IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

ALBERTO N., by his parents and next friends, Mr. and Mrs. N.; ALICE F., by her next friend, Ms. K; KEYAIRA R.-D., by her parent and next friend, Ms. D.; KAITLYN C., by her parent and next friend, Ms. C; AARON D., by his parent and next friend, Ms. D; ANDREW M., by his parent and next friend, Ms. M.; EVAN W., by his parents and next friends, Mr. and Mrs. W.; CHELSEA C., by her parent and next friend, Ms. C.; on behalf of themselves and others similarly situated; and TASH	§	
Plaintiffs,	§	
VS.	§	CASE NO. 6:99CV459
ALBERT HAWKINS, in his official capacity as Executive Commissioner of the Texas Health and Human Services Commission; and JAMES HINE, in his official capacity as Commissioner of the Texas Department of Aging and Disability Services,	§	
Defendants	§	

SECOND PARTIAL SETTLEMENT AGREEMENT

INTRODUCTION

The Parties acknowledge that the purpose of this Agreement is to facilitate Defendants' compliance with Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. The Parties further acknowledge that federal law and the terms of this Agreement will govern any future action under this Agreement.

The terms of this Agreement apply only to Medicaid-funded services provided to Medicaid beneficiaries under the age of 21 years who have been determined eligible to participate in the Early and Periodic Screening, Diagnosis, and Treatment ("EPSDT") program. To the extent that this Agreement encompasses categories of Medicaid-funded benefits that are also provided to other Medicaid beneficiaries who have not been determined eligible to participate in the EPSDT program,

the Parties acknowledge that nothing in this Agreement changes the type, definition, amount, duration, or scope of services provided to these other Medicaid beneficiaries.

1. DEFINITIONS

1.1 **"Agency"** means the Health and Human Services Commission and, when appropriate, the agency operating the relevant part of the Texas Medical Assistance Program.

1.2 **"Beneficiary"** means any individual under the age of 21 years who has been determined eligible to participate in the Early and Periodic Screening, Diagnosis, and Treatment program (currently known as Texas Health Steps), established by the Texas Medical Assistance Program.

1.3 **"Contractor"** means the entity with which the Agency contracts to administer prior authorization of the categories of benefits encompassed by this Agreement, pursuant to the requirements of 42 C.F.R. Part 434. Currently, the Contractor for the Texas Medical Assistance program is ACS State Healthcare.

1.4 **"Day"** means a calendar day, unless otherwise noted herein.

1.5 **"DME list"** refers to any and all lists of DME the Agency has, or may develop, to expedite the prior authorization or approval process.

1.6 **"Durable medical equipment (DME)"** includes medical supplies, equipment, and appliances, as these terms are used in 42 C.F.R. § 440.70(b)(3) and further defined in 1 TAC § 354.1031(11)-(12). To the extent the Agency defines items of DME or describes the purpose of items of DME in policy, guidelines, and manuals, it will do so consistent with applicable law, the definitions and descriptions generally accepted by health care practitioners, and generally accepted standards of medical practice. The Agency will define items of DME, or describe their purpose, in a manner that does not exclude medically necessary DME.

1.7 **"Home Health Skilled Nursing services"** are nursing services, as described by the Texas Nursing Practice Act and its implementing regulations, that are authorized when a Beneficiary requires nursing services that can be met on a per-visit basis. Home Health Skilled Nursing services may be provided to meet acute needs or on an on-going basis to meet chronic needs, and may be provided on consecutive days. The Agency will identify the maximum length of a Home Health Skilled Nursing visit and the permissible number of visits per day. Once identified, this temporal component will be incorporated into the definition of "Home Health Skilled Nursing services." Until the Agency identifies the temporal component, as an interim measure, they will not deny requests for 28 hours or more per week of Private Duty Nursing services on the basis that the services could be provided through Home Health Skilled Nursing services.

1.8 **"Medicaid"** means the Texas Medical Assistance Program established under the provisions of Chapter 32, Texas Human Resources Code, and subject to the requirements of Title XIX of the Social Security Act and its regulations.

1.9 **"Medicaid Managed Care Organizations"** means any entity with which the Agency contracts, pursuant to the requirements of 42 C.F.R. Part 438, that provides Medicaid-funded services to individuals who fall within the definition of Beneficiary in paragraph 1.2.

1.10 **"Medical Director"** means the Contractor's Medical Director or Associate Medical Director/Director of Children's Services.

1.11 **"Notice"** means a letter provided by the Agency to a Beneficiary informing the Beneficiary of any reduction, denial, or termination of a requested service, as described in 42 C.F.R. §§ 431.206 and 431.210.

1.12 **"Nurse Reviewer"** means any nurse who is employed by the Agency or its Contractor to make prior authorization determinations for the Medicaid benefits and services encompassed by this Agreement.

1.13 "**Nursing services**" as described by the Texas Nursing Practice Act and its implementing regulations, include observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings of a Beneficiary who has a disability or chronic health condition or who is experiencing a change in normal health processes. Nursing services also include the supervision of delegated nursing tasks. Tex. Occ. Code § 301.002 (Vernon 2004).

1.14 **"Other Contractors"** means any entity with which the Agency contracts, pursuant to the requirements in 42 C.F.R. Part 434, that provides information to beneficiaries or providers, enrolls beneficiaries, monitors quality of services, or provides case management services, related to the categories of benefits encompassed by this Agreement.

1.15 **"Parent/Guardian"** means the person or persons lawfully charged with the duty of taking care of the Beneficiary, and includes biological parents, adoptive parents, foster parents, guardians, and individuals court-appointed as managing conservators.

1.16 **"Personal Care Services"** are support services provided to Beneficiaries who require assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health related functions due to physical, cognitive, or behavioral limitations related to their disability or chronic health condition. ADLs include, but are not limited to, eating, toileting, grooming, dressing, bathing, transferring, maintaining continence, positioning, and mobility. IADLs include, but are not limited to, personal hygiene, meal preparation, grocery shopping, light housework, laundry, communication, transportation, and money management. Health related functions include, but are not limited to, medication

administration and management, range of motion, exercise, skin care, use of durable medical equipment, reporting as to the Beneficiary's condition, including changes to the Beneficiary's condition or needs, and completing appropriate records. Personal care services may include nurse-delegated tasks as permitted by the Texas Nursing Practice Act and its implementing regulations. Personal care services include hands-on assistance, cuing, redirecting, or intervening to accomplish the task. Personal care services may be provided on a per-visit or on going basis. Personal care services may be provided outside of the Beneficiary's home (in the community).

1.17 **"Policy"** means all written terms, criteria, guidelines, and standards that guide the actions of the Agency and its Contractor, related to the categories of benefits encompassed by this Agreement.

1.18 **"Private Duty Nursing services"** are nursing services, as described by the Texas Nursing Practice Act and its implementing regulations, that are authorized when the Beneficiary requires more individual and continuous care than is available from Home Health Skilled Nursing services. Private Duty Nursing services are available only through the EPSDT program. 42 C.F.R. § 440.80.

1.19 **"Provider"** means a Medicaid-enrolled individual or entity that provides the Medicaid benefits and services encompassed by this Agreement.

2. CORE REQUIREMENTS

All Medically Necessary Services

2.1 The Agency will authorize all requested medically necessary DME for Beneficiaries, as required by 42 U.S.C. § 1396d(r)(5).

2.2 The Agency will authorize all requested medically necessary nursing services, either through Home Health Skilled Nursing services or Private Duty Nursing services, to Beneficiaries, as required by 42 U.S.C. § 1396d(r)(5).

2.3 The Agency will authorize all requested medically necessary personal care services, as described in paragraphs 1.16 and 5.4, to Beneficiaries, as required by 42 U.S.C. § 1396d(r)(5). Personal care services are medically necessary when the requested services satisfy the personal care services criteria under the Texas Medicaid State Plan or the criteria for the new Personal Care Services benefit that will be established by the process described in paragraphs 5.1 and 5.2.

Amount, Duration, and Scope of Services

2.4 The Agency will authorize all requested medically necessary Private Duty Nursing services that are required to meet all of the Beneficiary's Private Duty Nursing needs over the span of time the needs arise, as the needs occur over the course of a 24-hour day. 42 U.S.C. § 1396d(r)(5).

2.5 The Agency will authorize all requested medically necessary Personal Care Services that are required to meet all of the Beneficiary's personal care needs over the span of time the needs arise, as the needs occur over the course of a 24-hour day. 42 U.S.C. § 1396d(r)(5).

2.6 The Agency will not establish or apply an absolute cap on the amount of DME available to Beneficiaries. To the extent that the Agency establishes quantity guidelines on DME for administrative convenience, the listed quantities must not be arbitrary and must be sufficient to meet typical use by children with disabilities and other chronic health conditions. 42 U.S.C. §§ 1396d(r)(5), 1396a(a)(17), 1396a(a)(10)(B); 42 C.F.R. § 440.230(c).

2.7 The Agency will not establish or apply an absolute cap on the frequency of replacement of DME available to Beneficiaries. 42 U.S.C. §§ 1396d(r)(5),1396a(a)(10)(B); 42 C.F.R. § 440.230(c).

2.8 The Agency will not establish or apply a cap on the amount of medically necessary nursing or personal care services available to Beneficiaries. 42 U.S.C. §§ 1396a(a)(10)(B), 1396a(a)17, 1396d(r)(5); 42 C.F.R. § 440.230(c).

Diagnosis Based Denials Prohibited

2.9 The Agency will not arbitrarily deny or reduce the amount, duration, or scope of DME to a Beneficiary solely because of diagnosis, type of illness, condition, or functional limitations that are unrelated to the medical necessity of the item.

2.10 The Agency will not arbitrarily deny authorization of nursing services or reduce the number of requested hours of services based solely upon the diagnosis, type of illness, or condition of the Beneficiary. 42 U.S.C. §§ 1396a(a)17, 1396d(r)(5); 42 C.F.R. § 440.230(c).

2.11 The Agency will not arbitrarily deny authorization of personal care services or reduce the number of requested hours of services based solely upon the diagnosis, type of illness, or condition of the Beneficiary. 42 U.S.C. §§ 1396a(a)(10)(B), 1396a(a)17, 1396d(r)(5); 42 C.F.R. § 440.230(c).

Reasonable Promptness

2.12 Prior authorization for medically necessary DME, when required, will be provided with reasonable promptness to ensure timely access to this Medicaid benefit. For purposes of this

Agreement, prior authorization determinations for DME will be completed by the Agency or its Contractor within three (3) business days of receipt of a complete request. 42 U.S.C. § 1396a(a)(8).

2.13 Requests for medically necessary Home Health Skilled Nursing services, Private Duty Nursing services, or Personal Care Services will be prior authorized with reasonable promptness to ensure timely access to these Medicaid benefits. For purposes of this Agreement, prior authorization determinations for Home Health Skilled Nursing services, Private Duty Nursing services, or Personal Care Services will be completed by the Agency or its Contractor within three (3) business days of receipt of a complete request. 42 U.S.C. § 1396a(a)(8); 42 C.F.R. §§ 435.930, 441.56(e).

2.14 With the advice of the workgroup described in paragraph 7.1, the Agency will review and, if necessary, revise or establish policies and procedures for retroactive authorization of medically necessary DME, Home Health Skilled Nursing services, Private Duty Nursing services, and Personal Care Services, for Beneficiaries experiencing an urgent medical need.

Prior Authorization Tools, Grading Scales, and Processes

2.15 The Agency will make available all DME lists to Beneficiaries and Providers. Each DME list will prominently include a statement that the list is not exhaustive, and that other categories and items of DME not identified are available to Beneficiaries when medically necessary.

2.16 The Agency will make available to Beneficiaries and Providers all DME criteria and a description of the prior authorization process for DME, including a description of the process for obtaining items of DME not specifically identified in any DME list. 42 U.S.C. § 1396a(a)(43)(A).

2.17 The Agency will make available to Beneficiaries and Providers all processes, tools, and grading scales used to prior authorize nursing services and personal care services, by publishing them on the Agency's website and in the *Texas Medicaid Provider Procedures Manual*. When prior authorizing nursing or personal care services, the Agency and its Contractor will use only tools, grading scales, and processes made available to Beneficiaries and Providers. 42 U.S.C. § 1396a(a)(17); 42 C.F.R. § 431.18; Due Process Clause of the 14th Amendment to the United States Constitution.

Services to be Provided in the Most Integrated Setting Appropriate

2.18 DME is a covered benefit for Beneficiaries, whether they reside in the community or in an institutional setting. 42 U.S.C. § 1396d(r)(5).

2.19 The Agency will provide all medically necessary nursing services and personal care services to Beneficiaries in the most integrated setting appropriate to the needs of the Beneficiary, in accordance with *Olmstead v. L.C.*, 527 U.S. 581 (1999), so that these Beneficiaries will not have to enter an institution to receive all medically necessary nursing services or personal care services. 42 U.S.C. §§ 1396d(r)(5), 12132; 28 C.F.R. § 35.130(d).

Application of this Agreement to Providers, Medicaid Managed Care Organizations, and Other Contractors

2.20 The Agency will require Providers to comply with the relevant terms and conditions of this Agreement, and with all relevant policies of the Agency developed or revised in accordance with this Agreement, when they carry out activities related to the categories of benefits encompassed by this Agreement.

2.21 The Agency will require Medicaid Managed Care Organizations to apply the definitions and medical necessity standards described in this Agreement, and to comply with all relevant medical benefit and program policies of the Agency developed or revised in accordance with this Agreement, when they carry out activities related to the categories of benefits encompassed by this Agreement.

2.22 The Agency will require all Other Contractors to comply with the relevant terms and conditions of this Agreement, and with all relevant medical benefit and program policies of the Agency developed or revised in accordance with this Agreement, when they carry out activities related to the categories of benefits encompassed by this Agreement.

3. DURABLE MEDICAL EQUIPMENT

Criteria for DME

3.1 DME is medically necessary when it is required to correct or ameliorate disabilities or physical and mental illnesses or conditions. 42 U.S.C. § 1396d(r)(5). When prior authorization is required, the Beneficiary's treating physician or other appropriate practitioner of the healing arts must provide documentation of the medical necessity for the requested DME. The Agency and its Contractor will apply the above medical necessity standard as the basis for all DME prior authorization determinations.

Scope of Coverage of DME

3.2 The Agency will regularly update Medicaid coverage of DME to reflect available technology and current standards of medical practice.

3.3 To the extent that the Agency maintains lists of DME, such DME lists will not exclude categories of, or specific items of, DME.

3.4 Requests may be made for any item of DME not identified on DME lists in the same manner as requests for items identified on such lists. If prior approval is required, the Provider must submit documentation sufficient to support the medical necessity for the requested item. All medically necessary DME for which federal financial participation is allowed must be approved.

4. NURSING SERVICES

Criteria for Nursing Services

4.1 The Agency and its Contractor will authorize nursing services when:
   (a) the prior authorization request is complete, as described in paragraph 4.7;
   (b) the requested services are nursing services as defined by the Texas Nursing Practice Act and its implementing regulations;
   (c) the requested services correct or ameliorate the Beneficiary's disability or physical or mental illness or condition; and
   (d) there is no third party resource, as described in the *2004 Texas Medicaid Provider Procedures Manual*, section 1.5.3, financially responsible for the requested services.

4.2 Nursing services correct or ameliorate the Beneficiary's disability or physical or mental illness or condition when the services improve, maintain, or slow the deterioration of the Beneficiary's health status.

4.3 When a Beneficiary's medical needs have not decreased, as documented by the prior authorization request, the Agency and its Contractor will not deny or reduce the amount of nursing services on the basis that the Beneficiary's condition or health status is "stable" or has not changed.

Prior Authorization Process for Nursing Services

4.4 The Agency will authorize nursing services, either through Home Health Skilled Nursing services or Private Duty Nursing services, based upon a plan of care, which includes the physician's orders and is supplemented by a service plan, a Title XIX form (if required), and any additional materials submitted by the Provider to support medical necessity for the requested service. The plan of care is established and periodically reviewed by the treating physician in consultation with home health agency staff and the Beneficiary's Parent/Guardian. The Agency and its Contractor may also consider any relevant records to which they are legally entitled. 42 C.F.R. § 484.18.

4.5 The Agency and its Contractor will utilize licensed nurses (Nurse Reviewers) to make prior authorization determinations for nursing services. These nurses must act within their scope of practice as established by the Texas Board of Nurse Examiners.

4.6 When reviewing requests for nursing services, the Agency and its Contractor will apply the definitions of these services as set forth in paragraphs 1.7, 1.13, and 1.18 of this Agreement.

4.7 The Agency or its Contractor will review requests for nursing services to confirm that: (a) the Beneficiary's current diagnosis, functional status, and condition are clearly and consistently described throughout the documentation; (b) the treatment is described consistently throughout the documentation; and (c) an explanation has been provided as to how the requested nursing services correct or ameliorate the Beneficiary's disability or physical or mental illness or condition. If any of this information is missing, the Agency or its Contractor will follow the procedure for Incomplete Requests described in paragraph 20 of the Partial Settlement Agreement effective April 19, 2002.

4.8 For complete requests, the Agency or its Contractor will determine whether: (a) the requested services are nursing services as defined by the Texas Nursing Practice Act and its implementing regulations; (b) the Beneficiary's nursing needs could be met on a per-visit basis through Home Health Skilled Nursing services; and (c) the requested services correct or ameliorate the Beneficiary's disability or physical or mental illness or condition. When the Agency or its Contractor determine that the requested services are not nursing services, they will then determine whether the documentation may support a request for personal care services.

4.9 The Agency or its Contractor will authorize Private Duty Nursing services when: (a) the request is complete, as described in paragraph 4.7; (b) the requested services are nursing services as defined by the Texas Nursing Practice Act and its implementing regulations; (c) the explanation is sufficient to support that the requested services correct or ameliorate the Beneficiary's disability or physical or mental illness or condition; (d) the Beneficiary's nursing needs cannot be met on a per-visit basis through Home Health Skilled Nursing services; and (e) there is no third party resource, as described in the *2004 Texas Medicaid Provider Procedures Manual*, section 1.5.3, financially responsible for the services.

4.10 The Agency or its Contractor will authorize Home Health Skilled Nursing services when: (a) the request is complete, as described in paragraph 4.7; (b) the requested services are nursing services as defined by the Texas Nursing Practice Act and its implementing regulations; (c) the explanation is sufficient to support that the requested services correct or ameliorate the Beneficiary's disability or physical or mental illness or condition; (d) the Beneficiary's nursing needs can be met on a per-visit basis; and (e) there is no third party resource, as described in the *2004 Texas Medicaid Provider Procedures Manual*, section 1.5.3, financially responsible for the services.

4.11 The Nurse Reviewer may deny authorization for nursing services when: (a) the request is incomplete; (b) the information in the request is inaccurate or inconsistent as described in paragraph 4.7 or does not provide an explanation as to how the requested services correct or ameliorate the Beneficiary's disability or physical or mental illness or condition; or (c) the

requested services are not nursing services as defined by the Texas Nursing Practice Act and its implementing regulations. The Nurse Reviewer may also deny authorization for Private Duty Nursing when the Beneficiary's nursing needs could be met on a per-visit basis through Home Health Skilled Nursing visits.

4.12 Only Nurse Reviewers acting within the scope of their license may make a preliminary determination that the requested nursing services do not correct or ameliorate the Beneficiary's disability or physical or mental illness or condition.

4.13 Prior to denying or reducing nursing services on the bases described in paragraph 4.11, or prior to making a preliminary determination that the requested services do not correct or ameliorate the Beneficiary's disability or physical or mental illness or condition, the Agency or its Contractor will contact the nursing services Provider and/or the treating physician to determine whether additional information or clarification can be provided that would allow for the authorization of the requested nursing services.

4.14 When the Agency or its Contractor determines that the requested nursing services are not nursing services and that the documentation may support authorization of personal care services, the notice denying the nursing services will describe the basis for this determination, in accordance with paragraph 18 of the Partial Settlement Agreement effective April 19, 2002. The notice will include template language briefly describing the Personal Care Services benefit and where and how to request prior authorization for Personal Care Services. The template language to be used is as follows:

> "The medical information received may support authorization of Personal Care Services. Personal Care Services are support services provided to Medicaid Beneficiaries under 21 years of age who require assistance with activities of daily living and health related functions because of a physical, cognitive, or behavioral limitation related to their disability or chronic health condition. For more information and to find out how to obtain Personal Care Services for a Medicaid Beneficiary under 21 years of age, you should contact [the appropriate agency]."

4.15 When the Agency or its Contractor determines that the services requested do not support a request for Private Duty Nursing services because the services could be provided on a per-visit basis through Home Health Skilled Nursing services, the notice denying the Private Duty Nursing services will describe the basis for this determination, in accordance with paragraph 18 of the Partial Settlement Agreement effective April 19, 2002. The notice will include template language briefly describing the Home Health Skilled Nursing services benefit and where and how to request prior authorization for Home Health Skilled Nursing services. The template language to be used is as follows:

> "The medical information received may support authorization of Home Health Skilled Nursing services. Home Health Skilled Nursing services are nursing services provided on a per-visit basis. Home Health Skilled Nursing services may be provided to meet acute care needs or on an on going basis to meet chronic needs. For more information and to find out how to obtain Home Health Skilled Nursing services, you should contact [the appropriate agency]."

4.16 When the Nurse Reviewer makes a preliminary determination that the requested nursing services do not correct or ameliorate the Beneficiary's disability or physical or mental illness or condition, and additional information or clarification from the nursing services Provider and/or the treating physician does not change this preliminary determination, the Nurse Reviewer will forward the request and all documentation related to the request to the Contractor's Medical Director for review. The Medical Director will determine whether the requested nursing services correct or ameliorate the Beneficiary's disability or physical or mental illness or condition.

4.17 If the Medical Director determines that the requested nursing services correct or ameliorate the Beneficiary's disability or physical or mental illness or condition, the Medical Director will authorize the services. If, however, the Medical Director determines that requested nursing services do not correct or ameliorate the Beneficiary's disability or physical or mental illness or condition, the Medical Director will call and confer with the Beneficiary's treating physician prior to making a final determination.

4.18 If a request for nursing services is denied or reduced on the basis that requested services do not correct or ameliorate the Beneficiary's disability or physical or mental illness or condition, the notice to the Beneficiary of this determination will describe why the requested nursing services do not correct or ameliorate the Beneficiary's disability or physical or mental illness or condition, as provided in paragraphs 18 and 19 of the Partial Settlement Agreement effective April 19, 2002.

4.19 When the Medical Director denies a request for nursing services and the Beneficiary requests a fair hearing, the Medical Director must attend the fair hearing and provide testimony describing why the requested services do not correct or ameliorate the Beneficiary's disability or physical or mental illness or condition. 42 C.F.R. § 431.242.

5. PERSONAL CARE SERVICES

Development of the Personal Care Services Benefit

5.1 By September 1, 2006, the Agency will implement a new Personal Care Services benefit for Beneficiaries. The Agency will convene a Personal Care Services workgroup to advise the Agency as to the development of the policies and procedures, including the setting of

reimbursement rates, necessary to implement the Personal Care Services benefit. The workgroup will include, but not be limited to, Providers, relevant professional groups, including associations of home health care Providers, and a representative for Plaintiffs. The workgroup will participate throughout the development of the policies and procedures for the Personal Care Services benefit. The Agency will provide the workgroup, and all other persons participating in the development of the Personal Care Services benefit, a copy of this Agreement, and will inform them that the policies and procedures developed for the Personal Care Services benefit must conform to the terms and conditions of this Agreement.

5.2 The policies and procedures for the Personal Care Services benefit, developed by the Agency with the advice of the workgroup described in paragraph 5.1, must:

(a) conform to the terms and conditions of this Agreement;

(b) promote the well-being of the child in the context of his or her family and the community; and

(c) require the authorization decision to take into account:

(1) the Parent/Guardian's need to sleep, work, attend school, and meet their own medical needs;

(2) the Parent/Guardian's legal obligation to care for, support, and meet the medical, educational, and psycho-social needs of their other dependents;

(3) the Parent/Guardian's physical ability to perform the personal care services; and

(4) whether requiring the Parent/Guardian to perform the personal care services will put the Beneficiary's health or safety in jeopardy.

5.3 To ensure effective and timely communication regarding the development of the policies and procedures necessary to establish and implement the Personal Care Services benefit, beginning with the effective date of this Agreement, the Agency or its counsel will submit a written status report to Plaintiffs' counsel every one hundred twenty (120) days until the policies and procedures are finalized. The status reports will include the working draft of policies and procedures developed to establish and implement the Personal Care Services benefit, current at the time the status report is due. Plaintiffs' counsel will provide the Agency with their comments to the draft policies and procedures within fifteen (15) business days of receipt of each status report.

Criteria for Personal Care Services

5.4 Personal Care Services are medically necessary only when a Beneficiary has a physical, cognitive, or behavioral limitation related to his or her disability or chronic health condition that inhibits the Beneficiary's ability to accomplish ADLs, IADLs, or health-related functions.

Prior Authorization of Personal Care Services

5.5 The Agency or its Contractor will authorize Personal Care Services based upon a service plan.

5.6 When reviewing requests for Personal Care Services, the Agency or its Contractor will apply the definitions of these services set forth in paragraph 1.16 of this Agreement. The Agency or its Contractor will review requests for personal care services to confirm that the service plan includes all of the required information. The Agency or its Contractor may observe the Beneficiary in the setting where the services will be provided to confirm that the Beneficiary is unable to accomplish activities due to the physical, cognitive, or behavioral limitations caused by his or her disability or chronic health condition.

6. INCREASING THE NUMBER OF PROVIDERS THAT CAN DELIVER THE FULL ARRAY OF NURSING AND PERSONAL CARE SERVICES

6.1 Some Providers may be capable of delivering all of the following services: Home Health Skilled Nursing services, Private Duty Nursing services, and Personal Care Services. When such Providers conduct an assessment of a Beneficiary to determine the need for all of these services and submit the assessment to the Agency for prior authorization, the Agency will reimburse such Providers for the assessment, regardless of whether the services are ultimately authorized. The Agency will allow such Providers to submit a single request for authorization that may include a combination of any or all of these services.

7. DEVELOPMENT OF FORMS TO BE USED IN THE PRIOR AUTHORIZATION PROCESS FOR NURSING AND PERSONAL CARE SERVICES

7.1 The Agency will convene a workgroup, which will include, but not be limited to, Providers, relevant professional groups, including associations of home health care Providers, and a representative for Plaintiffs, to advise the Agency as to the development of the service plan forms that will be used by Providers to request authorization for nursing services and Personal Care Services. The service plan forms to be used for nursing services will be developed by September 1, 2005; the comprehensive service plan forms to be used for nursing and Personal Care Services, which will include the new Personal Care Services criteria, will be developed by September 1, 2006. At a minimum, the service plan forms will require a description of:

(a) the Beneficiary's disability or chronic health condition and the support needs related to the disability or chronic health condition;
(b) the necessary nursing interventions, clinical observation, assessment, evaluation, and on going exercise of nursing judgment;
(c) any non-nursing supports, including durable medical equipment, therapy services, and personal care services;
(d) an explanation as to how the requested services correct or ameliorate the

Beneficiary's disability or physical or mental illness or condition, including an explanation of the frequency of the requested service;

(e) the time periods during which the nursing services and other non-nursing supports are required by the Beneficiary, as they occur over the course of a 24-hour day, and a 7-day week (the description of the time periods during which nursing services are required will include an estimation of the amount of time it takes to provide the particular nursing interventions, as well as the span of time over which the nursing interventions, clinical observation, assessment, evaluation, and the exercise of nursing judgment are necessary);

(f) a contingency plan for the provision of services when unanticipated events prevent the regular Provider from providing services or when the need for services occurs intermittently and at indeterminate times;

(g) the Parent/Guardian's ability to perform the nursing services as part of a contingency plan; and

(h) the amount of nursing services, if any, that the Parents/Guardians are willing to provide to the Beneficiary.

The service plan forms may not be designed or applied, in any manner, contrary to the terms and conditions of this Agreement. Once developed, the service plan forms will replace the then-current forms used to request prior authorization for, or establish eligibility for, nursing and personal care services.

7.2 To the extent that the Agency or its Contractor uses forms to review requests for prior authorization for nursing services and Personal Care Services, the forms must be consistent with the service plan forms described in paragraph 7.1. Should the Agency choose to use forms to review requests for prior authorization for nursing services and Personal Care Services, the same group described in paragraph 7.1 will advise the Agency as to the development of these forms, and the forms will be developed by the same deadlines. The forms to be used by the Agency and its Contractor to review requests for nursing services and Personal Care Services may not be designed or applied, in any manner, contrary to the terms and conditions of this Agreement. Once developed, the forms to be used by the Agency and its Contractor to review requests for nursing services and Personal Care Services will replace the then-current forms used for this purpose.

7.3 The Agency will provide any new forms developed pursuant to paragraphs 7.1 and 7.2 to Plaintiffs' counsel for review and comment at least one month prior to the date on which the forms are to replace the then-current forms. Plaintiffs will provide comments to the Agency within fifteen (15) business days of receipt of these documents.

7.4 Once new forms have been developed pursuant to paragraphs 7.1 and 7.2, the Agency and its Contractor will not use the "private duty nurse reviewer assessment tool," the Form 2060, the Community Care Assessment Tool, or any other tool or instrument that calculates the amount of time it takes to perform particular nursing or personal care tasks rather than

determining the continuous span of time over which the Beneficiary's needs arise, when reviewing requests for prior authorization for nursing services and Personal Care Services.

7.5 Implementation of new forms will, in some cases, require rulemaking actions or implementation of benefit policy changes. In those cases, implementation of the related forms will be subject to the time frames required for policy or rule changes. However, the Agency and its Contractor will cease using the "private duty nurse reviewer assessment tool" by September 1, 2005.

8. CHANGES TO POLICIES, GUIDELINES, AND MANUALS

Durable Medical Equipment

8.1 All DME policies, guidelines, or Provider manuals will prominently display the following statement when describing the scope of DME available to Beneficiaries:

> "Medicaid beneficiaries under the age of 21 years are entitled to all medically necessary DME. DME is medically necessary when it is required to correct or ameliorate disabilities or physical or mental illnesses or conditions. Any numerical limit on the amount of a particular item of DME can be exceeded for Medicaid beneficiaries under the age of 21 years if medically necessary. Likewise, time periods for replacement of DME will not apply to Medicaid beneficiaries under the age of 21 years if the replacement is medically necessary. When prior authorization is required, the information submitted with the request must be sufficient to document the reasons why the requested DME item or quantity is medically necessary."

8.2 Beginning with the effective date of this Agreement and prior to the publication of the *2007 Texas Medicaid Provider Procedures Manual*, the Agency will review all medical benefit policies for DME to identify changes necessary to conform the policies to the terms and conditions of this Agreement, including, but not limited to, the medical necessity standard described in paragraph 3.1. The Agency will provide Plaintiffs' counsel with a copy of all DME policies to be reviewed. As medical benefit policies for DME are revised or written, the Agency will provide Plaintiffs' counsel with the revised or new policies. All changes to DME policies necessary to conform to the terms and conditions of this Agreement will be included in the *2007 Texas Medicaid Provider Procedures Manual*. The Agency will provide Plaintiffs' counsel with the text to be published in the *2007 Provider Procedures Manual* ten (10) business days after the Agency receives the first draft of the *Manual*. Plaintiffs will provide comments about the draft Manual to the Agency within ten (10) business days. To the extent that the Agency makes changes to medical benefit policies for DME prior to the publication of the *2007 Texas Medicaid Provider Procedures Manual*, the Agency will describe the new or revised policies in the next regularly scheduled provider

publication (currently called the *Texas Medicaid Bulletin*). The Agency will provide any text to be published to Plaintiffs' counsel for review and comment within ten (10) business days after the Agency receives the first draft. Plaintiffs will provide any comments about the draft text to the Agency within ten (10) business days of receipt.

Nursing Services

8.3 All nursing services policies, guidelines, or Provider manuals will prominently display the following statement when describing the scope of Private Duty Nursing Services and Home Health Skilled Nursing services available to Beneficiaries:

> "Medicaid beneficiaries under the age of 21 years are entitled to all medically necessary Private Duty Nursing services and/or Home Health Skilled Nursing services. Nursing services are medically necessary when the requested services are nursing services as defined by the Texas Nursing Practice Act and its implementing regulations; the requested services correct or ameliorate the Beneficiary's disability or physical or mental illness or condition; and there is no third party resource financially responsible for the services. Requests for nursing services must be submitted on the required Medicaid forms and include supporting documentation. The supporting documentation must: clearly and consistently describe the Beneficiary's current diagnosis, functional status, and condition; consistently describe the treatment throughout the documentation; and provide a sufficient explanation as to how the requested nursing services correct or ameliorate the Beneficiary's disability or physical or mental illness or condition. Medically necessary nursing services will be authorized either as Private Duty Nursing services or as Home Health Skilled Nursing services, depending on whether the Beneficiary's nursing needs can be met on a per-visit basis."

8.4 Starting with the effective date of this Agreement and prior to the publication of the 2007 *Texas Medicaid Provider Procedures Manual*, the Agency will review all medical benefit policies for Private Duty Nursing services and Home Health Skilled Nursing services to identify changes necessary to conform the policies to the terms and conditions of this Agreement. The Agency will provide Plaintiffs' counsel with a copy of all nursing services policies to be reviewed. As medical benefit policies for Private Duty Nursing services and Home Health Skilled Nursing services are revised or written, the Agency will provide Plaintiffs' counsel with the revised or new policies. All changes to nursing services policies necessary to conform to the terms and conditions of this Agreement will be included in the 2007 *Texas Medicaid Provider Procedures Manual*. The Agency will provide Plaintiffs' counsel with the text to be published in the 2007 *Provider Procedures Manual* ten (10) business days after the Agency receives the first draft of the *Manual*. Plaintiffs will provide

comments about the draft *Manual* to the Agency within ten (10) business days. To the extent that the Agency makes changes to medical benefit policies for Private Duty Nursing services and/or Home Health Skilled Nursing services prior to the publication of the 2007 *Texas Medicaid Provider Procedures Manual*, the Agency will describe the new or revised policies in the next regularly scheduled Provider publication (currently called the *Texas Medicaid Bulletin*). The Agency will provide the text to Plaintiffs' counsel ten (10) business days after the Agency receives the first draft of the Provider publication. Plaintiffs will provide any comments about the draft text to the Agency within ten (10) business days.

9. TRAINING

9.1 The Agency will train, or cause to be trained, its relevant staff, including Office of the Inspector General staff, and the relevant staff of its Contractor, the Managed Care Organizations, and Other Contractors, as to the requirements of this Agreement, in a timely fashion based on established protocols, but not later than one hundred eighty (180) days after the development of any new policies. Training will begin within sixty (60) days of the effective date of this Agreement and be completed by April 1, 2008.

9.2 The Agency will include in the curriculum regularly offered to Providers the requirements of this Agreement, and the new policies to be developed in accordance with this Agreement, in a timely fashion based on established training protocols.

9.3 The Agency will provide Plaintiffs' counsel a schedule of all upcoming training dates. The Agency will provide copies of all training materials to Plaintiffs' counsel prior to their initial use for training. Plaintiffs' counsel may observe three (3) trainings of their choice.

10. QUALITY ASSESSMENT

Durable Medical Equipment and Supplies

10.1 Beginning with the fourth quarter of Fiscal Year ("FY") 2005, and until the publication of the 2007 *Texas Medicaid Provider Procedures Manual*, the Agency will review, quarterly, one hundred fifty (150) DME reduction or denial notices, so as to identify the changes necessary to conform DME policies to the terms and conditions of this Agreement, including, but not limited to, the medical necessity standard described in paragraph 3.1. The Agency will provide Plaintiffs' counsel with copies of these notices by the forty-fifth (45th) day of the subsequent quarter. The provision of these notices to Plaintiffs' counsel will satisfy the Agency's obligation to provide an equal number of notices pursuant to paragraph 45(c) of the Partial Settlement Agreement effective April 19, 2002.

10.2 Beginning with the publication of the *2007 Texas Medicaid Provider Procedures Manual* and for one year thereafter, the Agency will provide to Plaintiffs' counsel one hundred (100) DME reduction or denial notices each quarter, with fifty (50) notices selected from the Home

Health program and fifty (50) notices selected from the Comprehensive Care Program. If there are not fifty (50) denials or reductions from one program, the difference will be made up from the other program. The Agency will provide Plaintiffs' counsel with copies of these notices by the forty-fifth (45th) day of the subsequent quarter.

10.3 The notices described in paragraphs 10.1 and 10.2 will be selected randomly and will be redacted.

Nursing Services

10.4 Beginning ninety (90) days after the effective date of this Agreement, each quarter, the Agency will select sixty (60) requests for Private Duty Nursing services that resulted in denial or reduction of Private Duty Nursing services and provide to Plaintiffs' counsel copies of all documents related to each request, including, but not limited to:

(a) all documents submitted in conjunction with the request for Private Duty Nursing services;
(b) all documents and forms used to make the prior authorization determination;
(c) all information considered by the Agency or its contractors in making the prior authorization determination;
(d) any notes generated by the Nurse Reviewer;
(e) any notes generated by the Medical Director; and
(f) the denial/reduction notice associated with each request.

The Beneficiary's name, Medicaid number, Medicaid nursing Provider, and authorization number will be redacted from these documents. The requests and documents selected by the Agency will be a combination of all the denials or reductions that resulted in a request for fair hearing, plus additional requests to be selected randomly, to make up the total number of requests selected. The Agency will provide the documents to Plaintiffs' counsel by the forty-fifth (45th) day of the subsequent quarter.

10.5 Beginning ninety (90) days after the effective date of this Agreement, each quarter, the Agency will randomly select sixty (60) requests for Home Health Skilled Nursing services that resulted in denials or reductions of Home Health Skilled Nursing services and provide to Plaintiffs' counsel copies of all documents related to each request, including, but not limited to: (a) all documents submitted in conjunction with the request for Home Health Skilled Nursing services; (b) all documents and forms used to make the prior authorization determination; (c) any notes generated by the Nurse Reviewer; and (d) the denial/reduction notice associated with each request. The Beneficiary's name, Medicaid number, Medicaid nursing Provider, and authorization number will be redacted from these documents. The requests and documents selected by the Agency will be a combination of all the denials or reductions that resulted in a request for fair hearing, plus additional requests to be selected randomly, to make up the total number of requests selected. The Agency will provide the documents to Plaintiffs' counsel by the forty-fifth (45th) day of the subsequent quarter.

10.6 The Agency will produce the documents described in paragraphs 10.4 and 10.5 until the publication of the *2008 Texas Medicaid Provider Procedures Manual*.

Personal Care Services

10.7 For two years after the implementation of a new Personal Care Services benefit, each quarter, the Agency will select sixty (60) requests for Personal Care Services through the THSteps Comprehensive Care Program that resulted in denial or reduction of Personal Care Services and provide to Plaintiffs' counsel copies of all documents related to each request, including, but not limited to: (a) all documents submitted in conjunction with the request for Personal Care Services; (b) all documents and forms used to make the prior authorization determination; (c) any notes generated by the entity responsible for making prior authorization determinations; and (d) the denial/reduction notice associated with each request. The Beneficiary's name, Medicaid number, Medicaid nursing Provider, and authorization number will be redacted from these documents. The requests and documents selected by the Agency will be a combination of all the denials or reductions that resulted in a request for fair hearing, plus additional requests to be selected randomly, to make up the total number of requests selected. The Agency will provide the documents to Plaintiffs' counsel by the forty-fifth (45th) day of the subsequent quarter.

11. NOTICE TO PROVIDERS AND BENEFICIARIES

Banner Message, *Texas Medicaid Bulletin*, Agency Websites

11.1 Within thirty (30) days of the effective date of this Agreement, the Agency will publish the following language as a banner message:

> "HHSC has settled a lawsuit that affects Private Duty Nursing services, Home Health Skilled Nursing services, Durable Medical Equipment and Supplies, and Personal Care Services for all Medicaid beneficiaries under the age of 21 years. A summary of the Settlement Agreement will be published in a future *Texas Medicaid Bulletin* and a copy of the Agreement is available on the following websites: www.hhsc.state.tx.us, www.dads.state.tx.us, and www.advocacyinc.org."

Within sixty (60) days of the effective date of this Agreement, the Agency will prominently post a redacted copy of this Agreement on the websites of the Texas Health and Human Services Commission and the Texas Department of Aging and Disability Services. The Agency will publish an agreed-upon summary of this Agreement in the *Texas Medicaid Bulletin* (or any successor publication) in accordance with established time frames for submission of materials for publication, but no later than 60 days after the effective date of this Agreement.

11.2 Within thirty (30) days of completion of the activities described in Section 5 of this Agreement, the Agency will publish a description of the Personal Care Services benefit as a banner message. Within sixty (60) days of completion of the activities described in Section 5 of this Agreement, the Agency will prominently post a description of the Personal Care Services benefit and all policies related to the Personal Care Services benefit on the websites of the Texas Health and Human Services Commission and the Texas Department of Aging and Disability Services. The Agency will publish a description of the Personal Care Services benefit and all policies related to the Personal Care Services benefit in the *Texas Medicaid Bulletin* (or any successor publication) in accordance with established time frames for submission of materials for publication, but no later than 60 days after the completion of the activities described in Section 5.

11.3 Within thirty (30) days of changes to the DME and nursing services benefits made pursuant to this Agreement, the Agency will publish a description of the changes as a banner message. Within sixty (60) days of changes to the DME and nursing services benefits made pursuant to this Agreement, the Agency will prominently post a description of the changes and all policies related to the changes on the websites of the Texas Health and Human Services Commission and the Texas Department of Aging and Disability Services. The Agency will publish a description of the changes and all policies related to the changes in the *Texas Medicaid Bulletin* (or any successor publication) in accordance with established time frames for submission of materials for publication, but no later than 60 days after the changes are made.

11.4 Within one hundred eighty (180) days of the effective date of this Agreement, the Agency will send the following notice, as an insert or part of an insert included in a regularly scheduled mailing, to all Beneficiaries under the age of 21 years:

> "HHSC has settled a lawsuit that affects Private Duty Nursing, Home Health Skilled Nursing, Durable Medical Equipment and Supplies, and Personal Care Services for Medicaid beneficiaries under the age of 21. A copy of the Settlement Agreement is at: www.hhsc.state.tx.us and www.advocacyinc.org. If you have any questions, call Advocacy, Inc. at (800)___ -____."

12. RULEMAKING

12.1 The Agency agrees to propose, amend, withdraw, or repeal agency rules so that agency rules conform to the terms and conditions of this Agreement. The Agency will initiate the rulemaking process within forty-five (45) days of any action required by this Agreement that necessitates a rule to be promulgated, amended, withdrawn, or repealed.

12.2 For all rulemaking required by paragraph 12.1, the Agency will provide to Plaintiffs' counsel the draft of each proposed rule, amendment, or repeal when it is routinely provided to the members of the Medical Care Advisory Committee.

13. APPROVAL OF AGREEMENT BY STATE OFFICIALS

13.1 This Agreement is subject to the approval of the Attorney General, the Governor, and the Comptroller of the State of Texas. The Agency will obtain all necessary approvals by the date set by the Court.

14. CONTINUING JURISDICTION AND ENFORCEMENT

14.1 It is the intention of the parties that the Agreement be approved, adopted, and fully incorporated into an order of the Court, and it is agreed and stipulated that the United States District Court for the Eastern District of Texas will retain exclusive jurisdiction over all matters relating to the enforcement of the Agreement and attorneys' fees. This Agreement may be enforced until July 1, 2009.

14.2 The Parties agree that Plaintiffs will amend the Complaint to add TASH, an organizational plaintiff, for purposes of enforcing the terms of this Agreement.

15. EFFECTIVE DATE OF THE AGREEMENT

15.1 This Agreement is effective as of the date of the filing of the Court's order approving, adopting, and incorporating the Agreement.

16. COMPLIANCE DISPUTES ARISING UNDER THIS AGREEMENT

16.1 In the event that any party fails to comply with any part of this Agreement, the party alleging noncompliance may seek enforcement of the Agreement in the United States District Court for the Eastern District of Texas. Prior to seeking enforcement, absent an emergency, the party alleging noncompliance will provide notice to the opposing party and will give them thirty (30) days to correct the alleged noncompliance.

16.2 Failure by a party to enforce any provision of this Agreement will not be construed as a waiver of the party's right to enforce other provisions of the Agreement.

17. DISMISSAL OF CERTAIN CLAIMS

17.1 Within forty-five (45) days of the effective date of this Agreement, the Parties will file with the Court a Joint Stipulation of Voluntary Dismissal, in accordance with Rule 41(a) of the Federal Rules of Civil Procedure. The Stipulation will dismiss with prejudice all claims against James R. Hine, Commissioner of the Texas Department of Aging and Disability Services. The Stipulation will dismiss with prejudice all claims against Albert Hawkins, Executive Commissioner of the Texas Health and Human Services Commission except for Plaintiffs' claims related to the following:

Whether Title XIX of the Social Security Act requires the Agency or its Contractor to eliminate all prior authorization criteria or any other criteria that require a Beneficiary's Parent/Guardian to provide part of the Beneficiary's nursing services; and

Whether Title XIX of the Social Security Act prohibits the Agency or its Contractor from denying or reducing the amount of requested nursing services because the Beneficiary's Parent/Guardian is trained and capable of performing nursing services tasks, but chooses not to do so.

Either Party may seek a judicial ruling by motion for summary judgment as to the above undismissed claims no sooner than September 15, 2005, but no later than December 31, 2005. If no judicial ruling is sought before January 1, 2006, the Court will dismiss all remaining claims with prejudice.

18. ATTORNEYS' FEES, COSTS, AND EXPENSES

18.1 After the effective date of the Agreement, Plaintiffs will timely file their motion for attorneys' fees, costs, and expenses with the Court. Concurrently with the filing of Plaintiffs' motion for attorneys' fees, the Parties will move the Court to abate a ruling on Plaintiffs' motion for ninety (90) days, to give the Parties time to negotiate a settlement of attorneys' fees. The Parties will advise the Court as to the outcome of the negotiations. If a settlement is reached and approved, Defendants, upon receipt of the attorneys' fees check from the Comptroller, will promptly deliver the check, payable to Advocacy, Inc., to Advocacy, 7800 Shoal Creek Blvd., Suite 171-E, Austin, Texas 78757. If a settlement cannot be reached, or the Defendants are unable to obtain approval of the settlement, the Court, after the timely filing of any response or reply brief, will consider and rule on Plaintiffs' motion for attorneys' fees, costs, and expenses.

19. SEVERABILITY

19.1 To the extent that any provision of this Agreement is held to be invalid or unenforceable, such provision will be severed from the remainder of the Agreement and the Agreement will be construed as if the invalid or unenforceable provision did not exist.

20. MODIFICATION

20.1 This Agreement will not be modified, amended, or supplemented except by a writing executed by counsel for all parties or by an order of the Court.

The Parties agree that nothing in this Agreement prohibits the Agency from making changes to Texas Health Steps or any other Medicaid program that would otherwise conflict with the terms of this Agreement, in response to:

changes, subsequent to the effective date of this Agreement, permitted or required by federal law or regulation; or

changes, subsequent to the effective date of this Agreement, to state law, to the extent that such changes do not contravene federal law.

The Agency will make a good faith effort to identify and publish notice in the Texas Register of all such changes to Texas Health Steps or any other Medicaid program affected by this Agreement, at least thirty (30) days prior to making such changes.

21. COUNTERPARTS

21.1 This Agreement may be executed in multiple counterparts, each of which, if fully executed, may be admitted in evidence as a duplicate original.

22. BINDING

22.1 This Agreement is final and binding on the parties, including all principals, agents, administrators, representatives, successors, and assigns. Each party has a duty to so inform any such principal, agent, administrator, representative, successor, or assign.

23. EXECUTION OF AGREEMENT

23.1 Counsel for Defendants have been fully authorized by their clients to enter into and execute this Agreement, under the terms and conditions contained herein.