE CULTURE INOCULATION AND PRESUMPTIVE IDENTIFICATION RELATED TO HERPES		X		
TX	58565	HYSTEROSCOPY, WITH OCCLUSION FOR PERMANENT STERILIZATION	X			
TX	74740	HYSTEROSALIPINGOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION		X		
TX	E1399	OCCLUSIVE STERILIZATION DEVICE		X		
TX	58340	INTRODUCTION OF SALINE OR CONTRAST FOR HYSTEROSALIPINGOGRAPHY RELATED TO OCCLUSION FOR PERMANENT STERILIZATION		X		