Module 1 – THSteps Overview

Objectives

The information covered in this module is an overview of the following**:**

- THSteps Legislative basis and funding
- THSteps administration
- THSteps goals
- Medical home
- Program services
- Medically necessary services
- Program eligibility
- Client notification of services
- Client access to services
- Confidentiality of records
- Client rights

Legislative Basis and Funding

The Texas Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is a federally mandated health care program of prevention, diagnosis, and treatment for Medicaid clients from birth through age 20. In Texas, the EPSDT Program is known as the Texas Health Steps (THSteps) Program. Services are provided in accordance with federal law (Title XIX of the Social Security Act, as amended), federal regulations, Texas State Plan for Medical Assistance, and state rules. The state and federal governments jointly fund the program.

Who administers the Texas Health Steps Program?

The Texas Department of State Health Services (DSHS), a Health and Human Services Commission (HHSC) agency, administers the THSteps Program, in coordination with HHSC. Implementation of the scope of THSteps services and program benefits is a true partnership effort of clients, providers, state agencies, health delivery models, and others.

What are the THSteps Program Goals?

The goals of the THSteps Program are to:

- Detect and treat medical and dental problems for eligible Medicaid clients from birth through age 20.

- Provide continuing preventive health care to infants, toddlers, children, adolescents and young adults covered by Medicaid as soon as possible.
- Link clients with primary health care providers who can provide a medical home to meet their needs for care.
- Link clients with providers for preventive and ongoing care.

How does THSteps work to meet and these goals?

The THSteps Program works to meet these goals by:

- expanding client awareness of existing health, dental, and case management services offered by THSteps and Medicaid;
- encouraging and increasing client use of preventive health services; and
- recruiting and retaining a qualified provider pool to assure that comprehensive preventive health, dental, and case management services are available.

What is a Medical Home?

HHSC and DSHS encourage providers participating in the Texas Medicaid Program to practice the "medical home concept" for clients with Medicaid. To realize the maximum benefit of health care, each family and individual needs to be participating member of a readily identifiable, community-based medical home. The medical home provides primary medical care and preventive health services and is the individual's and family's initial contact point when accessing health care. It is a partnership among the individual and family, health care providers within the medical home, and extended network of consultative and specialty providers with whom the medical home has an ongoing and collaborative relationship. The providers in the medical home are knowledgeable about the individual's and family's specialty care and health-related social and educational needs, and are connected with necessary resources in the community that will assist the family in meeting those needs. When referring for consultation, specialty/hospital services, and health and health-related services, the medical home maintains the primary relationship with the individual and family, keeps abreast of the current status of the individual and family through a planned feedback mechanism, and accepts them back into the medical home for continuing primary medical care and preventive health services.

A Medical Home is a respectful partnership between a child, the child's family, and the child's primary health care setting. A Medical Home is **family centered** health and dental care that is accessible, continuous, comprehensive, coordinated, compassionate, and culturally competent. THSteps promotes the medical home partnership.

What are the THSteps Program Services?

THSteps services include the following. All are covered in more detail later in this overview.

Medical Checkups:

- Complete and comprehensive medical checkups at periodic intervals according to the stages of development.
- Periodicity schedule based on "Recommendations for Preventive Pediatric Health Care of the Committee on Practice and Ambulatory Medicine of the American Academy of Pediatrics (AAP)".

Important: Checkups must be complete!

Dental Services:

- Complete and comprehensive dental care services (preventive, therapeutic, orthodontic, and emergency).
- Routine periodical dental checkups every 6-months beginning at age 1.
- Emergency and treatment services available at any time .
- Orthodontic services available with appropriate referral and criteria.

Medically Necessary Care

Any health care service that is medically necessary and appropriate and is a federally allowable Medicaid service (see Module 12-Medically Necessary Services). Some medically necessary services benefits include, but are not limited to:

- Durable medical equipment and medical supplies
- Private duty nursing services
- Counseling and nutritional counseling services
- Speech therapy, occupational therapy, and physical therapy
- Orthodontics (braces)
- Prosthetics (artificial limbs or eyes)
- Vision
- Inpatient psychiatric services
- Inpatient rehabilitation services
- Extended hospitalization

Who is Eligible for THSteps Services?

Medicaid clients from birth through age 20 are eligible for THSteps services. THSteps benefits continue until the end of the month in which the client becomes age 21.

Exceptions:

- Payment for medically necessary services end on the client's 21st birthday.
- For THSteps client who are 21 years old and are losing Medicaid eligibility prior to completion of orthodontic treatment, payment is made to complete the orthodontic treatment if the treatment was authorized and initiated while the client Medicaid/THSteps eligible and the treatment is completed in 36 months.
- If a client's Medicaid Identification Card (Form 3087) states "Emergency Care" only, "Presumptive", or "Qualified Medicare Beneficiary", the client is ineligible for THSteps services.

The Medicaid Identification Form

Medicaid/THSteps eligibility is confirmed by:

- A current month Medicaid Identification Form, Form 3087
- Or a current Form 1027-A, issued by Health and Human Services (HHSC) eligibility staff or DFPS staff. This temporary form identifies eligible clients when the Medicaid Identification Card is lost or has not been issued. Questions about an individual's Medicaid/THSteps eligibility are to be directed to the Medicaid Hotline by calling TMHP at **(800) 252-8263**

How does a Client access THSteps Services?

The client/parent/guardian applies for Medicaid Coverage via:

- Telephone
- Internet
- Mail Medicaid/CHIP application
- Walk-in and apply at a local HHSC office
- HHSC staff review application for completeness and determine eligibility for Medicaid.
  - If approved, HHSC sends client notice of approval and Medicaid Identification Form, Form 3087
  - If denied, HHSC sends client a notice of denial and forwards application to CHIP for processing for possible eligibility under that program.
- The Medicaid Identification Form, Form 3087 documents the client's eligibility for Medicaid Benefits and for THSteps services. This form will also advise the client or providers when a client is due for a THSteps Medical or Dental Checkup. Once a client receives their Medicaid ID form, they may choose a provider for those services and begin to access them.
- THSteps, via Texas Access Alliance (TAA) and other partners attempt to contact clients/parents/guardians to promote understanding of and how to access THSteps services.

- THSteps, via TAA, offers additional support services such as including but not limited to:
    - assistance with finding and selecting a provider;
    - assistance with scheduling appointments;
    - linking clients to case management; and
    - assistance with accessing services.
- Clients choose to access services and make/keep provider appointments.
- Providers then provide the client services and bills for Medicaid covered services (as appropriate).
- Providers then receive reimbursement for services. Any reimbursement made by Medicaid for a Medicaid-covered service is considered payment in full for the service and the client is not responsible for any difference.
- THSteps sends due and overdue letters to client/parent/guardian advising that they are due/overdue for:
    - Medical Checkup
    - Dental Checkup
    - Immunizations
- Client access services at regularly scheduled intervals.

Client Confidentiality

Information about the diagnosis, evaluation, or treatment of a client with Medicaid coverage by a person, licensed or certified to perform the diagnosis, evaluation, or treatment of any medical, mental, or emotional disorder, or drug abuse, is usually confidential information that the provider may disclose only to authorized people. Family planning information is sensitive, and confidentiality must be ensured for all clients especially minors.

Only the client may give written permission for release of any pertinent information before client information can be released, and confidentiality must be maintained in all other respects. The client's signature is not required on the claim form for payment of a claim, but HHSC recommends the provider obtain written authorization from the client before releasing confidential medical information. A release may be obtained by having the client sign the indicated block on the claim form after the client has read the statement of release of information that is printed on the back of the form. The client's authorization for release is requested by and made to DADS, HHSC, DSHS, TMHP, EPSC, HHSC, OIG, the Texas Attorney General's Medicaid Fraud Control Unit or Antitrust and Civil Fraud Division, or HHS.

Client Rights

THSteps providers enrolled in the THSteps Program enter into a written contract with the HHSC to uphold the following rights of the Medicaid/THSteps client:

- The right to receive medical/dental/case management services, which meet or exceed the standards of care established by the laws relating to the practice of medicine, dentistry, or case management.
- The right to receive information following an examination regarding the diagnosis, scope of proposed treatment (including alternatives and risks), anticipated results, and the need for administration of sedation or anesthesia (including risks)
- The right to full participation in the development of the treatment plan and the process of giving informed consent
- The right to freedom from physical, mental, emotion, sexual, or verbal abuse or harm from the provider or their staff
- The right to freedom from overly aggressive treatment in excess of that required to address documented medical necessity

NOTE: A provider's failure to ensure any of the client rights may result in termination of the provider agreement or contract, and other civil or criminal remedies.

Module 2 – THSteps Medical Checkups

Objectives

This module provides the following information:

- Purpose of medical checkup
- Medical checkup components
- Medical checkup periodicity
- Medical checkup providers
- Reimbursement - medical checkups
- Reimbursement -exceptions to periodicity
- Reimbursement - follow-up visits
- Provider referrals

What is the purpose of a THSteps Medical Checkup?

The primary purpose of THSteps medical checkups is to detect health problems early so they can be diagnosed and treated. Routine, periodic medical checkups assist the provider in detecting problems. These periodic examinations also provide an opportunity for the healthcare provider to offer guidance on a child's growth and development. In performing medical checkups, health care providers use procedures to help identify problems or abnormalities. An abnormal checkup finding may not be a diagnosis, but it may indicate the need for follow-up, diagnosis and/or treatment services.

What are the Medical Checkup Components?

Required components are a/an:

- Medical History(of the family and child)-
  - Initial History
  - Interim History
  - Screening for adolescent lifestyle risk factors is to include eating disorders, sexual activity, alcohol (and other drug use), tobacco use, school performance, depression, and risk of suicide.
  - Behavioral risk for adolescents
- Physical Examination- Age-appropriate complete unclothed physical exam is required at each checkup. Older children are to be appropriately draped. For adolescents who are sexually active, a pelvic exam should be part of the examination.

- Nutritional history and screening
- Measurements-
  - Length: birth- 2 years
  - Height: 3 – 20 years
  - Weight: birth – 20 years
  - Body mass index (BMI): 2 – 20 years
  - Head circumference: birth to 2 years
  - Blood pressure: age 3 years - 20
- Developmental screening-
  - Physicians, physician assistants, and advanced practice nurses (pediatric nurse practitioners and family nurse practitioners) conducting THSteps checkups for children birth up to and including the 6 year checkup must include:
    - A standardized developmental screen (the provider's choice of observational or parent questionnaire) for a child between 9 through 12 months of age, 18 through 24 months of age, and every other year thereafter.
    - Standardized screening should also be conducted if a parent expresses concern about the child's developmental progress.
    - Developmental screening at all other visits to include a review of milestones (gross and fine motor skills; communication skills, speech-language development; self help/care skills; social, emotional, and cognitive development) and mental health.
    - Registered nurses conducting THSteps medical checkups for children birth up to and including the 6 year checkup A standardized observational screen for children in the following age groups: 9 through 12 months of age; 18 through 24 months of age; and if the child does not have a record of a standardized observational developmental screen, again between 24 up to and including the 6 year checkup A standardized parent questionnaire at all other periodic visits through the 6th year of age or when a parent expresses concern about the child's developmental progress.
- Mental health screening and mental health status
- Vision screening-
  - Birth through 2 years of age—Screening includes history of high-risk conditions, observation, and physical examination.
  - Ages 3 through 10, 12, 15, and 18 years of age—Screening includes administration of an age-appropriate vision chart.
  - Documentation of test results from a school vision-screening program may be used if conducted within 12 months of the checkup.

- Hearing screening-
  - Birth through 3 years of age—Screening includes history, observation, and screening by use of the Parent Hearing Questionnaire.

  Ages 4 through 10, 12, 15, and 18 years of age—A puretone audiometer should be used to screen hearing at checkups. Subjective screening may be completed at all other checkups.
  - Documentation of results from a school audiometric screening program may be used if conducted within 12 months of the checkup.
- Tuberculosis screening- Tuberculin test supplies are available free of charge to all medical checkup providers from local or regional health department offices. See periodicity schedule for testing requirements for areas of low prevalence and height prevalence. Screening questionnaires are available on line.
- Laboratory tests (including lead screening and newborn screening)- Refer to periodicity schedule for requirements for specific tests. All blood specimens are to be submitted to the DSHS Laboratory for analysis. There is no charge to the medical checkup provider for processing of lab specimens. The DSHS laboratory furnishes providers with free laboratory or client collection supplies and postage paid mailing containers. Screening questionnaires for identification of lead poisoning are on line.
- Oral Health screening and referrals to dental providers- Each medical checkup is to include a referral for a dental checkup for clients one year of age or older. A client may have a dental checkup every 6 months and may be seen at other times for therapeutic or emergency care. Although an oral health screening is part of the THSteps medical checkup, it does not substitute for a dental checkup by a dentist.
- Immunizations- The client's immunizations should be checked at each visit and given unless medically contraindicated or because of parent's reasons of conscience including a religious belief. Clients are not to be referred to the local health department for immunizations.
- Health education- Age appropriate education should be part of each visit in face to face meeting with parent/guardian.
- Referrals as needed to other health care providers.

When are THSteps Medical Checkups recommended?

THSteps medical checkups are offered according to a periodicity schedule:

- Inpatient, newborn
- Ages 1 – 2 weeks through 18 month: 8 medical checkups
- Ages 2 – 9 years: 6 medical checkups
- Ages 10 – 20 years: 11 checkups

See the current *Texas Medicaid Provider Procedures Manual (THSteps, Section 42)* for the "THSteps Medical Checkup Periodicity Schedule for Infants and Children, and Adolescents.

What are some of the benefits of a THSteps Medical Checkup?

- Frequent medical checkups during **infancy** facilitate proper primary care for infants and newborns and the administration of immunizations according to recommended schedules and provide health education for the parents/guardians.
- For **toddlers and school-aged children**, THSteps medical checkups evaluate health factors and other health indicators that contribute to school readiness, such as development, hearing, and vision in addition to the benefits for infants.
- **Adolescent** medical checkup visits are important because this age period can present significant challenges for teen and pre-teen clients and their families. Adolescent medical checkups are designed to meet the needs of the teen and pre-teen age groups. Adolescent checkups include an emphasis on health guidance on diet and fitness, safety practices, healthy lifestyles, and adolescent growth and development in addition to the complete physical assessment.

NOTE: Public schools support the THSteps Program. Clients are excused from school for THSteps medical and dental checkups.

Who can be THSteps medical checkup provider?

The following provider types may enroll independently as THSteps medical checkup providers in addition to enrollment as a Medicaid provider:

- Physicians (M.D. or D.O.)
- Physician Assistant (PA) – It is recommended that the PA have additional education or expertise in comprehensive pediatric assessment.
- Health care providers of facilities (public/private) capable of performing the required checkup procedures under the direction of a physician, such as health departments and rural health clinics.
- Family and pediatric nurse practitioners
- Certified nurse-midwife (for adolescent females and newborns up to two months of age)
- Women's health care nurse practitioner (for adolescent females)
- Adult nurse practitioners (for adolescents)

Note: A registered nurse (RN) may not enroll independently as a THSteps medical checkup provider, but they may perform a medical checkup under a physician's supervision.

Important: All RN's performing a THSteps a comprehensive THSteps checkup must have additional education and training or completed post-graduate nursing school courses in pediatric assessment prior to providing THSteps medical-checkups. For more details refer to the *Texas Medicaid Provider Procedures Manual (Texas Health Steps, Section 42).*

The Texas Nurses Association offers two courses that meet the requirements:

- "Basic Concepts in Identifying the Health Needs of Adolescents"
- "Comprehensive Pediatric Assessment"

Both of these courses are available to PAs who may need additional education in the area of pediatric assessment.

How are providers reimbursed for Medical Checkups?

- Providers are reimbursed for complete medical checkups (performed in accordance with the required protocol specified on the Medical Checkup Periodicity schedule as shown in the *Texas Medicaid Provider Procedures Manual-Section 42*.
- A separate fee is paid for the administration of each vaccine given at the time of the medical checkup. For more detailed information, see the THSteps and Claims Filing sections of the *Texas Medicaid Provider Procedures Manual-Section 42*.

To be reimbursed for performing medical checkups, a fee-for-service provider must:

- Be enrolled with the Medicaid claims administrator as a THSteps medical checkup provider.
- In managed care areas, the providers must also be enrolled with an MCO.
- Have a THSteps Texas Provider Identifier (TPI) or when appropriate, a National Provider Identifier (NPI).
- Perform checkups on individuals who are Medicaid/THSteps clients and periodically eligible for services. (see below section on "Reimbursement-Exceptions to Periodicity")
- Perform a complete medical checkup (including immunizations and lab work when required)
- Submit a claim as directed by the MCO, if providing services as part of an MCO or to the claims administrator if providing these services as fee for service.

NOTE: As a condition for provider reimbursement, children younger than age 15 must be accompanied by the parent, guardian, or other authorized adult at the medical checkup visit.

When can a provider provide medical checkup services outside of the required ages of the periodicity schedule?

Payment is made for medical checkups that are exceptions to the medical checkup periodicity schedule if the service falls into one of these categories:

- Medically necessary (e.g., suspected child abuse, developmental delay)
- Required to meet state or federal examination requirements such as for Head Start, daycare, foster care, or pre-adoption
- Prior to general anesthesia required for dental procedures

NOTE: No prior approval is required to receive reimbursement for medical checkups that are exceptions to the medical checkup periodicity schedule, however the provider must use the appropriate modifier when submitting a claim

How are providers reimbursed for follow-up visits?

Providers are reimbursed for a follow-up to a THSteps medical checkup if the visit is necessary to complete procedure(s) related to a medical checkup. For example, a follow-up visit may be necessary to "catch up" on immunizations or to repeat laboratory work.

NOTE: Refer to the *Texas Medicaid Provider Procedures Manual (THSteps, Chapter 42)* for more information on reimbursement. Medical Checkup providers may also call the Medicaid/THSteps Claims Administrator (TMHP) at 1-800-757-5691. Also may want to see May/June 2006 Medicaid Bulletin article on follow-up visits.

How are provider referrals for THSteps services made?

A major objective of THSteps is diagnosis and treatment for client problems, issues or health condition or mental health conditions discovered during a medical checkup.

- A provider who performs the medical checkup is often qualified to provide needed diagnosis and treatment.
- If the THSteps medical checkup provider is unable to perform the needed follow-up diagnosis/treatment services, that provider is then responsible for referring the client to a Medicaid provider, of the client's choice, who is qualified to perform the required service(s). Clients enrolled in managed care needing follow-up diagnosis and/or treatment services must be referred by their Primary Care Physician.

- **Referrals include:**
  - Dental
  - Genetic and family planning, if appropriate,
  - Hearing
  - ECI
  - Medically Necessary Services

Module 3 – Immunizations

Objectives

Information on the following is covered in this module:

- Required immunizations
- Texas Vaccines for Children Program (TVFC)
  - Provider reimbursement
  - Provider enrollment in TVFC
- ImmTrac

What are the required immunizations?

Immunizations (based on the immunization schedule established by the Advisory Committee on Immunization Practices (ACIP), and as adapted by the state) are a mandated federal and state component of a THSteps medical checkup and must be given at the time of the checkup.

NOTE: See the ACIP immunization schedule in the *Texas Medicaid Provider Procedures Manual-Texas Health Steps* and ongoing updates in the bulletin. The schedule is update yearly and released by CDC in early January. A copy of the current schedule can be viewed at the following web link: http://www.cdc.gov/nip/recs/child-schedule-color-print.pdf

New Vaccines

During 2006 ACIP has made several new recommendations. These recommendations include:

- Rotavirus for infants
- A second dose of Varicella is now recommended as a booster to help prevent breakthrough Varicella in children.
- HPV (for the prevention of cervical cancer)
- Tdap, which is a new booster for the adolescents and adults protecting them from Pertussis. Vaccinating adults is designed to reduce the exposure of infants, who are not fully immunized. Pertussis is potentially fatal in infants. There has been a significant increase in Pertussis over the last few years and infant deaths.

- Meningococcal conjugate vaccine

Complete ACIP recommendations for these and any other vaccine can be found at http://www.cdc.gov/nip/publications/acip-list.htm.

The THSteps medical checkups periodicity schedule for infants, children, adolescents, and young adults incorporates the ACIP schedule as required protocol (based on age).

NOTE: See the medical checkups periodicity schedules in the *Texas Medicaid Provider Procedures Manual-Texas Health Steps Code.*

- All THSteps medical checkup providers (fee-for-service and managed care) are responsible for the administration of immunizations (based on the ACIP schedule) at the time of a THSteps medical checkup**. This supports the medical home.**
- Every child's immunization records should be reviewed at every visit and all appropriate vaccines administered.
- Providers must not refer clients to local health departments or other providers for immunizations, but should provide this service themselves.
- Families who receive financial assistance from the HHSC can receive sanctions for failure to obtain immunizations on a timely basis (unless showing good cause).
- There are certain true contraindications for immunizations so observing them will cut down on missed opportunities. Please visit the following link for more information:

  http://www.cispimmunize.org/pro/Medical%20Home%20Supplemental%20Materials/External%20Immunization%20Resources/Physician%20Resources/Contraindications_Guide-CDC.pdf

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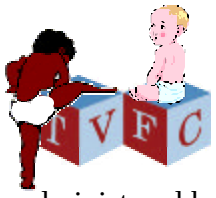
What is the Texas Vaccines for Children Program (TVFC)?



The TVFC is:

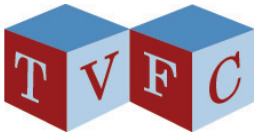
- A federally and state funded vaccine supply program administered by DSHS.
- Provides vaccines **at no cost** to public and private providers for certain groups of children, including children who are THSteps/Medicaid clients
- Covers vaccines recommended by the ACIP and approved by the Centers for Disease Control and Prevention

NOTE: THSteps medical checkup providers and other Medicaid providers (fee-for-service and managed care) who immunize THSteps clients must enroll in TVFC to receive free vaccine. Vaccines available from TVFC will not be reimbursed separately.

How do providers get reimbursed for immunizations under the TVFC?

- THSteps/Medicaid reimburses providers for the administration of each TVFC vaccine given to a THSteps client. (This fee is in addition to the reimbursement for a medical checkup.)

Providers enrolling in the TVFC program, agree to:



- Comply with the appropriate immunization schedule dosage and contraindications established by the ACIP
- Provide "Vaccine Information Statements" in accordance with the National Childhood Vaccine Injury Act and report adverse events following vaccination (as they occur)
- Administer vaccines supplied by the TVFC to THSteps clients at no charge to the client (including administration fees)

NOTE: For questions about TVFC and/or to enroll in the program, call 1-800-252-9152

What are the benefits of TVFC?

TVFC benefits THSteps medical checkup providers and clients by:

- Eliminating the need for providers to refer children to a public health center or another provider for immunizations
- Removing the financial costs of vaccines to the families and provider
- Allowing more children to receive immunizations in their "medical home" and receive their complete series of immunizations at age appropriate times

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What is ImmTrac?

ImmTrac Texas Immunization Registry

ImmTrac is a statewide registry and tracking system operated by the *DSHS

- Consolidates immunization records from multiple providers into one easily accessible record
- Enables participating providers to review patient immunization histories (providing the records are forwarded to the system) and enter information on administered vaccines
- Assists providers in dealing with complex vaccination schedule requirements
- Produces recall and reminder notices for vaccines that are due or overdue

NOTE: Immunization providers are required by law to submit immunization information to ImmTrac for all children under the age of 19. **The release of a child's individual immunization data to ImmTrac requires parental consent.** The current Texas birth certificate registration form includes a consent statement for the registry. Parental consent given on the birth certificate is valid until age 18, unless the consent is revoked. Consent may be revoked at any time.

How to contact ImmTrac?

Call: 1-800.252.9152
Email: ImmTrac@dshs.state.tx.us
Write to: DSHS Immunization Branch
1100 West 49th St.
Austin, TX 78756

Module 4 - Laboratory Procedures - 4

Objectives

Information on the following is covered in this module:

- Required laboratory procedures
- Laboratory testing
- Laboratory supplies

What are the required laboratory procedures?

Laboratory screening procedures are a federal/state required component of a THSteps medical checkup. Laboratory screening is done in accordance with the age and frequency specified on the THSteps medical periodicity schedule (see the *Texas Medicaid Provider Procedures Manual).* Laboratory specimen collection is done at the time of the client's medical checkup by the THSteps medical checkup provider**.**

The THSteps medical checkup for infants and children requires (when specified) laboratory testing for newborn screening conditions PKU, GALT, CH, CAH, Sickle Cell Disease. Screening for hemoglobin type includes screening for total hemoglobin, total cholesterol, lipid profile, glucose, and lead. Screening will expand to 27 disorders in early 2007.

Texas law requires newborns to be screened for PKU, other heritable diseases, and hypothyroidism. More information is available in the module on newborn screening. (See Module 6). The first newborn test is completed at 24-48 hours of age and is the responsibility of the provider caring for the newborn. The second test at 7-14 days of age is the responsibility of the medical checkup provider at the baby's two-week medical checkup.

The THSteps medical checkup includes (when specified) the following laboratory tests:

- Total cholesterol /lipid profile/glucose
- Total hemoglobin
- Hemoglobin type
- Lead
- Gonorrhea/Chlamydia
- Syphilis
- HIV
- Pap Smear

Laboratory Testing

THSteps medical checkup providers must submit specimens, with the exception of Pap Screens, for required medical checkup laboratory screening **tests** (performed as part of a medical checkup for infants/children/adolescents/young adults) to:

Department of State Health services
Laboratory- THSteps
PO BOX 149163
Austin, Texas 78714-9803
1-888-963-7111

Exceptions:

Pap smears are submitted to the Cytology Laboratory at:

Women's Health Laboratories
2303 S.E. Military Dr. Bldg. 533, Suite #1
San Antonio, TX 78223-3597
1-888-440-5002

There is no charge to the provider or the Medicaid/THSteps client for laboratory screening procedures required as part of a THSteps medical checkup.

Newborn Screening Lab link: http://www.dshs.state.tx.us/lab/nbs_about.shtm

NOTES:
*Reimbursement for a THSteps medical checkup covers laboratory specimen collection.
*The new laboratory forms are available and must be completed in their entirety!

The DSHS laboratory mails test result reports to providers, including brief explanatory notes in approximately seven to 10 days following receipt of the specimen at the DSHS laboratory. The provider is contacted by telephone and letter, if there is a significant abnormality or as requested by the provider.

How do providers get laboratory supplies?

The DSHS Austin Laboratory or the Women's Health Laboratory (for pap smears) provides the following supplies free of charge to enrolled THSteps medical checkup providers to be used for THSteps clients:

- Newborn screen collection forms, envelopes, and provider address labels
- Venipuncture vacuum tubes
- Fingerstick collectors
- Needles, needle holders, lancets (but not for newborn screening testing)
- Gen-Probe collectors
- Mailing/shipping containers with pre-paid postage labels
- Newborn screen specimen collection wall chart
- Newborn screen collection procedures – video (loan)
- THSteps whole blood collection procedures – video (loan)
- Lab link for supplies:
  http://www.dshs.state.tx.us/lab/MRS_forms.shtm#supplies

Note: Refer to the *Texas Medicaid Provider Procedure Manual-Texas Health Steps* for detailed information on laboratory processes and procedures.

NOTES:
* All specimens collected during the medical check-up must be sent, in DSHS approved tubes, to the DSHS Laboratory located in Austin, Texas, to perform all the laboratory testing on blood/serum specimens. There is no charge to the medical check-up provider. The DSHS laboratory furnishes providers with free laboratory or client collection supplies and postage paid mailing containers (see Module 4 - Laboratory Testing). The only exception is for pap smears which are sent to the Cytology Laboratory in San Antonio.

Module 5 – THSteps Dental Checkups and Treatment Services

Objective

The information covered in this module is a review of the following:

- Dental services
- Dental Periodicity
- Exceptions to periodicity for dental services
- Provider participation
- Documentation requirements
- Client eligibility
- Client rights
- Parental accompaniment
- Informed consent/standards of care
- Complaints

Why is an understanding of dental services important to those providing medical services?

THSteps is a comprehensive program addressing medical, dental and case management needs. The medical checkup includes an oral health evaluation and referrals to THSteps dentists as appropriate. An understanding of the covered benefits of THSteps dental services is important to anyone providing THSteps services.

What dental services are available under THSteps?

THSteps dental checkup and treatment services include:

Preventive services

- Dental examinations (initial, periodic, or problem)
- Cleaning (prophylaxis)
- Instruction in proper oral hygiene
- Application of topical fluoride
- Application of sealants to teeth at risk of dental decay
- Maintenance of space

Treatment services

- Restorations (fillings, crowns)
- Endodontic treatment (pulp therapy, root canals)
- Periodontic treatment (gum disease)
- Prosthodontic (full or partial dentures, fixed bridge work)
- Implants
- Oral surgery (extractions and other procedures)
- Orthodontia (braces) if medically necessary (requires prior authorization)
- Maxillofacial prosthetics

Emergency /Trauma related services

- Procedures necessary to control bleeding, relieve pain, and eliminate acute infection
- Operative procedures required to prevent imminent loss of teeth
- Treatment of injuries to the teeth or supporting structures

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When do THSteps clients receive dental services?

THSteps clients begin to receive periodic dental checkups and preventive services beginning at age 1 and every 6 months thereafter, following the last date of such service. THSteps clients are eligible for emergency services and medically necessary treatment services from birth through age 20.

Exceptions to Periodicity

Payment is made for dental checkups that are exceptions to the dental checkup periodicity (every six months) schedule to allow for the following:

- A dental checkup is medically necessary based on risk factors and health needs (this includes clients under age one).
- A dental checkup is required to meet federal or state exam/checkup requirements for Head Start, day care, foster care, or pre-adoption.
- The client changes their dental service provider.

What are the requirements to be a THSteps dental provider?

To participate in Medicaid/THSteps, a dentist must:

- Be currently licensed by the Texas State Board of Dental Examiners (TSBDE).

- Complete the required THSteps Dental Provider enrollment forms through TMHP for the Medicaid Program.

Documentation

Dental providers must maintain appropriate client records/ documentation to support medical necessity for services for at least 5 years from the date of service.

NOTE: For more information refer to the THSteps Dental Program, Section 20 in the *Texas Medicaid Provider Procedures Manual.*

Who is eligible for THSteps Dental Services?

An individual must meet the following criteria at the time that any dental services are requested and delivered:

- Be a current Medicaid client
- Be THSteps eligible and under 21 years of age

NOTE: Form 3087 (Medicaid Identification Form) indicates the eligibility status of the client for Medicaid/THSteps services through a specific date (printed on the form), usually the last day of the month in which the form is issued. Form 3087 also reminds the client if they are due for a periodic dental checkup that month. If a client does not receive their dental checkup in the month of the due date (for whatever reason), they are still entitled to receive a dental checkup in the following months, as well as other needed dental treatment services. The absence of a reminder of a periodic dental checkup on the Form 3087 for a particular month does not preclude the client from receiving other needed dental services. An emergency Medicaid form is also valid for the delivery of dental checkup and treatment services.

If a periodic dental checkup has been conducted in a given six-month period, this does not preclude the client from receiving a second dental checkup. (See above section on "Exceptions to Periodicity".)

A provider's first priority is to determine whether the individual patient is a current Medicaid/THSteps client on the day dental services are to be provided. If the client's Medicaid Identification (Form 3087) does not show a reminder that the client is periodically due for a dental checkup, but the client is requesting one, the provider should determine whether they provided a dental checkup during that current six-month period. If the provider has already performed a dental checkup, the provider will not be reimbursed for a second one, however, other covered needed dental services may be provided and reimbursed.

Parental Accompaniment

As a condition for provider reimbursement, a child younger than 15 years of age must be accompanied by the parent, guardian, or other authorized adult at all dental visits. Exceptions are school health clinics, Head Start programs, and childcare facilities if the clinic, program, or facility encourages parental involvement and obtains written consent for the services. The consent from the child's parent or guardian must have been received within the one-year period prior to the date services are provided and must not have been revoked.

Informed Consent/Standards of Care

Only THSteps clients or their parents or legal guardians may give written informed consent for dental services. THSteps clients or their parents or legal guardians, who can give written informed consent, must receive the following information after an oral examination:

- Dental diagnosis
- Scope of proposed treatment (including alternatives/risks)
- Need for administration of sedation or anesthesia (including risks)
- Full explanation of the treatment plan

NOTE: Parental or guardian accompaniment of the client to the dental visit facilitates the provider obtaining written informed consent.

Complaints

Complaints from any source regarding dental services received by the THSteps Dental staff are reviewed and referred, if necessary, to the appropriate entities for investigation/disposition, i.e., Texas State Board of Dental Examiners, Office of Inspector General at the Health and Human Services Commission, provider relations staff at TMHP, and the THSteps regional staff. Texas Access Alliance (TAA) receives complaints through a toll free line (1-877-847-8377) and forwards appropriate complaints to HHSC and THSteps staff to address.

The complainant is notified in writing that their complaint has been received and is being investigated (when appropriate). Complaints received at THSteps are documented and tracked to monitor frequency, volume, and trends.

Module 6 – Newborn Screening Program

Objectives

The information covered in this module explains the Newborn Screening Program:

- Newborn Screening Statutes
- Goals/Achieving Goals
- Program Description
- NBS Follow-Up/Case Management
- Information and Education
- Current Estimates for NBS

Newborn Screening Statutes

Chapter 33 of the Health and Safety Code and TAC Rules 37.51-37.67 detail the NBS program.

House Bill 790, 79th Legislative Session required the Department of State Health Services to expand the Newborn Screening (NBS) Program. An additional 20 disorders will be screened for in addition to the current 7 disorders for a total of 27 disorders. This expanded panel is recommended by the American College of Medical Genetics (ACMG).

NBS Program Goals

The goals of the Texas Newborn Screening Program are to ensure that:

- each baby born in Texas receives two newborn screening tests, the first before leaving the hospital (24-48 hours after birth) and the second at one to two weeks of age;
- all infants with an abnormal screen receive prompt and appropriate confirmatory testing; and
- all individuals diagnosed with newborn screening conditions are maintained on appropriate medical therapy.

Achieving these goals requires coordinated efforts from three groups:

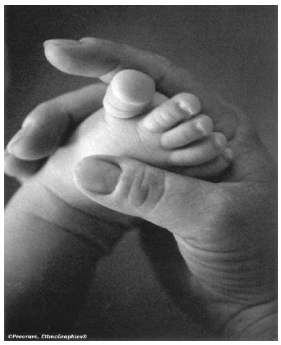
Healthcare providers are responsible for: the collection of, handling and labeling of both the first and second screening specimens; the prompt follow-up testing if indicated by screening results; the medical care; and the provision of parent education, support and referral to specialty care when needed.

The Texas Department of State Health Services (DSHS) Laboratory is responsible for specimen analysis, record keeping, quality control of laboratory methods and notification of results to practitioners and case managers.

The NBS follow-up team tracks abnormal screens and diagnosed cases, assists in the assurance of appropriate medical care, serves as a source of information for practitioners, parents and the public about the newborn screening disorders and maintains registries of diagnosed cases.

Current Screening Panel

The current Newborn Screening panel is:



- CAH
- PKU
- Galactosemia
- Hypothyroid
- Sickle Cell Disease
  - Sickle Cell Anemia
  - Hemoglobin SC Disease
  - Sickle Beta Thalassemia

Additional Disorders

The additional disorders to be screened effective early 2007 are:

- (5) Amino acidopathies
- (5) Fatty Acid oxidation disorders
- (9) Organic Acid disorders
- Biotinidase Deficiency

Newborn Screening Lab link: http://www.dshs.state.tx.us/lab/nbs_about.shtm

Lab link for supplies: http://www.dshs.state.tx.us/lab/MRS_forms.shtm#supplies

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What does NBS Follow-up/Case Management do?

- Track babies with abnormal screens and ensure further testing is performed.
- Ensure confirmed cases receive medical care if necessary.
- Ensure ongoing communication with sub-specialists regarding protocols, literature and cutoffs.
- Serve as a source of information/education for clinicians, parents and the public about the newborn screening disorders.
- Provide formula for newly diagnosed babies for certain disorders.
- Provide formula on an ongoing basis depending on eligibility and available funding for children diagnosed.
- Coordinate with CSHCN and DSHS Case Management when necessary.

Is there more Information and Education available?

- Brochures with general and disorder specific information are available through the NBS website.
- Literature and materials will be available to reflect the expansion of the Newborn Screening program.
- Regular newsletter is sent to submitters.
- NBS Educator will be doing on-site training for provider on newborn screening.
- Training module, slide show and further information will be available online at: www.dshs.state.tx.us/newborn/default.shtm .
- Online CEU's will be available for providers regarding the NBS program and expansion of the screening panel.

Current NBS

Births in Texas	385,000
Specimens DSHS Laboratory will process	750,000
Abnormal screens NBS Case Management will follow up	12,000
Diagnosed cases	400

Important Points

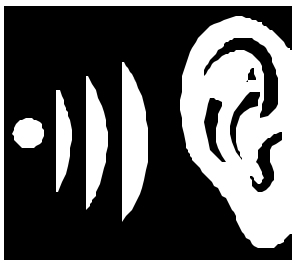
- 1st Screen on all babies at 24 – 48 hours
- 2nd screen on all babies at 1-2 weeks
- Mail to DSHS within 24 hours of collection
- Six day work week – DSHS NBS staff will process panic results on Saturdays
- Prior authorization may be needed for confirmatory testing

Module 7 – Hearing Services/Program for Amplification for Children of Texas (PACT)

Objectives

The information covered in this module explains the Texas Early Hearing Detection and Intervention (TEHDI) program and the Program for Amplification for Children of Texas (PACT). Department of State Health Services administers both programs:

- Background
- Service providers
- Eligibility for services
- Covered services
- Non-Covered services
- Access to services



Background

The Department of State Health Services (DSHS) administers both the TEHDI program and PACT.

TEHDI Background

The newborn hearing screening law became effective September 1, 1999, and was implemented across two years. Birth facilities located in counties with a population of more than 50,000 residents, and birthing centers with 100 or more births per year must offer a newborn hearing screen to all newborns before the newborn is discharged.

What are TEHDI covered services?

- The hearing screen is a covered service of Texas Medicaid, and is performed at the birth facility.
- Any necessary diagnostic follow-up care related to the newborn hearing screening test provided to a newborn who is Medicaid eligible is a covered service of Texas Medicaid.
- Hearing aids needed for newborns are provided through the Program for Amplification for Children of Texas (PACT). (see following)

TEHDI Referrals

Newborns identified with hearing loss or deafness must be referred to the Early Childhood Intervention (ECI) program at the Department of Assistive and Rehabilitative Services (DARS) for service coordination/intervention services. Their toll free number for referral is 1-800-250-2246.

PACT Background

PACT has been in existence since the 1960s and serves children/youth from birth through 20 years of age who have permanent hearing loss are enrolled in Medicaid or the Children With Special Health Care Needs (CSHCN) Program. The Texas Department of State Health Services (DSHS) administers PACT.

NOTE: Hearing brochures and posters can be downloaded from the website: www.thstepsproducts.com .

Who may be PACT Service Providers?

Only providers that have contracts with PACT may be reimbursed for PACT services. A list of PACT providers is available at:

www.dshs.state.tx.us/audio/pactpro.shtm

The list represents approximately 130 sites across Texas and can be used for making referrals to PACT providers who will generate the paperwork needed for approval of PACT services for eligible hearing-impaired children/youth.

Note: Individuals served by PACT must have the use of their hearing aid approved by a physician who is an Otologist or Otolaryngologist.

Who may be eligible for PACT services?

To receive PACT hearing services, children/youth must meet the following eligibility criteria:

- Be enrolled in Medicaid or the CSHCN Program
- Be between the ages of birth through 20 years

- Have permanent hearing loss or a suspicion of permanent hearing loss or a hearing loss that makes a hearing aid medically necessary
- Complete the application and approval process for PACT services
- Be accepted into the program prior to receiving services

What services are covered by PACT?

PACT hearing services include:

- Evaluation by an audiologist
- Evaluation by an otologist
- Hearing aid evaluation (to determine the correct hearing aid for the client's needs)
- Hearing aids
- Ear molds to use with issued hearing aids
- Hearing-aid counseling with the client and family
- Follow-up evaluation of the hearing aid's appropriateness
- Ear mold replacement
- Hearing aid repairs

In Note: Hearing aids are ordered directly from the manufacturer on contract with PACT, as requested by PACT providers for children/youth who have qualified for services.

What services are not covered by PACT?

PACT services that are not covered:

- Routine medical procedures
- Hearing screening
- Hearing evaluations for individuals with middle ear problems
- Surgical procedures such as tubes, cochlear implants and bone anchored implants
- Services provided by non-PACT providers
- Any unauthorized PACT service

Note: Refer to the *Texas Medicaid Provider Procedures Manual* for more information on PACT services.

Note: If a hearing service is not offered by PACT, but is medically necessary, it is covered under the Texas Medicaid Program.

How does a client access PACT Services?

To receive PACT services, clients must:

- Complete a PACT application and send it through a PACT provider
- Receive written approval for PACT services from DSHS
- Schedule an appointment with a PACT provider for services

Note: DSHS receives between 1200 and 1500 PACT service requests each month. Families and providers are notified by mail as to their approval or denial for PACT services.

Other Medicaid hearing services include cochlear implants, testing and diagnosis not related to permanent hearing loss, etc.

Module 8– Vision Services

Objective

This module provides information about the following:

- Vision screen
- Vision benefits
- Vision providers
- Training

What is a THSteps Vision Screen?

THSteps clients (ages 0 through 20 years of age) receive a vision screen as part of a THSteps medical check-up. The type of screening is based on the client's age, and ability to cooperate. The medical check-up provider who identifies screening abnormalities should refer the child/youth for diagnosis and treatment by a specialist.

What Vision Benefits are available to children?

THSteps/Medicaid Services provide diagnosis and treatment for vision problems, including eyeglasses for defects in vision. The following eye examination and eyewear services are available for THSteps clients:

- One eye examination with refraction per state fiscal year (September 1 – August 31) for the purpose of obtaining eyewear.
  - **Exception**: The yearly eye exam limitation can be exceeded when the school nurse, teacher, or parent requests an exam or if the exam is medically necessary.
- Eyeglasses every two years, with no limit on the number of replacements for eyeglasses/contact lens that are lost or destroyed.
  - **Exception**: The eyeglass limitation can be exceeded whenever there is a diopter change of 0.5 or more.

Note: Eyewear must be medically necessary and prescribed by a doctor of medicine (M.D.), doctor of optometry (O.D.), or doctor of osteopathy (D.O.).

Who provides Vision services?

The following are providers of vision services:

- Doctors of Optometry
- Doctors of Osteopathy
- Doctors of Medicine
- Opticians

NOTE: Vision care providers must enroll with each STAR and STAR+PLUS Health Plan to be reimbursed for services provided to STAR and STAR+PLUS members

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What training is available on Vision services?

- DSHS Vision and Hearing Screening Program provides training workshops to certify vision screeners.
- DSHS Vision Department staff or department-approved instructors of screening shall issue a certificate to individuals who successfully complete the department's vision screening course.

What are the vision screening requirements?

- Screening for vision shall be performed by a licensed professional, or an individual trained to conduct vision screening that is certified by the DSHS Vision Department.
- Individuals who have completed high school and who have successfully completed the department's vision or hearing screening course are eligible to be certified as screeners.
- Certified screeners may screen children for vision problem for a period of five years.
- A vision screener shall test distance acuity for both eyes with one of the following charts or a telebinocular instrument with a distance acuity test capability:
  - Sloan Letter Chart
  - Snellen Letter Chart
  - Snellen "Tumbling E" Chart
  - HOTV Crowded Test Set
- A vision screener shall refer for professional examination all children less than five years of age whose test results indicate visual acuity of less than 20/40 in either eye or a difference of two or more lines between passing acuities in either eye.
- A vision screener shall refer for professional examination all children five years of age or older whose test results indicate less than 20/30 acuity in either eye.

Module 9- Outreach and Informing

Objectives

The information covered in this module explains:

- Purpose of THSteps client outreach and informing
- Outreach and informing methods

Who provides THSteps Outreach and Informing Services?

Informing clients about the THSteps program, benefits and services is a partnership with many participants. These partners include but are not limited to:

- Texas Access Alliance (TAA) – under contract with HHSC TAA maintains an Austin-based call center to handle recipients needs, maintains field staff to conduct regional based outreach activities, mail all brochures and publications related to THSteps and conducts community-based activities.
- State Agencies
  - HHSC – Office of Eligibility Services
  - DSHS – THSteps Program Staff
  - DFPS - Foster Children/Children leaving conservatorship
- Community Based Organizations
- Providers
- Managed Care Organizations

What is the purpose of THSteps outreach/informing?

The purpose of THSteps outreach /informing is to:

- Seek out THSteps clients (or their families) to provide information about program services and benefits, by using informing methods designed to describe:
  - Available services under the THSteps Program
  - Benefits of preventive medical and dental health services and case management
  - Where services are available
  - How to obtain services
  - Availability of necessary transportation and scheduling assistance
  - Availability of services and benefits (to the client)
  - How to locate providers

What methods are used to convey information about THSteps benefits and services?

Following are some methods that are currently in use by this partnership to provide client-based outreach/informing:

- Face-to-face informing by Texas Health and Human Services Commission (HHSC) Office of Eligibility services for those clients who apply in person.
- Face-to-face and telephone "Health Care Orientations" performed by community-based organizations and THSteps contracted staff.
- Home visits upon request of the client or family or targeting specific populations.
- Distribution of written materials (e.g., letters and brochures explaining the program, encouraging participation, and offering assistance with scheduling and transportation) by HHSC, THSteps staff and Managed Care Organizations.
- Medical and dental check-up periodic due dates printed on the client's monthly Medicaid Identification Form (Medicaid Identification Form 3087).
- THSteps program information "stuffers" mailed with the client's monthly MED ID form.
- Letters to clients indicating:
  - When a medical or dental check-up is due
  - When a medical or dental check-up is overdue
- Oral presentations by THSteps staff at WIC centers, health fairs, housing projects, food pantries, schools, summer food programs, migrant family meetings, public clinics, social services agencies, and other miscellaneous locations frequented by client families. Written THSteps materials are also distributed on both a routine and ad-hoc basis.
- Other types of outreach/informing performed by:
  - Texas Education Agency Education Service Centers during contact with THSteps farm worker families.
  - Head Start grantees, during contact with parents of THSteps children enrolled in Head Start.
  - Texas Department of Family and Protective Services, during parenting classes for foster parents and families (before clients are reunited with their families).
  - Targeted outreach/informing initiatives conducted by THSteps staff to high-risk client groups, e.g., children of migrant farm workers, teens, pregnant women, and families with babies.

How do clients know where to get a THSteps check up?

- THSteps maintains a list of medical, dental, and case management providers that are used during THSteps outreach and informing encounters.
- THSteps compiled lists are used to inform clients about where they can get services in their area.
- Clients use this information to schedule appointments
- The THSteps lists are updated routinely using information from TMHP or from the provider via THSteps regional provider relations staff.

Important: It is important for providers to notify TMHP of changes in their contact information!

Module 10 – Case Management for Children and Pregnant Women (CPW)

Objectives

This module contains information on the following topics:

- What is Case Management for Children and Women (CPW)?
- CPW provider qualifications
- CPW client eligibility
- Basic components of CPW service provision and documentation
- THSteps Outreach and Informing Special Services Unit (SSU)
- Coordination with client's managed care organization (MCO).

What is Case Management for Children and Pregnant Women (CPW)?

Case Management for Children and Pregnant Women (CPW) provides services to children with a health condition/health risk, from birth through 20 years of age and to high-risk pregnant women of all ages, in order to encourage the use of cost-effective health and health-related care. Together, the case manager and family shall assess the medical, social, educational and other medically necessary service needs of the eligible recipient.

Case management assists with gaining access to:

- Appropriate health care
- Help for family concerns
- School/education
- Transportation
- Community referrals
- Appointments for client
- Durable medical equipment and supplies

Case management is NOT:

- A referral service
- A gatekeeper service
- A service to provide medical care

Successful case managers:

- Provide family centered services
- Provide comprehensive services
- Provide community based services
- Use a multidisciplinary approach
- Provide culturally competent services

- Ensure client confidentiality

Family centered services:

- Recognize family is a constant in the client's life
- Recognize and build on family strengths
- Facilitate collaboration with parents, family members, and professionals
- Honor diversity
- Respect a family's right to refuse services

Community based services:

- Focus on services near client's home
- Require case managers learn about communities where their clients live
- Use services outside the community only as a last resort or if it is the client's choice

Comprehensive services:

- Identify needs and resources in all aspects of the life of the client/ family
- Identify potential barriers to services
- Problem solve with client/family to remove barriers to accessing services

Multidisciplinary services:

- Team approach to meeting needs
- Collaboration among all service providers
- Strong collateral contacts
- Utilize referrals and other resources

Service coordination, referrals, and resources:

- Case managers must have knowledge of resources
- Case managers must ensure that choice of referrals/resources is provided
- Referrals must appropriately address the needs
- Document choices provided and referrals made
- Coordinate care with MCO when appropriate

What qualifications must a CPW Provider have?

CPW case managers must be:

- A registered nurse (with a diploma, an associate's, bachelor's or advanced degree).
- A social worker (with bachelor's or advanced degree), licensed by their respective Texas licensure board and whose license is not temporary or provisional in nature.
- All case managers must have maintained their professional licenses as determined by their respective Texas examiner's boards.

Case managers must possess:

- Two years of cumulative paid full-time work experience in the past ten years; and/or
- Two years of supervised, full-time educational internship/practicum experience in the past ten years;
- Experience must include working with children, up to age 21, and/or pregnant women; and
- Experience must include assessing the psychosocial and health needs and making community referrals for these populations.

Who is eligible to receive CPW services?

A client is eligible for case management services if he or she is:

- A child, birth through age 20, with a health condition/health risk or high-risk pregnant woman;
- Medicaid eligible in Texas;
- In need of services to prevent illness(es) or medical condition(s), to maintain function or slow further deterioration; and
- Desires case management and provides consent.

Establishing the need for CPW services:

- A person without an individual need is not eligible for CPW services
- CPW need must be related to health or high risk condition and, if not met, would lead to deterioration of the condition
- Documentation in the client record must support this need

Providers will serve all clients referred who meet the criteria listed:

- Services cannot be denied based on race, color, sex, religion, national origin, language preference, sexual orientation, and type or extent of high risk or disabling condition.

What are the components of CPW Service Provision and documentation?

The basic components of CPW service provision and documentation are:

Intake and enrollment

- Prior authorization request
- All CPW service contacts must be prior authorized. Prior authorization is not guarantee of payment.

Comprehensive visit

- Family needs assessment (FNA)
- Initial service plan (ISP)

Follow up contacts

- Face-to-face
- Telephone

Collateral contacts

- Not billable
- Request for additional services
- Case transfer/closure

Who can make a referral for CPW services?

Referrals for CPW services may be made by individuals and/or public or private agencies:

- Physician referral
- Dentist referral
- Other agency referral - e.g., the Department of Family & Protective Services, community agencies, or schools
- Self-referral by the client or other family members
- Outreach/Informing - Texas Access Alliance (TAA) Special Services Unit (SSU)
- Referrals from managed care organizations (MCOs)

SSU Outreach and Informing

The outreach and informing activities the Special Services Unit (SSU) performs for the CPW program include:

- Refers callers to CPW providers in the caller's area by:
  - Three-way call with CPW provider, potential client, and SSU staff
  - Mailing list of CPW providers in the area
  - Providing the list of CPW providers by phone
- Does not determine eligibility for CPW services
- Does not locate clients for missed appointments but does verify address and phone number

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Coordination with Client's MCO/HMO

MCOs/HMOs **do not provide** CPW services. However, MCO/HMO coordination with the CPW program includes that the MCO/HMO:

- Educate HMO members and HMO providers about the services available through CPW as described on the program's website http://www.dshs.state.tx.us/caseman/default.shtm.
- Coordinate services with CPW regarding a Member's health care needs that are identified by CPW and referred to the MCO/HMO.
- Ensure that access to medically necessary health care needed by the Member is available within the standards established by HHSC for respective care.
- Refer MCO/HMO clients to the CPW program for CPW services.

CPW Service Providers

Approved private and public providers, as well as DSHS regional social work staff, provide CPW services to:

- Small agencies, health departments, home health agencies, hospitals, schools, individual providers.
- CPW provider applications are approved by regional and central office staff.
- After approval, CPW providers enroll with the Medicaid claims administrator at Texas Medicaid Health Partnership (TMHP).

Referring Clients

It is important that clients have a choice of providers:

To refer someone to the CPW program, please:

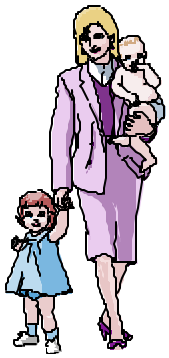
- Call the THSteps hotline at 877-THSteps/(877-847-8377), or
- Go to the CPW website for a list of CPW providers in your area: http://www.dshs.state.tx.us/caseman/default.shtm

Referral information includes:

- Name of child and parent/guardian
- Client's date of birth
- Client's Medicaid number (if available)
- Address and phone number of family
- Reason for referral
- Your contact information
- Indicate whether or not the referral is urgent in nature

Module 11-Department of Family Protective Services (DFPS)
Children's Protective Services (CPS)

Objectives



This module provides the following information about the Department of Family Protective Services (DFPS) and the Children's Protective Service (CPS):

- Background
- Recognizing the unique needs of CPS involved children
- State and federal requirements for medical and dental care
- Transition from Medicaid managed care to Fee for Service Medicaid for children who enter foster care
- Brief introduction to Medical Consent policies
- Eligible for all Medicaid services including CPW and medically necessary services

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Background

The Child Protective Services Division investigates reports of abuse and neglect of children. It also:

- provides services to children and families in their own homes;
- places children in substitute care;
- provides services to help youth in foster care make the transition to adulthood; and
- places children in adoptive homes.

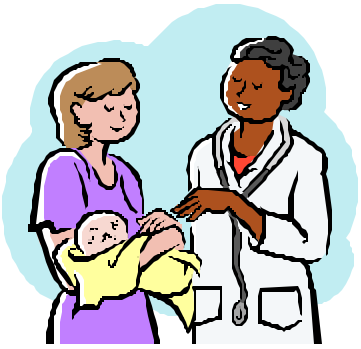
Recognizing the unique needs of CPS involved children

- Children served by CPS in their own homes:
    - Services are provided to families where there is continued risk of abuse or neglect.
    - Services to families are designed to prevent removal.
    - Health care and behavioral health care may be included in a family's agreed service plan for ameliorating abuse or neglect.
    - A family may be required by court order to participate in CPS services and to ensure children receive needed Medical or behavioral health care.
    - Almost 60% of all children served in their own homes are enrolled in Medicaid.
- Children in Substitute Care:

- Each month approximately 1,400 children enter foster care across the state.
- Age of children in foster care fiscal year 2005:

–	Birth through 2 years	21.8%
–	3 to 5 years	14.6%
–	6 to 9 years	17.1%
–	10 to 13 years	18.6%
–	14 to 17 years	26.1%
–	18 to 20 years	1.8%

What are the state and federal requirements for medical and dental care for children in foster care?



- Exams required for state or federal foster care requirements are referred to in the Texas Medicaid Healthcare Partnership Provider Manual as exceptions to periodicity. Foster care requirements are:
  - medical exam within 30 days after admission to foster care;
  - medical exam within 3 days for a child with primary medical needs;
  - immediate medical exam for a child who shows symptoms of abuse or illness;
  - annual well child check each year;
  - dental exam scheduled within 30 days of admission and dental exam within 90 days of admission; and
  - dental exam every 6 months.

Transition from Medicaid Managed Care to Fee for Service Medicaid for children who enter foster care

- Many children are enrolled in Medicaid at the time of they enter CPS conservatorship. Some challenges related to obtaining Medicaid covered services in time to meet the above requirements are:
  - Transition between Medicaid Managed Care and Fee for Service Medicaid usually takes 30 to 60 days.
  - During this time the Medicaid Managed Care plan is responsible for the health care of the child.
  - If the child is placed outside the area covered by the Managed Care Plan, out of network care may be necessary.
  - The Medicaid status is not always immediately known to the CPS caseworker removing the child.

Brief introduction to DFPS medical consent policies

- Medical consent policies, established by the 79th Legislature, require that each child in foster care have an individual authorized to consent for medical care. The court may authorize an individual or DFPS to be the medical consenter.
  - Individuals authorized by the court will be named in a court order. If the court authorizes DFPS, the agency will designate a medical consenter and back-up medical consenter.
  - Medical consenters and back up medical consenters are issued form 2085 B if they are non-DFPS employees and 2085 C if they are DFPS employees.
  - Medical consenters may participate in THSteps exams by giving written permission for the residential provider or another person to take the child for the appointment unless the health care provider requires the medical consenter's participation in person or by phone.
  - The medical consenter or backup medical consenter provides this authorization by issuing form 2085 D to the person taking the child to the appointment.

Children in foster care are eligible for all Medicaid services including CPW and Medically Necessary Services.

- All children in the managing conservatorship of DFPS are eligible for Medicaid.
- Children in substitute care may be placed in foster care, kinship care, or pre-adoptive placements.

Module 12-Medically Necessary Services: Comprehensive Care Program (CCP)

Objectives

This module provides the following information about medically necessary services that are provided for Texas Health Steps (THSteps) clients:

- Background
- Client Eligibility
- Benefits
- Service limitations
- Provider eligibility

Background

The Omnibus Budget Reconciliation Act of 1989 expanded EPSDT/THSteps program benefits to include payment for any federally allowable Medicaid service, which is medically necessary to treat or ameliorate a defect, physical, or mental illness, or a condition identified by a THSteps medical check up.

Section 1902 (a)(30)(A) of the Social Security Act requires a State Plan (for Medical Assistance {Medicaid}) to provide methods and procedures relating to the utilization of, and payment for, care and services available under the plan as may be necessary to safeguard against unnecessary utilization of care and services (and to assure that payments are consistent with efficiency, economy, and quality of care). Texas employs a system of prior approval for certain medically necessary services to safeguard against unnecessary utilization of care and services. The goal of prior authorization is to assure that the care and services proposed to be provided are actually needed and/or medically necessary, that all equally effective, less expensive alternatives have been given consideration, and that the proposed service and materials conform to commonly accepted standards.

Client Eligibility

- Individuals receiving medically necessary services must be Medicaid/THSteps clients (aged 0 through age 20) at the time of the service request and service delivery
- If a Medicaid Identification (Form H 3087) states “Emergency Care” only, Presumptive (PE), or Qualified Medicare Beneficiary (QMB), the client is ineligible for THSteps – medically necessary services.

- All THSteps clients are ineligible for medically necessary services beginning the day of their 21st birthday.

Benefits

Some medically necessary services benefits include, but are not limited to:

- Durable medical equipment (such as manual and power wheelchairs, lifts, hospital beds)
- Medical supplies (such as glucose monitors, diabetic strips, syringes, bandages, nebulae's, apnea monitors, incontinency supplies, and certain special medical formulas)
- Private duty nursing services
- Counseling services provided by a licensed professional counselor, or licensed master of social work-advanced clinical practitioner (counseling services provided by a psychiatrist or psychologist are covered under the traditional Medicaid program)
- Nutritional counseling services provided by a licensed dietitian
- Speech therapy, occupational therapy, and physical therapy
- Orthotics (braces)
- Prosthetics (artificial limbs or eyes)
- Vision
- Hearing (medically necessary needs not covered by PACT)
- Inpatient psychiatric services (in a freestanding psychiatric facility-JCAHO accredited)
- Inpatient rehabilitation services (in a freestanding rehabilitation facility)
- Extended hospitalization

NOTE: Requirements for obtaining specific medically necessary services and supplies can be found in the THSteps section of the *Texas Medicaid Provider Procedures Manual.* Authorization procedures and approved providers may differ for clients enrolled in managed care. Prior authorization is sometimes required. Contact the client's specific plan for details.

Service Limitations

Some services, such as those listed below are not covered medically necessary services:

- Vehicle modification, mechanical and/or structural (e.g., wheelchair lifts)
- Structural changes to homes, domiciles, or other living arrangements

- Environmental equipment, supplies and services
- Ancillary power sources and other types of stand-by equipment
- Educational programs, supplies, and equipment
- Equine or hippo therapy
- Exercise equipment, home spas or gyms, toys, therapeutic balls, tennis shoes
- Respite care
- Aids for daily living
- Take home drugs from hospitals
- Therapy involving any breed of animal

Note: Attendant care will be covered on September 1, 2006.

NOTE: For questions and/or prior authorization of some medically necessary services, contact the CCP Unit by calling 1-800-846-7470.
Medicaid/THSteps clients and families may contact CCP Customer Service by calling 1-800-252-8263.

Provider Eligibility

Providers wishing to participate must:

- Meet the Health and Human Services Commission Medicaid participation standards to enroll in the program and receive reimbursement for medically necessary Medicaid services.
  Enroll with each STAR,STAR + PLUS, and PCCM Health Plan to be reimbursed for services provided to covered members.

NOTE: For more information on provider enrollment see the *Texas Medicaid Provider Procedures Manual.*

Module 13– Medical Transportation Program

Objectives

This module provides the following information about the Medicaid Medical Transportation Program (MTP):

- Background
- Program eligibility
- Description of services
- Requests for services
- Cancellations of service requests
- Transportation of minors
- Service exclusions
- Ambulance services

What is MTP?

The MTP is a program that is essential for Medicaid/THSteps clients who have no other means of transportation to and from providers of medical or dental health care services.

MTP arranges the most cost-effective mode of transportation to and from the medically necessary healthcare facility that can meet the client's medical needs, including dental services for clients younger than 21 years of age.

Who is eligible for MTP Services?

In order for an individual to receive MTP services, he/she must:

- Be a current Medicaid client or receive services through the Children with Special Health Care Needs (CSHCN) Program.
- Have no other means of transportation to obtain Medicaid covered services.

What are MTP services?

MTP regional staff assists Medicaid clients by arranging transportation and transportation related services that include:

- Transportation in a private vehicle driven by an Individual Driver Registrant (*IDR).
- Transportation through a mass transit provider (e.g., city bus, light-rail).
- Transportation by a commercial provider (e.g., van service, taxi, intra-city bus line, airline).

For certain Medicaid clients under 21 years of age, MTP services may also include:

- Stays at lodging facilities (e.g., contracted hotels, Ronald McDonald House) for the client and one attendant
- Meal expenses for the client and one attendant
- Travel advances (up-front funds)

NOTE: *IDRs are individuals who drive a client to a Medicaid medical/dental appointment. An IDR may be a family member, relative, friend, or a neighbor. IDRs are reimbursed for the mileage they incur while transporting a client. IDRs must have a current driver's license, vehicle registration, and automobile liability insurance. They must also sign an IDR agreement with the Texas Department of Transportation MTP. IDRs are reimbursed for mileage at the same rate state employees receive.

How does a client request services?

Medicaid clients can request services by calling the Medical Transportation Program at the toll-free telephone number (1-877-633-8747). To schedule transportation, a client should call:

- Weekdays between 8:00 a.m. and 5:00 p.m.
- For transportation services within a county or a county adjacent to the resident county, clients or their advocates should call the MTP office at least 2 business days before the scheduled appointment.
- For transportation services beyond the adjacent county, clients should call the MTP office at least 5 business days before the scheduled appointment.

- The following information must be provided to the intake operator at the time of the call:
  - Medicaid number, CSCHN number, or social security number
  - Name, address, and telephone number, if available
  - Name, address, and telephone number of the health care provider
  - Purpose of the trip
  - Affirmation that no other means of transportation are available
  - Special Needs, wheelchair lift, or attendant need

MTP regional staff tries to accommodate critical same-day service requests when a transportation contractor is available to provide the service.

Clients are not to call MTP contractors to request services.

Cancellation of Service Requests

When cancellation of scheduled transportation is necessary, the client should notify MTP regional staff as soon as possible, at least one workday in advance of the scheduled service.

Transportation of Minors

The following program policy applies to THSteps clients who are minors:

- Clients age 14 years or younger must travel with an adult, parent, or guardian.
- Clients ages 15 to 17 years can utilize MTP transportation services if:
  - Provide a consent form from a parent or guardian.
  - They themselves are parents of children.
  - They are seeking confidential family planning services and do not wish to inform their parents/guardians.

MTP Exclusions

MTP excludes transportation for:

- Clients in residential facilities, such as nursing homes, if the nursing home rate includes the cost of transportation
- Hospital in-patients
- Unaccompanied minors, age 13 years or younger
- Siblings of clients receiving the Medicaid services

- Deceased persons
- Emergency or non-emergency ambulance transportation (see below section on "Ambulance Services")
- Obtaining non-Medicaid covered services

Ambulance Services

If a client has a severe disability and the use of an ambulance is the only appropriate means of transport, the client should discuss this transportation need with their health care provider. The health care provider is responsible for requesting prior authorization for non-emergency ambulance service by:

- *Calling 1-800-925-9126 (toll free)
- *Faxing 512-514-4205

* Between 8:00 a.m. to 500 p.m., Monday through Friday, CST For emergency ambulance transportation services, clients should call an EMS service (911).

NOTE: For more information about emergency and non-emergency ambulance transports, see the *Texas Medicaid Provider Procedures Manual*.

Module 14-Alberto N Lawsuit

Objectives

- Origins of Lawsuit
- Mediation process and settlements
- DME and supplies changes
- Nursing Services and Private Duty Nursing
- Personal Care Services
- Additional changes
- Workgroup activities and progress
- PCS Implementation

What was the impact of the Alberto N. et al. vs. Albert Hawkins, et al. lawsuit on Medicaid Policy?

How did the Lawsuit originate?

- Federal lawsuit filed on August 9, 1999, in the United States District Court for the Eastern District of Texas, Tyler Division.
- Plaintiffs: Texas Medicaid-enrolled children with disabilities and chronic health conditions.
- (Representing roughly 2000 children statewide with conditions that require ongoing skilled care, special equipment, and/or physical therapy
- Allegation: claim to have been denied medically necessary in-home Medicaid services.
- Legal Basis: Title XIX of the Social Security Act, as amended by OBRA 89, requires state Medicaid programs to provide < 21clients all medically necessary services that *could* be provided under their state plans, whether or not they are provided to adults.
- Medicaid Programs at Issue:
  - THSteps – CCP (HHSC)
  - Medicaid Home Health Care Services (HHSC)
  - Primary Home Care (DADS)

What happened when the court ordered both parties into mediation?

- Court ordered the parties to enter into mediation in 2000.
- Parties agreed to divide mediation into two phases:
  - Phase 1- Addressed issues that parties considered circumscribed and amenable to specific solutions.
  - Phase 2- Addressed issues including access to and scope of services, medical necessity, and the role of parents in the health care of their children.

First Partial Settlement Agreement

- Phase 1 work concluded with the execution of the First Partial Settlement Agreement on April 19, 2002.
- Main elements of the First Agreement were:
  - THSteps-CCP eligible clients will receive all medically necessary services, whether or not they are a benefit for adults.
  - No predetermined limits on requested services with documentation of medical necessity.
  - A requested service may be reduced, denied or terminated only if it is not medically necessary or federal financial participation is not available.
- Clients will receive a notice of reduction, denial, or modification for the requested service.
- Prior authorization process will change to more effectively handle incomplete requests.
- Provide clients with fair hearing information.
- Install increased monitoring and verification.
- Implement ongoing reporting of approved, denied, or modified services for PDN, HHSN, DME and supplies, and OT/PT/ST

Second Partial Settlement Agreement

- Phase 2 work concluded with execution of Second Partial Settlement Agreement on June 23, 2005
- Agreement applies only Medicaid clients under the age of 21 who are eligible for EPSDT.
- Requires the State to provide all "medically necessary" PDN, PCS, and DME.
- Did not define "medical necessity," but relied on EPSDT statutory language that the service or DME item has to "correct or ameliorate" a physical or mental illness or condition.

Main Elements

- HHSC will authorize all medically necessary benefits for THSteps clients.
- Medically necessary benefits will not be denied or reduced based only on diagnosis, type of illness, condition or functional limitations.
- Once medical necessity is documented, nursing and personal cares services will be provided to meet a client's needs as they arise over 24-hour period.
- HHSC will move personal care services for <21 population from DADS to HHSC to provide an improved opportunity for a continuum of care. Effective date of change: 9/1/2006.
- HHSC will convene a workgroup to advise the agency on the development of:
  - new criteria for authorizing personal care services for <21 Medicaid clients; and,
  - a comprehensive assessment that will be used by providers to authorize nursing services and personal care services.

Immediate Impacts of Second Partial Settlement Agreement

- TMHP will cease using an "Internal Nurse Reviewer Tool" during prior authorization for PDN by 9/1/2005
- TMHP will begin using a revised nursing addendum, including a new 24-hour schedule, or "flow sheet." Flow sheet will track nursing services and take into account:
  - if tasks are skilled or unskilled;
  - time allotted for skilled tasks;
  - ability of parent/guardian to participate in care; and,
  - parent/guardian need to sleep, work, care for others

What changes in DME and supplies resulted?

- DME and supplies are medically necessary when required to correct or ameliorate disabilities, or physical and mental illnesses or conditions
- Published DME lists are not exhaustive. HHSC will not exclude any DME categories and providers can requests DME items that are not on lists.
- DME quantities will not be subjected to a cap.
- Provider must document medical necessity of requested DME

How did the Lawsuit affect Nursing Services?

- HHSC will authorize all medically necessary services through either home health skilled nursing or CCP private duty nursing.
- Requested nursing must correct or ameliorate a child's disability, physical and mental illness or condition.
- PA request must be complete, document medical necessity, and request services that meet definition of nursing in the Texas Nursing Practice Act.
- HHSC will not cap medically necessary nursing services for <21 EPSDT clients.

- When a client's needs have not decreased, HHSC will not deny or reduce the amount of nursing hours due to stable or unchanged health status.
- PDN services are authorized when the client requires more individual and continuous care than is available through home health skilled nursing.

How did the Lawsuit affect Private Duty Nursing?

- All requested, medically necessary PDN services will be based on a plan of care and will be authorized as required to meet client PDN needs over a 24-hour time span.
- If HHSC determines that requested PDN services are not medically necessary, the denial notice will have to explain basis for denial, the PA process, and the personal care service benefit.

How did the Lawsuit affect Personal Care Services?

- Second Partial Settlement Agreement defined personal care services as support services provided to THSteps/CCP –eligible children who require assistance with ADLs, IADLs, and health related functions due to physical, cognitive, or behavioral limitations related to their disability or chronic health condition.
- HHSC will convene a workgroup to advise on the development of new PCS policies and authorization procedures that will take into account the parent/guardian's need to sleep, work, attend school, care for other dependents, and ability to perform PCS.
- HHSC will authorize PCS based on a service plan that documents a client's need for PCS and addresses the continuous 24-hour span of time over which his/her PCS needs arise.

What additional changes were made due to the litigation?

- HHSC will add new statements to existing HHSN, PDN, and DME policies explaining the scope of the benefits.
- HHSC will review existing policies and publications to address development of a new delegated nursing benefit.
- HHSC required to provide training regarding the Settlement Agreement requirements to State and contractor staff, and providers.
- HHSC required to provide a random sample of nursing and DME reduction/denial letters, once per quarter.

What activities did the Workgroup complete?

- Convened workgroup in Fall 2005 to develop draft PA forms for PDN and PCS
- Re-convened workgroup in Winter 2006 to address rule development. Work suspended.

- Re-convened workgroup on March 9, 2006 to begin work on new comprehensive assessment, PCS benefit definition, and new prior authorization processes.

What is the progress on the Workgroup?

- CA Form developed & refined
- CA Form instructions
- Reviewed PDN policy for connections to PCS
- Moving into PCS policy discussion
- PCS PA process next topic
- Other topics: rate setting for new CA, provider infrastructure, etc

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PCS

Implementation

- PHC benefit for <21 Medicaid CCP-eligible clients will terminate at DADS with implementation of PCS under HHSC.
- PCS implementation moved to January 1, 2007 to allow PCS workgroup time to accomplish goals.
- HHSC, DADS, and TMHP are working together toward achieving operational goals of the transition: transfer of current PHC caseload and authorizations, new PCS PA process at TMHP, enrolling new PCS-only providers, new PCS claims payment system.

Module 15–Texas Health Steps Lawsuit

Objectives

This module provides information about the origin and status of the THSteps lawsuit:

- Background
- Litigation Case Summary
- Consent Decree and MCOs

Why an understanding of Frew vs. Hawkins is important to your organization?

In 1993 two major events in Texas health and human services history determined the future of Texas Medicaid. The administration of Medicaid was transferred from the Texas Department of Human Services to the Health and Human Services Commission in September 1, 1993. On the same day, a class action lawsuit was filed against the State of Texas alleging that Texas did not adequately provide Medicaid Early and Periodic Screening, Diagnosis and Treatment services. While the legal requirements are complex, at the core are opportunities for improving the health and well being of Texas children. As a provider of Medicaid services, you too are obligated to understand the ramifications of Frew, Et. Al. V. Hawkins, Et. Al.

What follows is intended to supplement the training of staff who are involved in any aspect of Medicaid services. It is designed to provide a brief overview of the major areas to be considered when making decisions that will impact Medicaid recipients who are under 21 years of age.

What is the lawsuit?

The class action lawsuit filed against the State of Texas by plaintiffs represented by Texas Rural Legal Aid on behalf of more than 1.5 million indigent children entitled to health benefits through EPSDT, is now commonly known as Frew V. Hawkins. Because the allegations of the case are wide-ranging, it is almost certain that they pertain to one or more of your responsibilities or activities in providing services under the Texas Medicaid Program.

The key allegations in Frew vs. Hawkins, et. al are:

- Medical and dental screenings (checkups) were not provided in accordance with recognized periodicity schedules.
- Texas did not meet the federal screening goals.

- Texas did not effectively inform recipients about the benefits of the program.
- Texas did not provide adequate case management services.
- The Medical Transportation Program failed to meet the needs of recipients.
- Program access was denied because of an inadequate supply of providers which is the result of inadequate reimbursement rates, red tape, and providers' lack of knowledge of the program.

Although the case was filed more than a decade ago, the State has not been successful in its arguments to the court that the Consent Decree is no longer valid or necessary. Therefore the State is still obligated to comply with the requirements outlined in the document.

Key events of the Litigation

1993 – class action lawsuit filed alleging State violated federal law with respect to its implementation of EPSDT (referred to as THSteps in Texas).

1996 – lengthy Consent Decree entered, purported to implement numerous changes to the THSteps program.

1998 – Plaintiffs filed motion to enforce Consent Decree, asserting that the State had failed to comply with several provisions of the Decree. Defendants denied allegations and challenged the Court's continuing jurisdiction to enforce the Decree.

2000 – Court rejected State's arguments, found violations of certain Consent Decree provisions, and ordered defendant's to submit a corrective action plan (CAP).

2002 – U. S. Court of Appeals (5th Circuit) reversed the district court's order based upon the defendant's arguments, but the Supreme Court reversed the Court of Appeals.

2004 – Upon the case returning to the district court, defendants filed a motion to vacate or modify the Consent Decree. Plaintiffs filed motions to require the defendants to propose a CAP designed to address compliance issues identified in the court's 2000 order. Plaintiffs filed additional motions for sanctions, attorney's fees, and extension of certain Decree provisions.

2005 – Court ordered defendants to propose a CAP; defendants filed a proposed CAP; and plaintiffs filed an alternative CAP.

Summer, 2005 – Court held 8-day hearing on the defendants' motion to vacate or modify the Consent Decree, but denied the motion and defendants appealed to the 5th Circuit.

2006 – Plaintiffs asked the court to rule on pending motions and the court set hearing regarding a CAP for summer. In response to defendants'motion, court stayed the proceedings regarding the CAP until the appeal proceedings in the 5th Circuit are completed.

What areas are covered by Frew vs. Hawkins?

Most aspects of THSteps services are impacted in some way by Frew vs. Hawkins. General areas addressed by the Consent Decree include:

- Outreach and Informing
  - Specific requirements for oral and written outreach
  - Prescription of outreach standards (for example, waits in queue and abandonment rates for call centers
- Medical and Dental Services
  - Qualifications to maintain an adequate provider pool
  - Medical and dental service provisions
  - Case management requirements
  - Services for special groups (ie. foster care, migrant workers, teenagers
- Transportation Services
  - Range of services to which recipients are entitled
  - Additional training requirements
  - Specification for toll-free transportation lines
  - Annual assessments required
- Training
  - Training requirements for provider groups
  - Special training requirements for groups requiring special training, for example:
    - Pharmacists
    - Outreach and eligibility staff
    - Call center workers
- Measuring Outcomes and Reporting Information

o Evaluations of program effectiveness
  - Medical and dental services
  - Training effectiveness
  - Data and completion of statewide reports and corrective action plans.

How does the Consent Decree specifically relate to Managed Care Organizations (MCOs)?

Because Medicaid managed care had already been introduced in Texas at the time of the lawsuit, several provisions in the Consent Decree specifically related to MCOs, including:

- managed care organizations will provide medical and dental checkups in a timely manner to enrolled recipients

- State will collect from managed care organizations the number and percent of recipients who receive all medical and dental checkups when due and information for outcomes research
- managed care organizations must provide checkups to newly enrolled recipients no later than 90 days after enrollment **except when recipients knowingly and voluntarily decline or refuse services**
- managed care organizations must have the capacity to accelerate services to the children of migrant farm workers to accommodate their special circumstances
- managed care organizations must cooperate with outreach units so recipients who miss medical checkups receive prompt services
- managed care organizations must arrange appropriate training for all health care providers and their staff who serve recipients, to include training on program requirements relevant to their responsibilities and the relevant terms of the Frew settlement
- recipients who receive services from managed care organizations are entitled to challenge decisions made by managed care programs by fair hearings and otherwise
- managed care organizations must have an adequate supply of appropriate providers, including specialists, who can serve recipients conveniently (e.g., avoiding scheduling and appointment delays, and limiting travel times)
- recipients must be able to enroll promptly with a new managed care organization, if it exists, when moving from one location in Texas to another
- managed care organizations will be subject to independent evaluation of recipients' heath outcomes, recipient satisfaction, and process measures, including the number and percent of recipients who receive all checkups when due.

What's on the horizon? What does the future hold?

The prospect remains that the State will be subject to the strictures of the Consent Decree for the foreseeable future. The Quarterly reports required by the Consent Decree, which address compliance with its provisions, and related necessary data gathering will continue. Despite defendants pending appeals, the prospect of a hearing on a Corrective Action Plan looms large, perhaps before the end of this year. The CAP is expected to address the findings that the court made in 2000.

Findings made by the court, which specifically related to managed care organizations, include:

- Defendants violated the Conse t Decree by failing to provide timely checkups to managed care enrollees and the failing of MCOs to have the capacity to serve migrant farm worker children (e.g., efforts to accommodate migrant farm workers, accelerate services; use assessment tools to identify migrant farm workers).

- Defendants failed to assure that MCOs arrange appropriate training for all health care providers and their staff that serves recipients (e.g., HMO staff is not properly advised about the scope of healthcare services they must provide to recipients; some HMO staff do not answer recipients questions but instead refer them to their PCP handbooks.
- Because defendants must analyze annual reports regarding the number and percent of recipients who receive their medical checkups when due, determine which counties lag behind the state average, and develop plans designed to improve participation rates in those lagging counties, the identified counties with corrective action plans may include those serviced by MCOs.
- Defendants failed to ensure accurate collection of information to report outcome measures data or number/percentage of class members in each managed care organization who receive medical checkups when due.

This overview is one way in, which we work to meet the training requirements of Frew vs. Hawkins, et. al. MCOs are a valuable partner in providing THSteps services, as such their familiarity and compliance with the lawsuit provisions is essential.