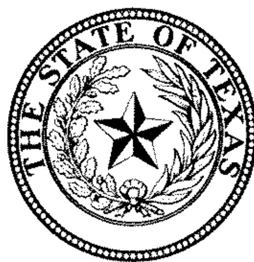
House Bill 15

Frew Expenditure Plan



Health and Human Services Commission

September 2007

FREW EXPENDITURE PLAN

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INTRODUCTION AND BACKGROUND

House Bill 15, 80th Legislature, Regular Session, 2007, appropriates an estimated $1.8 billion for the 2008-09 biennium to support state responsibilities and efforts in response to the agreed corrective action order. Provisions of H.B. 15 [Section 19(d)] further require the development and submission of a plan that details proposed expenditures for the *Frew* lawsuit in a manner that addresses the requirements of the consent decree, the joint motion, and the judicially-approved corrective action plans (CAPs). The Health and Human Services Commission (HHSC) is required to submit the plan to the Governor and the Legislative Budget Board (LBB) no later than September 1, 2007. The plan may be amended, as necessary, to reflect additional decisions regarding the expenditure of funds.

On July 9, 2007, the Eastern District Court, Judge William Wayne Justice, heard testimony from the state and the plaintiffs in a fairness hearing. Upon conclusion of that hearing, Judge Justice determined that the agreed corrective action plans are fair, reasonable, and adequate. Although a signed order from Judge Justice has not been finally executed, implementation of the corrective action plans has proceeded based on Judge Justice's verbal order at the close of the hearing.

H.B. 15 appropriations relating to *Frew* are provided for three general purposes: (1) to increase provider payments for services to the plaintiff class; (2) to implement specific corrective action plans; and (3) to finance various initiatives determined to support compliance with the consent decree and corrective orders. This initial H.B. 15 plan details the manner in which legislative decisions relating to provider rate increases is implemented, estimates the costs associated with each of the 11 corrective action plans, and describes the framework and process to determine the specific strategic initiatives to funded.

- Higher payment levels for health care services provided to persons enrolled in Medicaid under the age of 21 take effect September 1, 2007. This accomplishment reflects a tremendous staff effort to analyze 2,500 different billing codes, collaborate with external stakeholders, conduct rate hearings, publish rules, and request federal approvals to implement the rate changes. The estimated fiscal impact of these rate increases is $1.3 billion for the biennium. These and other rate changes were also previously submitted pursuant to requirements under H.B. 1.

- Eleven separate corrective action plans (CAPs) are included as part of the joint motion and agreed corrective action order. The estimated cumulative costs of these CAPs is $91.6 million for the biennium

- An appropriation of $150 million from general revenue is provided to finance strategic initiatives relating to health care services provided to children enrolled in Medicaid. This funding is intended to augment and further enhance efforts to ensure access to care and increased participation rates. To ensure cost-effective and accountable use of these funds, HHSC will engage plaintiffs' attorneys and representatives and other stakeholders to assess the viability and efficacy of proposed initiatives and identify the initiatives most likely to result in long-term, fundamental improvements in the Medicaid program and that will meet the goal of increasing access to services and providers for children under the age of 21.

Background on *Frew v. Hawkins*

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service is known as the Texas Health Steps (THSteps) program in Texas. It includes the Comprehensive Care Program (CCP) and the Medical Transportation Program (MTP). These services are health benefits for children enrolled in Medicaid under the age of 21 and are subject to Title XIX of the Social Security Act. The federally mandated activities of this Medicaid program include:

- Informing all recipients about the EPSDT program, the benefits of preventive health care and services available and how to obtain such services. This may be accomplished through a combination of written and oral methods.
- Screening through periodic comprehensive child health assessments and regularly scheduled exams and evaluations of the physical; dental; mental; growth; developmental; and nutritional health status of infants, children, and youth.
- Diagnosis and treatment of any condition identified during the screening.
- Continuing care by a provider who agrees to follow-up care; maintenance of records; services for acute, episodic, or chronic conditions; and appropriate referrals to other providers.
- Utilization of providers and coordination with related programs.
- Transportation and assistance with scheduling appointments and services.

In 1993, a class action lawsuit, now commonly known as *Frew v. Hawkins*, was filed against the State of Texas alleging that Texas did not adequately provide Medicaid EPSDT services. The lawsuit was filed by Texas Rural Legal Aid on behalf of more than 1.5 million indigent children entitled to health benefits through EPSDT services. The main allegations in the lawsuit include:

- Medical and dental screenings (check-ups) were not provided to children in accordance with recognized periodicity schedules.
- Texas did not meet the federal screening goals for children.
- Texas did not effectively inform recipients about the benefits of the program.
- Texas did not provide adequate case management services for children.
- The Medical Transportation Program failed to meet the needs of recipients.
- Program access was denied because of an inadequate supply of providers, which was the result of inadequate reimbursement rates, red tape, and providers' lack of knowledge of the program.

In 1996, the parties entered into a consent decree to resolve many of the issues in the suit. The plaintiffs filed motions to enforce the decree in 1998 and in 2000. After hearing evidence on the motion, the court found the state to be in violation of the consent decree and ordered corrective action. After the state exhausted all avenues for appeal, a hearing for corrective action was scheduled for April 2007. Prior to this hearing, the parties negotiated an agreed set of corrective actions. At a hearing on July 9, 2007, in the United States District Court for the Eastern District of Texas, Judge William Wayne Justice found the agreed corrective action plans to be fair, reasonable, and adequate.

Key Impacts

The cumulative effect of increasing provider payments, implementing corrective action plans and supporting strategic initiatives is expected to ensure adequate access to health care services and utilization of appropriate and necessary health care services by Medicaid enrollees under the age of 21. More distinct impacts are anticipated as described below:

(1) increased participation of children who receive THSteps medical and dental checkups;
(2) increased participation of medical and dental providers who serve children in the Texas Medicaid program;
(3) improved utilization of appropriate and medically necessary services; and
(4) improved coordination of health care delivery across medical services systems.

Corrective actions, provider payments and strategic initiatives are all directed toward the achievement of one or more of the following objectives:

Objective 1: Increase the number of children who receive THSteps medical and dental checkups.

Regular assessments and screening at time-appropriate intervals are the foundation for ensuring that health problems are identified and that effective preventive treatment is provided to Medicaid children. The following corrective action plans address the need to ensure timely and effective exams for all qualified children: *outreach and informing; check-ups and lagging counties; health outcomes and dental assessment; transportation; managed care; and toll-free numbers.*

Objective 2: Increase participation of medical and dental providers who serve children in the Texas Medicaid program.

A ready supply of providers who are adequately compensated and trained is crucial to serving all children in Texas who need Medicaid services. Recent rate increases passed by the 80th Texas Legislature will provide the foundation for meeting this objective. Current providers will be encouraged to provide additional services, and new providers will be enrolled with the supports provided through the following corrective action plans: *adequate supply of providers; and provider training.*

Objective 3: Improve appropriate utilization of medically necessary services.

Texas families and children on Medicaid need timely and pertinent information about available services and benefits in order to encourage them to access appropriate services. Several corrective action plans address strategies for increasing the numbers of children who successfully access needed services: *outreach and informing; health outcomes and dental assessment; and prescription and non-prescription medications, DME, and supplies.*

Objective 4: Improve coordination of care.

More effective planning, communications, and follow-up among health care professionals and organizations is essential to providing high-quality, cost effective health care for Texas children. Texas will improve the coordination of care delivered to children in Medicaid through the following corrective action plans: *case management; and managed care.*

Evaluation

HHSC is developing: core performance measures to assess the impact of program changes on client outcomes; numerous special studies in areas such as medical transportation and dental services; and routine reports on client utilization of services.

Any additional measures that are developed relating to the objectives above will be included in future H.B. 15 plan amendments.

SECTION I
PROVIDER RATE INCREASES

Appropriations made by H.B. 15 provided funding to significantly increase payment rates for Medicaid services to recipients under age 21. The methodology used by HHSC to implement the *Frew v. Hawkins*-related rate increases was developed in close cooperation with the medical and dental community. The approach used is expected to not only stabilize the current base of health care professionals who provide services to THSteps clients, but to also create incentives for other providers to initiate or expand access to their services for THSteps clients.

Rate Methodology

HHSC updated the relative value units (RVUs) in order to implement the *Frew v. Hawkins*-related rate increases. RVUs are values assigned to certain professional medical services by the Centers for Medicare and Medicaid Services (CMS). CMS develops and updates the RVUs on a systematic basis using the Resource Based Relative Value Scale (RBRVS). The RBRVS and the RVUs that the scale generates constitute the prevailing model used today in the United States for physician reimbursement. Based upon actual empirical measurement, RVUs quantify the relative work, practice, experience, and malpractice cost associated with each rate's services. Based on available appropriations, HHSC has not updated Medicaid RVUs for most billing codes to stay current with annual updates to the Medicare RVU schedule. Many Medicaid RVUs have not been updated since 1992.

Texas Medicaid's reimbursement methodology is primarily resource-based and updates RVUs as the primary way to increase rates.[1] Updating the RVUs in the fee schedule versus an across-the-board rate increase has the advantages of being evidence-based and nationally recognized, familiar and acceptable to medical professionals in Texas, and could be implemented by September 1, 2007.

The reimbursement methodology will increase reimbursement to specialists and sub-specialists by increasing the reimbursement for evaluation and management (E&M) procedures[2] used by most physicians and specialists, updating non-E&M procedure codes to the 2007 Medicare RVUs with a minimum of a five percent increase, and targeting certain providers like pathologists, radiologists, and anesthesiologists that do not regularly use the E&M procedures codes.

HHSC also targeted THSteps/EPSDT screening services, which are a subset of E&M procedure codes, for special consideration and fee increases. This targeted increase provided an incentive for providers to open their practices to new THSteps clients. This methodology also creates an

[1] Resource-based fees are based on actual resources required by an economically efficient provider to provide each individual service. HHSC may establish access-based fees if the agency determines that a particular resource-based fee may not be adequate to assure access to a particular service. Access-based fees are based on historical charges, Medicare fees, other state Medicaid fees, Medicaid fees for a similar service, and/or some combination or percentage of these data.

[2] Evaluation and management codes are the billing codes most commonly used by provider offices to bill Texas Medicaid for office visits.

incentive for physicians providing services to adolescents, as those services have been assigned higher RVUs and, therefore, will receive a higher reimbursement.

Medical Community Input

The medical community assisted HHSC with developing rate methodologies that would be fair and acceptable given the parameters established in the *Frew v. Hawkins* CAPs. HHSC, with the assistance of the Physician Payment Advisory Committee (PPAC), developed rate methodologies for implementing rate increases for medical professional services and dental services within appropriated funds effective for dates of service beginning September 1, 2007.

PPAC met on May 18, 2007, and on June 1, 2007. Preliminary fiscal analyses of the methodologies and priorities recommended by PPAC at the first meeting were presented by HHSC staff to PPAC at its June 1, 2007, meeting. PPAC made unanimous recommendations at its June 1, 2007, meeting, and those recommendations form the basis for the rate adjustments in order to address issues related to the *Frew v. Hawkins* corrective action plans for Medicaid services to recipients under age 21.

The dental reimbursement methodology was specifically developed by the dental provider organizations[3] as the best use of funds to improve access and participation in dental care by THSteps children. Services targeted for an increase are utilized by general dentists as well as the various dental specialists, including pediatric dentists, endodontists, oral surgeons, and periodontists. Orthodontic services were not included based upon consensus expressed by the orthodontic community that current fees are acceptable in the context of the goals of the rate adjustment.

The rate increases will result in HHSC fully expending appropriations for the 2008-09 biennium as authorized in the 2008-09 General Appropriations Act, including payment/rate restorations and *Frew v. Hawkins*-related rate increases.

The following rate increases will be effective for payments to physicians, certain other professionals, and dentists in all lines of business in the Texas Medicaid program including fee-for-service (FFS), primary care case management (PCCM), and managed care organizations (MCOs).

Managed Care Organization Compliance with Rate Increases

Since MCOs are able to contract directly with providers, the contracted fee normally could vary from the one that HHSC is proposing for FFS and PCCM. Contractual requirements that the rate increase be passed on were established, and HHSC will closely monitor and enforce that all MCOs adjust their physician fee schedules to reflect the physician pay increases funded by the 80th Legislature. If the MCOs reimbursed certain physicians based on the Medicaid fee-for-

[3] The dental rate increase methodology was developed by a collaborative process that involved HHSC; Department of State Health Services (DSHS); the Texas Academy of Pediatric Dentistry; Texas Dental Association; representatives from the plaintiffs' attorneys; Texas dental schools; and Dr. James Crall, a nationally recognized dental Medicaid expert.

service fee schedule (i.e., Medicaid fee schedule), then the MCO must pay for physician services provided on or after September 1, 2007, based on the updated Medicaid fee schedule. If the MCO paid for physician services based on a percentage of the Medicaid fee schedule, then the MCO must pay for the physician services provided on or after September 1, 2007, based on the same percentage of the updated Medicaid fee schedule. For example, if the MCO paid for physician services at 110 percent of the Medicaid fee schedule, the MCO is required to pay 110 percent of the updated Medicaid fee schedule. If the MCO used benchmarks other than the Medicaid fee schedule, such as a percent of Medicare payments, to pay for physician services, then the MCO must increase its rates by 25 percent for physician services to member under the age of 21.

HHSC will require each MCO Chief Executive Officer to attest that the MCO and its subcontractors have increased physician reimbursement as outlined above. Furthermore, HHSC will complete a comparative analysis of payments to providers pre- and post-September 1, 2007, to determine compliance with the *Frew v. Hawkins* pass-through increases and will hire an external audit organization to examine each MCO pass-through methodology.

The MCO is subject to remedies, including liquidated damages, if the MCO does not comply with the claims processing requirements and standards as stated above. Additionally, the MCO must pay providers interest at an 18 percent annual rate, calculated daily, for the full period in which a clean claim (or any portion of a clean claim) has not been paid after the 30-day claims processing deadline.

Rate Increases for Professional Services Provided by Physicians, Certain Other Professionals, and Physician Specialists

HHSC increased rates paid for services provided to children under the age of 21 by physicians, certain other professionals, and physician specialists by a total of $233.5 million in general revenue ($591.0 million in all funds) in state fiscal years 2008 and 2009. These rate increases assume elimination of the 2.5 percent payment reduction from the 79th Legislature, updating the relative value units (RVUs) for current Medicaid fees to the 2007 Medicare RVUs, implementing the recommendations from the June 1, 2007, PPAC meeting, and implementing fee increases within the appropriations for the 2008-2009 biennium.

The provider types included in the rate increase analyses were physicians (i.e., medical doctors and doctors of osteopathy, advanced practice nurses, physician assistants, and other professionals.[4]) In addition, only procedure codes for professional services actually performed by the physician or certain other professional were included.

PPAC agreed with HHSC that the provider classification (i.e., taxonomy) available to Medicaid for use in targeting specialist and sub-specialist providers is unsatisfactory for meeting the goals outlined in the *Frew v. Hawkins* CAPs. Instead, PPAC agreed that when taken as a whole, the

[4] Other professional in the analyses include psychologists, licensed professional counselors, licensed marriage and family therapists, licensed clinical social workers, comprehensive care program (CCP) social workers, CCP groups, CCP providers, podiatrists, chiropractors, optometrists, opticians, certified respiratory care providers, audiologists, prosthetists, orthothists, and genetic providers.

recommendations provided on June 1, 2007, form the most satisfactory basis for rate adjustments that most closely conform to all the goals established by the Legislature, are understandable and acceptable to professional providers (including primary and specialty care providers), can be implemented in a timely fashion, and provide a workable basis for measuring and enforcing compliance by Medicaid MCOs.

HHSC will increase the Medicaid rates for professional services delivered by physicians, certain other professionals, and physician specialists for procedure codes that had payments for Medicaid recipients under age 21 during fiscal year 2006. The increases are intended to increase service access and preventive care availability. Physician procedure codes for Texas Health Steps (THSteps) medical check-ups, evaluation and management (E&M) services, administration of immunizations, anesthesiology, and mental health services were targeted for increases.

The $233.5 million general revenue rate increase for the 2008-09 biennium for physicians, certain other professionals, and physician specialists for Medicaid clients under age 21 include the following components:

- $17. 8 million for the elimination of the 2.5 percent Medicaid payment reduction;
- $33.2 million to increase the current THSteps fees for medical check-ups to the 2007 Medicare fees for new clients and up to 92 percent of the 2007 Medicare fees for established clients (see Appendix A for more detailed information on THSteps fee increases for medical check-ups);
- $7.6 million to increase THSteps immunization administration fees by 60 percent;
- $101.8 million to increase Medicaid fees for E&M codes, which represent the majority of the billing for physicians, certain other professionals, and physician specialists;
- $7.4 million to increase Medicaid fees for anesthesia service codes;
- $4.6 million to increase Medicaid fees for non-THSteps immunization administration codes;
- $5.0 million to increase Medicaid fees for specific mental health procedures codes for psychiatric diagnostic interviews, comprehensive psychological assessments, and psychotherapy/psychological counseling;
- $1.4 million to increase Medicaid fees for professional interpretations performed by pathologists and radiologists;
- $25.7 million to update the Medicaid fees for remaining procedure codes in the analyses (i.e., paid procedure codes for fiscal year 2006) to the 2007 Medicare RVUs; and
- $29.0 million to provide a minimum 5 percent increase for the fees for any procedure codes for which a RVU update would have resulted in a lower fee than the current Medicaid fee and other adjustments as necessary.

Rate Increases for Services Provided by Dentists and Dental Specialists

HHSC increased rates for Medicaid dental services delivered to clients under the age of 21 by $278.2 million in general revenue ($704.1 million in all funds) in the 2008-09 biennium. The rate increases assume the elimination of the 2.5 percent payment reduction from the 79th Legislature, implementing fee increases for 35 select procedure codes, and implementing fee increases for an additional 13 prioritized procedure codes.

Providers in the analyses included dentists, oral maxillofacial surgeons, dentistry groups, THSteps dental providers, and THSteps dental groups. HHSC will increase the payments for the 48 specific dental codes identified and strongly supported by dental professionals to increase access and preventive care for Medicaid-eligible clients. Preventive care procedures include comprehensive and periodic evaluations and fluoride applications. The 48 specific dental codes represent up to 80 percent of all Medicaid dental payment made during fiscal year 2006. The specific dental procedure codes targeted for increases are included in Appendix B.

The $278.2 million general revenue rate increases for the 2008-09 biennium for Medicaid dental services for clients under age 21 include the following components:

- $8.7 million for the elimination of the 2.5 percent payment reduction;
- $262.7 million to increase Medicaid fees for 35 select dental procedure codes above current fees; and
- $6.8 million to increase Medicaid rates for an additional 13 prioritized dental procedure codes to dental specialists.

SECTION II
CORRECTIVE ACTION PLANS

Eleven separate corrective action plans are included as part of the agreed order. Details of some of the activities within each plan and HHSC staffing costs that have been provided to the courts are included below.

Case Management

This corrective action plan affects efforts related to case management for Children and Pregnant Women (CPW) at the Department of State Health Services (DSHS). This case management service operates as the required EPSDT case management benefit for children in Texas. Estimates provided to the court for this CAP included a cost in the 2008-09 biennium of $150,000 all funds, which include the following activities:

- THSteps is required to provide case management services to all who need and want the service.
- DSHS, the Medicaid claims administrator, and the THSteps outreach and informing contractor are teaming up to ensure that THSteps providers are aware of the availability and purpose of CPW case management services and expand recruiting activities for these providers.
- Navigant Consulting is completing an assessment of case management services in Texas. Upon completion of this study, HHSC will, as part of the CAP, provide the plaintiffs' counsel with a summary of report findings.
- HHSC will develop a future corrective action plan based on the recommendations and those costs cannot be determined.
- After one year, HHSC will provide an update report to the court. The court will determine if an additional independent study of CPW case management is necessary to determine unmet needs. If deemed necessary, any subsequent study of CPW will not begin until fiscal year 2010.
- HHSC, with DSHS, will complete quarterly and annual reports about participation in case management services in Texas. The reports will include CPW and other Medicaid targeted case management programs, such as case management for children with developmental delays, children with mental retardation, case management for children with mental health concerns, and children with visual impairments.

Check-up Reports and Lagging Counties

This corrective action plan extends the reporting requirements of the *Frew v. Hawkins* consent decree and provides additional direction and requirements for other reports. Estimates provided to the court for this CAP included a cost in the 2008-09 biennium of $150,000 in all funds.

- HHSC Strategic Decision Support will complete data reports, including a new requirement for dental checkup reports.

- DSHS THSteps will develop future corrective action plans to increase participation in counties that lag behind the statewide average. The cost for future corrective action plans cannot be determined.

Check-ups

This corrective action plan requires HHSC to contract with an independent party for a series of studies that include review of medical records for children under the age of 21. The record review will assess for completeness of THSteps medical check-ups. Estimates provided to the court for this CAP included a cost in the 2008-09 biennium of $850,000 in all funds. Completeness will be determined based on documentation of the federal minimum requirements of a check-up including:

- complete health and developmental history;
- comprehensive unclothed physical;
- appropriate immunizations;
- lab tests (including lead); and
- health education and anticipatory guidance.

Based on the findings of the study, HHSC is required to establish a targeted corrective action plan for any managed care organization that is found to have less than 80 percent of checkups complete. The cost for future corrective action plans cannot be determined.

Health Outcomes and Dental Assessment

This corrective action plan extends timeframes for health outcome measures and dental assessments for children under the age of 21 required by the consent decree. Estimates provided to the court for this CAP included a cost for the 2008-09 biennium of $450,000 in all funds. This estimate does not include future corrective action plans.

- HHSC will propose and study 12 health outcome measures over a period of several years.
- DSHS will develop a protocol and complete an assessment of dental care needs for children.
- Future corrective action plans will be developed to make improvements for each measure.

Managed Care

This corrective action plan requires additional contract requirements for Medicaid managed care and studies reviewing the reasons some recipients under the age of 21 do not receive any care. Estimates provided to the court for this CAP included a cost for the 2008-09 biennium of $46.2 million in all funds. The estimated cost includes potential rewards and sanctions for the managed care organizations for certain indicators developed by HHSC.

HHSC has made changes to PCCM and HMO contracts to include requirements for:

- Reporting of children under the age of 21 that receive timely medical check-ups upon enrollment into a health plan, and that receive medical check-ups when due throughout enrollment in the health plan.
- Development of a plan for identifying and accelerating services to children of migrant farm workers and an annual report of activities related to the plan.
- HHSC will contract for an independent study of children enrolled in Medicaid managed care that do not receive any health care services. HHSC will develop a corrective action plan based on the findings of the study. Costs for future corrective action plans cannot be determined.
- The study will be repeated after HHSC and managed care providers implement corrective action plans to address concerns identified in the first study.
- HHSC will determine a method for rewarding or sanctioning managed care programs that exceed or fail to meet standards associated with reporting requirements and studies.

Outreach and Informing

This corrective action plan requires a study of outreach and informing activities and reinforces the requirements of the consent decree. This corrective action plan also includes changes to the Medicaid identification form that were completed in May 2007. Estimates provided to the court for this CAP included a cost for the 2008-09 biennium of $8.65 million in all funds and include the following activities:

- HHSC will contract for an independent study of outreach and informing activities for children under the age of 21 and the cause of missed check-ups. The study will include analysis of all current activities, as well as a 12-month assessment of the effectiveness of 5 specific outreach methods.
- A future corrective action plan will outline changes to be made to THSteps outreach and informing activities based on the recommendations in this study. The cost for future corrective action plans cannot be determined.
- The outreach and informing contractor will continue to send letters to children under the age of 21 that are due or overdue for medical and dental check-ups until the completion of the study. These letters may be altered as part of the action plan to address concerns identified in the outreach and informing study.
- HHSC will provide additional training to eligibility workers regarding THSteps information to be provided to all applicants for children's Medicaid and the process for requesting additional informing for these applicants.
- HHSC, with DSHS and its contractors, will develop a plan to effectively coordinate all Medicaid and child health-focused approaches made toward children on Medicaid and their families. The plan will avoid conflicting and duplicative messages.
- HHSC will develop a plan to coordinate outreach and informing with other state agencies and contractors that provide services and information about benefits to or for children on Medicaid.
- DSHS will resume reporting on outreach and informing activities and the impact on accessing preventive health care services.

Prescription and Non-Prescription Medications, Durable Medical Equipment (DME) and Supplies

This corrective action plan includes specific activities to educate pharmacies about the vendor drug program emergency supply prescription drug rule and DME services for children. Estimates provided to the court for this CAP included a cost for the 2008-2009 biennium of $1.7 million in all funds and include the following activities:

- HHSC will provide a 72-hour emergency supply of prescription drugs for all children under the age of 21 for all drugs not on the preferred drug list if the denial is solely due to lack of prior authorization.
- HHSC will provide an automated instant reply to any request for prior authorization that has emergency override capabilities for the pharmacy at the point of sale.
- HHSC will provide direct mailings and one-on-one intensive targeted education for low-performing pharmacy providers about the 72-hour emergency supply prescription drug provision. HHSC will also revise the electronic message received by a pharmacy on a prescription denied because it needs prior authorization to remind the pharmacy that a 72-hour emergency supply can be provided and offer emergency override capabilities or a hotline number for additional information.
- HHSC will complete studies regarding pharmacy utilization of the 72-hour emergency supply of prescription drugs and how that correlates to prior authorizations for medications provided by the pharmacy.
- HHSC has included requirements in Medicaid managed care contracts to encourage enrollment of pharmacies as DME providers and to encourage nurse help lines to receive training about the 72-hour emergency supply prescription drug provision.
- HHSC has implemented an on-line subscription service for health care providers that allows them to use a computer or hand-held device to determine if a prescription is on the preferred drug list or if it requires prior authorization.

Adequate Supply of Providers

This corrective action plan details many activities focused on increased access to health care providers for children under the age of 21 and includes contract changes for managed care and a web-based provider look up system. Estimates provided to the court for this CAP included a cost for the 2008-2009 biennium of $3.7 million in all funds. The cost estimate does not include rate increases or strategic initiatives that are outlined in this plan. The $3.7 million includes the following activities:

- HHSC has made changes to the contract for primary care case management (PCCM) that includes the timeliness standards that are currently included in Medicaid health maintenance organization (HMO) contracts.
- HHSC has made contract changes to require that at least two providers (when two are available) meeting the distance and timeliness standards required by the contract are provided to children under the age of 21 that are seeking a provider.
- HHSC has contracted with the Medicaid claims administrator to develop a web-based provider look-up system that will meet the requirements of the approved corrective action

plans, as well as the provisions outlined in H.B. 2042. This on-line system is scheduled to be available for use at the end of November 2007.

- HHSC will complete annual assessments of the provider supply available to children on Medicaid. The assessments will be completed each year for the next four years.
- HHSC will compile a semi-annual report of the adequacy of the provider supply in PCCM and HMOs based on their monthly reporting on the provider supply.

Provider Training

This corrective action plan includes efforts currently under way for on-line training and requires new training for dentists. Estimates provided to the court for this CAP included a cost in the 2008-09 biennium of $4.3 million in all funds and include the following activities:

- DSHS will complete on-line training modules and will provide required reports.
- DSHS will work with dental groups and dental schools to develop training for general dentists on exams for children ages 1-3. Training for these exams is not part of the regular curriculum for general dentists. This training should result in increased utilization and decreased incidence of dental disease.
- DSHS and their partners will provide the training throughout the state.

Toll-Free Numbers

This corrective action plan further defines the consent decree requirements for toll-free number promptness standards and requires reporting on these standards. Estimates provided to the court for this CAP included a cost in the 2008-09 biennium of $13 million in all funds, and include the following activities:

- HHSC is making changes to contracts with the enrollment broker and the claims administrator to incorporate the CAP standards and reporting requirements into the contracts for the enrollment broker hotline, Texas Health Steps hotline, and the Medicaid client helpline.
- HHSC is working with Texas Department of Transportation (TxDoT) to amend the interagency agreement to include the standards and reporting requirements for the Medical Transportation Program toll-free number.

Transportation

This corrective action plan reiterates the consent decree requirement for completion of assessments of the Medical Transportation Program (MTP). Estimates provided to the court for this CAP included a cost in the 2008-09 biennium of $7.6 million in all funds. This estimated cost included a 15 percent increase in utilization of medical transportation services as a result of an additional corrective action plan that is expected at the conclusion of the first report.

- HHSC will provide copies of the results of the current study underway to the plaintiffs.

- HHSC will develop a future corrective action plan to address any areas of concern identified by the studies; the first corrective action plan is expected to be developed in January 2008. The costs of the future corrective action plan cannot be determined.
- HHSC will contract for a second independent study in fiscal year 2010.

Staffing Expenses

HHSC has conducted a review of the court-ordered CAP requirements and existing staff and contract resources of the various state agencies and determined that additional state staff will be necessary to ensure timely compliance. HHSC has identified the need for 42.5 new full-time equivalent positions (FTEs) across three agencies: HHSC; DSHS; and TxDoT.

Staff will be allocated to the agencies with 20.5 FTEs at HHSC, 4 FTEs at DSHS, and 8 FTEs and 10 contracted staff at TxDoT. All staff will work directly on *Frew v. Hawkins* CAP responsibilities. HHSC will continue to monitor activities related to the approved corrective action plans and consent decree to identify any additional staffing needs that may arise and ensure full implementation of the plans. Appendix C provides a summary of the cost of each corrective action plan during the 2008-09 biennium.

SECTION III
STRATEGIC MEDICAL AND DENTAL INITIATIVES

H.B. 15 appropriated $150 million in general revenue for strategic initiatives for health care services to children enrolled in Medicaid. The funding for strategic initiatives is included as part of the corrective action plan related to increasing access to services and providers for children under the age of 21.

In general, projects or initiatives to be funded from the $150 million will be intended to result in fundamental or critical improvements in the Medicaid program, with particular emphasis on increasing access to services and providers for children under the age of 21.

To support sound and cost-effective determinations of which specific initiatives are funded and in order to maximize the impact these funds will have on increasing access to health care services for children, HHSC will utilize a structured process to consider and assess proposed initiatives.

The primary criteria against which proposed initiatives will be assessed are:

- whether the proposal materially supports the achievement of one or more of the established objectives;
- whether the scope and impact of the initiative would produce meaningful results; and
- the extent to which positive results can be demonstrated or reasonably expected.

Additional factors to be applied in considering proposed initiatives include the following;

(a) feasibility (can be operationalized or implemented);
(b) measurable (can be assessed for accountability);
(c) value-added or cost-effectiveness;
(d) likelihood of success;
(e) number of children impacted by proposal; and
(f) federal match (while not a requirement, projects will be evaluated on eligibility for federal Medicaid matching dollars in the short and long term).

HHSC will form an interagency group across the enterprise including the Medicaid and CHIP Division (MCD), the Department of State Health Services (DSHS), the Office of Eligibility Services (OES), the Office of Family Services (OFS), and others as appropriate to analyze feedback received. The interagency analysis will consider the overall goals, objectives, and the selection criteria above to prioritize projects, for operational planning, to establish timelines and work plans for each initiative selected.

HHSC will also establish a technical advisory group to directly engage stakeholders in the process of determining the initiatives to be financed. This group would include representatives of the plaintiffs and the medical, dental, advocacy, and academic communities to advise HHSC on which proposals best support established objectives.

HHSC will conduct an additional public stakeholder meeting and brief legislative offices about the funding status of strategic initiatives. HHSC will also submit amendment(s) to the Governor and the LBB outlining which specific initiatives HHSC plans to pursue and the timeline for implementing each project.

HHSC activities will be guided by the following timeframe for reviewing, analyzing, and funding medical and dental strategic initiatives.

Task: Solicit feedback from stakeholders on specific projects HHSC should fund. See Appendix D for a listing of strategic initiatives received to date from select stakeholders.
Completion Date: August 2007.

Task: HHSC interagency group prioritizes projects based on above selection criteria and determines operational details to implement selected projects.
Completion Date: First quarter of fiscal year 2008 and ongoing.

Task: HHSC reviews proposals and interagency findings with technical advisory group.
Completion Date: First quarter of fiscal year 2008 and ongoing.

Task: HHSC submits amendment(s) to the Governor and the LBB for approval to fund specific strategic initiatives.
Completion Date: First quarter of fiscal year 2008 and ongoing.

Task: HHSC reviews the status of funded initiatives periodically with the technical advisory group and other external stakeholders.
Completion Date: Ongoing.

Task: HHSC will provide a status report on the progress of implementing each of the strategic initiative projects.
Completion Date: At least every six months, beginning the fourth quarter of fiscal year 2008.

Appendices

Appendix A
New Fee Schedule for Preventive Medical Services
(THSteps Medical Screens)

THSteps/EPSDT screening services have been targeted for special consideration and fee increases. THSteps/EPSDT screening services are billed using preventive health services codes, which are a subset of evaluation and management (E&M) services:

- Texas Medicaid reimbursement for THSteps/EPSDT screening services will increase to 100 percent of Medicare rates for new patient visits.
- Medicaid reimbursement for established patient preventive medical services will be 92 percent of the rate paid for the corresponding new patient visit (92 percent of the Medicare rate).

In all cases, this represents an increase over the flat, $70 access-based fee that is currently paid for these services. PPAC members and provider associations, such as the Texas Pediatric Society, are satisfied with the proposed methodology, since it provides an incentive for opening practices to new patients who are class members. This methodology also creates an incentive for providing services to adolescents, as these services have been assigned higher relative value units (RVUs) and, therefore, will enjoy higher reimbursement.

Procedure Code	Procedure Code Description	THSteps Fee Effective September 1, 2007
99381	New patient younger than 1 year	$ 84.51
99382	New patient 1-4 years	92.47
99383	New patient 5-11 years	92.09
99384	New patient 12-17 years	100.43
99385	New patient 18-39 years	100.43
99391	Established patient younger than 1 year	77.75
99392	Established patient 1-4 years	85.07
99393	Established patient 5-11 years	84.72
99394	Established patient 12-17 years	92.40
99395	Established patient 18-39	92.40

Appendix B
September 1, 2007 Dental Fees
Compared to the Current Dental Fees Prior to September 1, 2007

Fees are listed in order of priority as proposed by the Physician Payment Advisory Committee.

Procedure Code	Procedure Code Description	Current Dental Fee Prior 09/01/2007	Dental Fees Effective 09/01/2007	Percent of Fee Increase	Note Code
D0120	Periodic oral evaluation	$14.72	$29.44	100%	
D0150	Comprehensive oral evaluation	$18.02	$36.04	100%	
D0210	Intraoral – complete series	$36.04	$72.08	100%	
D0220	Intraoral – 1st periapical	$6.41	$12.82	100%	
D0230	Intraoral – each add periapical	$5.87	$11.74	100%	
D0272	Bitewings – 2 films	$11.93	$23.86	100%	
D0274	Bitewings – 4 films	$17.66	$35.32	100%	
D0330	Panoramic film	$32.54	$65.08	100%	
D1110	Prophylaxis – adult	$28.00	$56.00	100%	
D1120	Prophylaxis – child	$18.75	$37.50	100%	
D1203	Topical fluoride w/out prophy – child	$7.50	$15.00	100%	
D1204	Topical fluoride w/out prophy – adult	$7.50	$15.00	100%	
D1206	Topical fluoride – moderate to high caries risk pt	$7.50	$15.00	100%	
D1351	Sealant - per tooth	$14.41	$28.82	100%	
D1510	Space maintainer - fixed - unilateral	$80.00	$160.00	100%	
D1515	Space maintainer - fixed - bilateral	$118.75	$237.50	100%	
D2140	Amalgam - 1 surface	$30.99	$61.98	100%	Primary (D7=94.31%)
D2140	Amalgam - 1 surface	$32.86	$65.72	100%	Permanent (D7)
D2150	Amalgam - 2 surfaces	$41.45	$82.90	100%	Primary (D8=94.79%)
D2150	Amalgam - 2 surfaces	$43.73	$87.46	100%	Permanent (D8)
D2160	Amalgam - 3 surfaces	$45.00	$90.01	100%	Primary (D2=0.78%)
D2160	Amalgam - 3 surfaces	$55.71	$111.42	100%	Permanent (D2)
D2330	Resin composite - 1 surface anterior	$39.67	$79.34	100%	
D2331	Resin composite - 2 surfaces – anterior	$52.57	$105.14	100%	
D2332	Resin composite - 3 surfaces – anterior	$68.64	$137.28	100%	
D2335	Resin composite - 4+ surfaces – anterior	$85.19	$170.38	100%	
D2391	Resin composite - 1 surface – posterior	$38.49	$76.98	100%	Primary (D6=91.56%)
D2391	Resin composite - 1 surface – posterior	$42.04	$84.08	100%	Permanent (D6)
D2392	Resin composite - 2 surfaces – posterior	$49.49	$98.98	100%	Primary (D5=89.82%)
D2392	Resin composite - 2 surfaces – posterior	$55.10	$110.20	100%	Permanent (D5)

Procedure Code	Procedure Code Description	Current Dental Fee Prior 09/01/2007	Dental Fees Effective 09/01/2007	Percent of Fee Increase	Note Code
D2751	Crown - porcelain/base metal	$264.00	$528.00	100%	
D2930	Prefab SSC – primary	$78.03	$156.06	100%	
D3120	Pulp cap – indirect	$15.00	$30.00	100%	
D3220	Therapeutic pulpotomy	$43.98	$87.96	100%	
D3310	Anterior root canal	$177.99	$355.98	100%	
D3320	Bicuspid root canal	$206.25	$412.50	100%	
D3330	Molar root canal	$312.13	$624.26	100%	
D7140	Extraction, erupted tooth	$33.52	$67.04	100%	
D7240	Removal of impacted tooth - completely bony	$150.00	$300.00	100%	
D9248	Non-IV conscious sedation	$125.00	$187.50	50%	
D2931	Prefab SSC – permanent	$81.25	$162.50	100%	
D7111	Extraction, coronal remnants	$8.00	$12.00	50%	
D7210	Surgical removal of erupted tooth	$58.75	$102.81	75%	
D7220	Removal of impacted tooth - soft tissue	$90.00	$157.50	75%	
D7230	Removal of impacted tooth - partially bony	$120.00	$180.00	50%	
D2750	Crown - porcelain/high noble	$264.00	$528.00	100%	
D2752	Crown - porcelain/noble metal	$264.00	$528.00	100%	
D2790	Crown - full cast high noble	$264.00	$528.00	100%	
D2933	Prefab SSC w/ resin window	$85.51	$156.06	83%	
D2934	Prefab esthetic coated SSC	$85.51	$156.06	83%	
D2940	Sedative filling	$20.90	$36.58	75%	
D9241	IV conscious sedation/analgesia - 1st 30 mins	$81.25	$121.88	50%	
D2393	Resin composite - 3 surfaces – posterior	$58.07	$87.11	50%	Primary (D3=86.09%)
D2393	Resin composite - 3 surfaces – posterior	$67.45	$101.18	50%	Permanent (D3)

Appendix C
Frew v. Hawkins Corrective Action Plans
Estimate to Court for the 2008-09 Biennium

	General Revenue	All Funds
Outreach and Informing	$ 4,325,000	$8,650,000
Check-ups	425,000	850,000
Checkup Reports/Lagging Co.	75,000	150,000
Supply of Providers	1,840,274	3,680,548
Managed Care	23,100,000	46,200,000
Toll Free Numbers	6,489,763	12,979,525
Transportation	3,056,402	7,612,803
Training for Providers	2,145,000	4,349,496
Case Management	75,000	150,000
Outcome Measures	225,000	450,000
Drugs/Supplies	767,455	1,723,940
Contingency Reserve	2,476,107	4,783,612
Totals	**$45,000,000**	**$91,579,924**

Appendix D
Strategic Initiatives Received from Public Stakeholders

On August 8, 2007, the Health and Human Services Commission held a public meeting to hear ideas on projects to fund using the $150 million for *Frew v. Hawkins*-related strategic initiatives as indicated in H.B. 15. Over 40 different stakeholders attended the public meeting and additional stakeholders submitted project ideas via mail or e-mail. Examples of organizations that submitted project ideas include, but is not limited to: Texas Medical Association; Texas Pediatric Association; Texas Academy of Family Physicians; Christus Santa Rosa Children's Hospital; University of North Texas Health Science Center at Fort Worth; Gateway to Care; San Antonio Nonprofit Council; Cook Children's Hospital; Texas Children's Health Plan; Texas Dental Association; Texas Children's Pediatric Associates Project Medical Home; Driscoll Children's Health Plan; Children's Medical Center of Dallas; Methodist Health Care Ministries; Superior Health Plan; Texas Association of Community Health Centers; and Advocacy, Incorporated.

The projects below are grouped by each major objective HHSC will use to meet the overall goal of improving access to care for children under the age of 21 enrolled in Texas Medicaid. An interagency workgroup will assess if, and to what extent, the objectives are met within each project to determine if the project should be funded with the $150 million appropriated funds.

HHSC will begin immediate implementation planning of certain projects, such as a dental mobile van in HHSC Region 11, as directed in H.B. 15 and select other projects listed below.

Increase the Number of Children who Receive Regular THSteps Medical and Dental Check-ups

Mobile Medical and Dental Vans: H.B. 15 provides the opportunity for the use of mobile medical and dental vans in underserved areas, beginning in health and human services region 11. In addition, HHSC received specific proposals to fund mobile units in other areas of the state and, in some instances, in partnership with certain children's hospitals. The estimated cost to begin providing health care services through a mobile unit is approximately $1.5 million per unit, with an ongoing cost of approximately $250,000 annually based on available information.

Medicaid Access Card (MAC): Currently available in limited areas of the state, the new Medicaid Access Card (MAC) system makes the client check-in process quicker and more accurate. When a Medicaid client arrives at the provider's office, the client presents his/her Medicaid Access Card to the provider reception staff for check-in. The client's card is inserted into the card reader and the client is asked to place a finger on a finger image scanner. The client's finger will be compared with the finger image stored on the card to authenticate that the individual presenting the card is the actual card owner.

After the finger image match, the system automatically performs an eligibility verification that enables the provider to view and print eligibility information. HHSC ensures that claims will not be denied based on eligibility if Medicaid providers use this check-in process to successfully authenticate the client and verify eligibility.

The Medicaid Access Card (MAC) system enables communication and reporting functionality that may provide beneficial support for the *Frew v. Hawkins* notification requirements for the THSteps.

Potential enhancements include:

- MAC report server will enable providers to access reports from the Internet about MAC client activities at their offices. This could include THSteps information and could be produced for daily, weekly, or monthly periods of activity either by client or by provider site locations. The MAC provider reports would identify THSteps appointments that are pending, scheduled, and past due. This enhancement would assist providers in identifying and scheduling THSteps appointments for their clients.

- Provider printout with notification would include a THSteps notification on the provider printout during client check-in. The enhanced printout would include information about THSteps appointments needing to be scheduled or that are past due. This would provide current relevant information to the provider to help ensure timely scheduling of THSteps appointments.

- Client notification printout would provide a small printout about THSteps appointments to be handed to the client during check-in. The enhanced printout would include information about THSteps appointments needing to be scheduled or that are past due. This would provide current relevant information to the client to help support timely notification and scheduling of THSteps appointments.

- Tracking notifications would provide reports to HHSC about all notifications printed for clients and providers about THSteps appointments needing to be scheduled or that are past due.

Nurse Training: HHSC should fund additional training for nurses to perform THSteps examinations in mobile units, schools, and home care settings.

Statewide Data System: HHSC should fund the development of a statewide data system to track and share key medical information among providers similar to the immunization registry at the DSHS. Information to be shared among Medicaid providers would include immunizations, emergency room utilization, THSteps examinations, and dental examinations to name a few. HHSC can then generate provider based "report" cards to include timeliness, accuracy, and referral rates and market to professional pride.

Standardized Method for THSteps Chart Audits: HHSC should integrate use of provider-generated internal quality assurance processes and support providers with financial incentives for implementing and measuring success in providing THSteps examinations.

Health Lifestyle Incentives for Parents and Teens: HHSC should develop a program to reward parents and teens who participate in recommended medical and dental check-ups. The program

would provide THSteps clients that receive preventive care with financial rewards that can be used to buy health care related goods and services and that are not covered by Medicaid. Each participating Medicaid THSteps client would receive access to his/her own healthy lifestyles account via a credit card account after the client has received a THSteps screen or other "healthy" related health care services. The credit card account would be established to restrict the card's use to approved healthcare goods and services. Participants would be able to use their cards to purchase health care services from any health care provider in the state that accepts MasterCard debit cards, as an example. Initial setup costs are estimated at $600,000 for consulting/building this model and marketing this option to clients. Additional costs would include initial card issuance and adding the "healthy lifestyle" reward amounts.

New, Expansion or Renovation of Clinic Sites Throughout the State: HHSC should provide either one-time or ongoing funding for outpatient clinics that can guarantee additional health care access will be available to Medicaid clients under the age of 21. Specific proposals received include:

- Children's Medical Center in Dallas: The medical center is planning for the construction of a new facility in early September, 2008. With a $1 million investment, the center can treat 30,000 patient visits per year, support a medical home, provide extended office hours and provide outreach and education on how to appropriately access health care services.

- Christus Santa Rosa Children's Hospital: Financial support for the Children's Health Center will allow Christus Santa Rosa to provide additional health visits and THSteps exams. This clinic supports ambulatory activities of the accredited pediatric residency program of The University of Texas Health Science Center at San Antonio School of Medicine.

- University of North Texas (UNT) expansion of primary care in Tarrant County: UNT is requesting a one-time investment of $862,000 to treat an additional 18,800 patient/visits a year in underserved areas of Tarrant County. Currently, patient access is limited by physical plant limitations. The clinic expansion will be close to major routes of transportation and will include sub-leasing for on-site pediatric specialty care through Cook Children's Hospital.

- UNT relocation/expansion of clinic in south Forth Worth: UNT is requesting a one-time investment of $690,800 to provide an additional 14,100 new patients' visits each year. Cook Children's would provide pediatric subspecialty care.

- UNT multi-specialty clinic in northwest Tarrant or southwest Denton County: UNT is requesting a one-time investment of $869,250 to recruit five new providers in these underserved areas providing an additional capacity of 23,500 patient encounters per year. Cook Children's would provide on-site pediatric subspecialty services based on referral volume and demand.

- Fort Worth Child Center: HHSC should fund the Fort Worth Child Center to re-open its dental clinic that services only Medicaid children.

Increase Participation of Medical and Dental Providers who Serve Children in the Texas Medicaid Program

Stipends, Loan Forgiveness, or Bonus Payments for Health Care Professionals: HHSC should fund or establish well structured loan forgiveness programs with a particular emphasis on primary care. The model for this program can be the federal U.S. Health Resources and Services Administration (HRSA) loan repayment program to recruit providers to underserved areas. HHSC can also model the program after the current DSHS program that provides assistance with student loans for physicians that provide health care services in medically underserved areas.

Targeted Rate Adjustments: Rate increases for physicians, dentists, specialists, and other health professionals will be in place effective September 1, 2007. As part of the court ordered corrective action, HHSC Strategic Decision Support will complete assessments of provider supply, and the assessments will include review of the available supply of specialists for children served in Medicaid. Using the assessment, HHSC, with the assistance of the provider community, will develop a plan to address any identified gaps in services. Targeted rate adjustments may be considered as part of the solution for obtaining provider participation in a particular area of the state.

Provider Complaint System and Physician Ombudsman: HHSC should develop a web-based interactive complaint system where providers can enter and track their complaints through a dedicated complaint system, and require a contractor to review complaints and address complaints in a timely manner.

On-line and In-person Physician Education Initiatives: HHSC should work with the medical community to develop an educational series and resources to educate primary care physicians on how to integrate mental health and behavioral health services, appropriate use of psychotropic medications, asthma and diabetes treatment, THSteps, and dental screens to name a few. Continuing medical education (CME) credits should be a part of this initiative. This is a current initiative at HHSC.

Medicaid Provider Enrollment Application: The current application to enroll Medicaid providers is 55 pages and often requires several attempts before an application is accepted. HHSC should develop the technology necessary to allow providers to enroll on-line and stop the application process when incorrect or incomplete information is provided. HHSC should allow providers to print the application from the web and submit with a signed/dated attestation statement or submit electronically and mail a signed/dated attestation statement. HHSC should confirm that the provider information will automatically populate the national provider identification number. In addition, HHSC should work to reduce the time to process an application from the current up to six-month timeframe and allow for providers to fill out only one application to be a THSteps provider and a general Medicaid provider.

Texas Medicaid Provider Procedures Manual: HHSC should develop a separate provider procedure manual for services provided to children to clearly outline for providers services eligible for reimbursement for children enrolled in Medicaid. The current manual may be

confusing to providers given that service limitations exist for adults that may not apply to children. A separate medical policy and review process may also need to be developed.

Pediatric Sub-specialty "Circuit Rider" Program: HHSC should underwrite existing or new "circuit rider" programs throughout the state where pediatric sub-specialty providers travel throughout underserved areas of the state to alleviate access barriers to specialty services. For example, a pediatric cardiologist in Dallas recently established such a program in Paris, Texas. Specifically, HHSC can financially support these programs by paying for the physician's travel costs and rental office space.

Rural and Urban Telemedicine Demonstrations: HHSC should establish telemedicine support networks to provide access to pediatric specialty services in rural and underserved areas. For example, the University of North Texas has proposed to set up pediatric telemedicine centers in the rural counties north and west of Tarrant County with limited pediatric sub-specialty support. UNT is requesting a one time funding of $1.3 million for facility leases, purchase telemedicine units, and hire additional providers. The result is expected to be improved access to pediatric specialists, enhanced coordination with primary care, decreasing emergency department services, and providing a medical home.

Improve Appropriate Utilization of Medically Necessary Services

Medical Transportation Improvements: HHSC has contracted with Texas A&M University to complete an assessment of the Medical Transportation Program (MTP). HHSC will receive an initial report in November 2007. The initial report will identify areas of the program that would benefit from changes or improvements. Upon receipt of the initial report, HHSC will develop a plan to make the suggested improvements in the program.

Over fiscal year 2008, the Medical Transportation Program (MTP) will transition to HHSC from the Texas Department of Transportation. HHSC does not anticipate making any immediate changes to the program during the transition but is analyzing suggestions for improving the program. Ideas for consideration include utilizing alternative methods for providing access to transportation services such as providing vouchers to providers' offices for patients to use buses or cabs when patients have identified barriers to medical transportation services. In addition, HHSC is completing a comprehensive review of current policies and rules governing the MTP and may modify certain rules perceived as barriers to care, such as advance notice for transportation services and closest-provider restrictions.

Telephone Consultations for Sub-Specialists: HHSC should make telephone consultations for sub-specialists a reimbursable benefit for specific sub-specialists in accordance with specific medical/program policy to ensure appropriate utilization.

Assessment of Eligible Reimbursement Codes for Children: HHSC should complete a comprehensive list of reimbursement codes eligible for federal matching funds but not currently covered in Texas Medicaid.

Medicaid Reimbursement for Cancer: HHSC should provide cost reimbursement for childhood cancer at Texas facilities and should cover the routine costs of care for appropriate clinical trials at state facilities to enhance access, diagnosis, and treatment of this disease. In addition, children diagnosed with cancer should be disenrolled from the commercial managed care model into traditional Medicaid.

Open Practice Clause in Hospital Contracts: HHSC should provide hospitals with increased stipends when they sign contracts to recruit, establish, or subsidize sub-specialists, provider groups, or licensed health professionals, and the contracts should include an "open practice" clause. The open access means contracted providers must accommodate requests to treat all Medicaid patients when the obligation to treat is part of an emergency department or other on-call coverage arrangement. The contracted hospital must also contract with every Medicaid HMO in the area.

Dental Varnish Pilots: HHSC should fund select pilots throughout the state where the primary care provider (PCP) applies vanish during well child visits and starts referring to a dental home at an early age. Funds provided by HHSC will assist in developing training curricula and project material, hire a project coordinator, recruit dentists and PCPs, and develop a database for training patients. These pilots can be structured after the similar "Into the Mouths of Babes" initiative in North Carolina.

Disease Management and Education Programs: HHSC should partner with organizations that currently run successful disease management programs and provide additional funding for those programs to reach a greater number of Medicaid children. The diseases to target include diabetes, asthma, and obesity.

Diabetes Educators: HHSC should add diabetes educators as a separate provider type in Medicaid and enroll them independently, develop rules in the comprehensive care program (CCP) on when diabetes educators should be used, and work with the disease management vendor to streamline activities as appropriate. In addition, HHSC should use the national standards and certifications for this provider type.

Mental Health Mentoring Programs: HHSC should fund a mental health mentoring program that partners primary care physicians with child and adolescent psychiatrists to improve the diagnosis, treatment, and management of mental illness in children. The PCP and partnering psychiatrist/psychologist would meet every other week to review and discuss active cases and discuss treatment and medication management. HHSC may also consider establishing a real-time referral and scheduling system for psychiatric services.

Clinical Best Practices: HHSC should complete a thorough assessment of the best clinical studies on how to deliver health care services to children and educate Texas providers about using these best practices in their regular course of practice.

Dental Home: HHSC should support and encourage the dental home model for all children in Medicaid, which would provide early intervention and prevention of dental disease by age one. HHSC should work with the dental community to establish local clinics/provider practices for

children under three to four years old. The dental home would apply varnish and sealants by at least 12 months of age and provide guidance and education to parents on maintaining dental health. HHSC could develop a collaborative partnership between physicians and dentists to cross train on early screenings to detect evolving dental and other health care issues.

Consultants as Resources: HHSC should hire a consultant(s) to research and develop best practices for developing a medical home concept and other best practices in EPSDT.

Frew Strategic Initiatives Technical Advisory Committee: HHSC should create an ad hoc technical advisory committee to advise HHSC on the best initiatives to pursue with the available funding that have the highest probability of increasing access to health care services for children enrolled in Medicaid.

Improve Coordination of Care

Medicaid Children with Special Health Care Needs Medical Home: HHSC should establish resources to better assist primary care providers who serve children with special health care needs. For example, the Texas Pediatric Society (TPS) has proposed to identify and develop educational materials for parents and providers, develop a web based directory listing physicians and sub-specialists with expertise in providing care to CSHCN, develop CSHCN continuing medical education presentations, provide CSHCN medical home education and logistical support for Medicaid/CHIP managed care organizations medical directors and networks, develop CSHCN "mini-fellowship" opportunities, and provide telephone support for providers across the state seeking information about the provision of the primary care model for CSHCNs. TPS is requesting $750,000 to fund a three-year effort to accomplish these tasks in cooperation with the state and other stakeholders.

Medical Home Activities across HHSC System: Currently the Department of State Health Services and the Medicaid/CHIP Medical Director have different workgroups working on developing the concept of a medical home in state public health programs and in Medicaid. Efforts to develop and establish a medical home for all children should be consolidated across the HHSC system and continue to involve stakeholders.

Increase Funding for Outreach and Education: These ideas focus on increasing funding for outreach and education to clients and their parents under the age of 21 through various avenues including:

- Greater use of promotoras, navigators, and community health workers to provide intensive assistance in accessing medical services, educating about basics in oral hygiene, assisting with a complete health assessment, and sharing health care information directly with families. This initiative assumes that outreach and education efforts are most successful when those providing this information are from the local communities and are very familiar with the specific needs of families in particular neighborhoods.

- Underwrite community education/outreach campaigns that have already been identified as successful rather than creating new campaigns.

- Develop and implement a statewide outreach program to educate families and providers regarding the new personal care service (PCS) for children with disabilities that will be available in the state Medicaid plan.

- Fund mobile outreach units, which would contain outreach staff in addition to medical staff when traveling via a mobile unit in underserved communities.

- Forge a stronger working relationship with schools throughout the school year on enrolling children in Medicaid as well as providing education/outreach information about accessing Medicaid services for children.

- Incorporate caregiver education about THSteps benefits in parenting, newborn, and prenatal classes throughout the community.

- Fund the "Mother's Network" initiative through Driscoll Health Plan, which provides educational sessions in "baby shower" settings for expecting mothers about key health prenatal and post-birth health care issue.

Raising Texas Plan: HHSC should fund one staff person to work with key stakeholders of the Social Emotional Development and Mental Health implementation team and to support the Insurance and Medical Home component included in the Raising Texas Plan. The Raising Texas initiative is a statewide collaborative and coordinated effort to strengthen Texas' system of services so that all children enter school healthy and ready to learn. In addition, HHSC should fund the printing of the Texans Care for Children Developmental Calendar, which provides developmental information and outreach to families on the importance of social and emotional development in young children.

Migrant Care Network: HHSC should contract with existing health care networks both in Texas and out of state to provide access to preventive care, primary care, specialty care, hospitals, dental services, mental health services, and pharmacy services. Before the families leave Texas, they will be provided with a provider directory listing available providers to care for their children while "in stream." HHSC should develop a toll-free number available 24 hours a day, 7 days a week, staffed by nurses to provide triage services and assist migrant families find the nearest available provider. The Migrant Care Network is not an expansion of benefits or expanded eligibility under Medicaid, but rather to assist in maintaining their coverage while traveling throughout Texas and in other states.

Another proposal would be for HHSC to fund specific case managers only for migrant families in select areas of the state with a high concentration of migrant families to facilitate access to care and coordination of their care.

Case Management Services: HHSC should increase the number of regional-based case management employees and rates paid to the staff given the volume of children who may request

case management services. Case managers should be from local communities familiar with the unique health care needs and socioeconomic conditions affecting children in their area of the state. Case managers should be an integral part of the "care team" so that medical, dental, behavioral, and social services are properly coordinated. HHSC may also consider assigning case managers to particular provider offices, highly utilized emergency room centers, schools, day care centers, and community centers, to name a few, to facilitate access to Medicaid eligible services.

Graduate Medical Education (GME): HHSC should fund the state share of the Medicaid graduate medical education programs in Texas in order to increase funding for critical residency programs in select Texas hospitals.