August 18, 2006

TEXAS HEALTH STEPS

Overview for MANAGED CARE ORGANIZATIONS

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

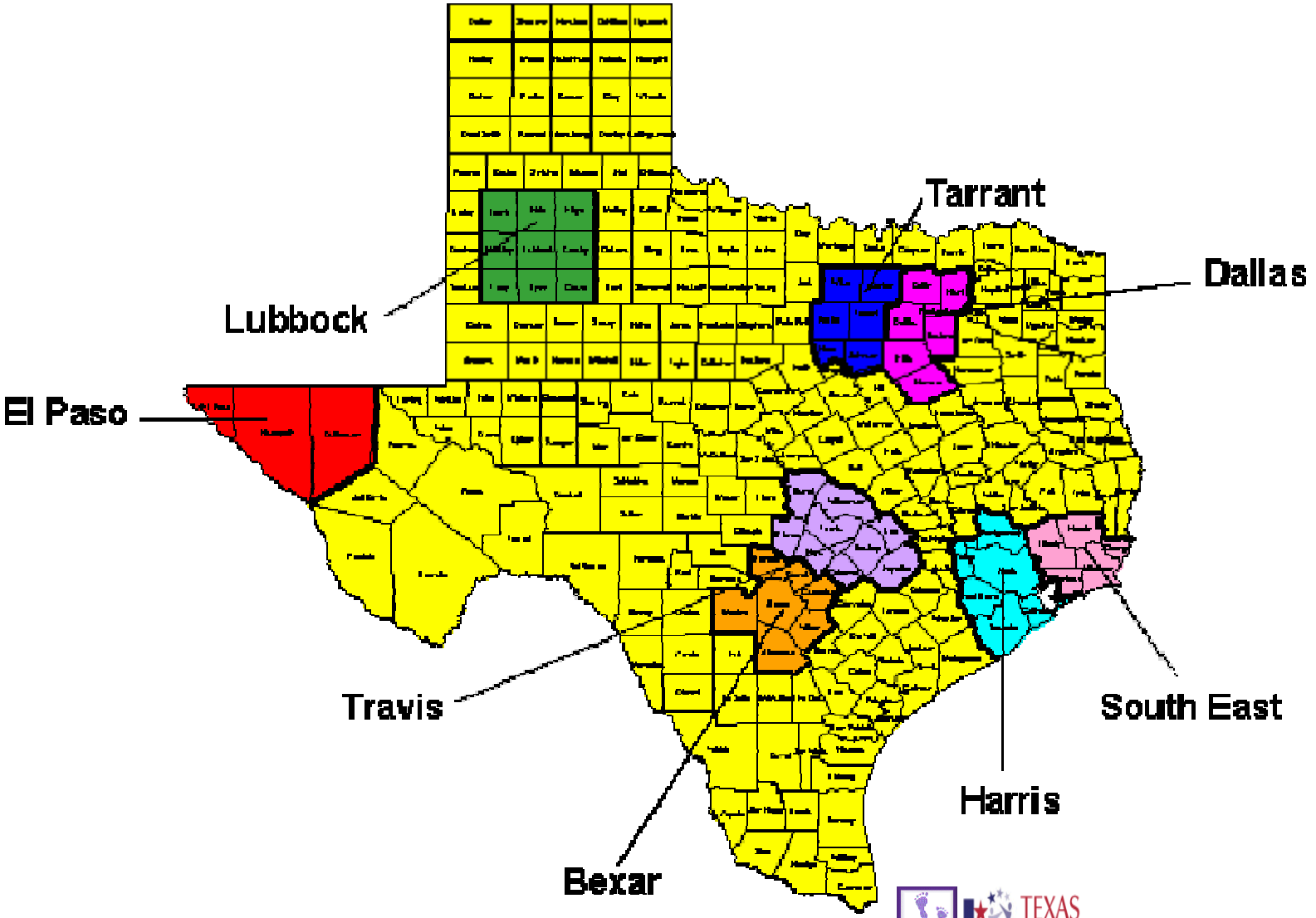
Providing leadership, direction, and innovation to achieve an efficient and effective health and human services system for Texans.

TEXAS Department of State Health Services

TEXAS Department of Family and Protective Services

Texas Medicaid Managed Care

Statewide Service Delivery Areas



August 18, 2006

Texas Health Steps

TEXAS Department of State Health Services

MODULE 1- THSteps Overview

Objectives-

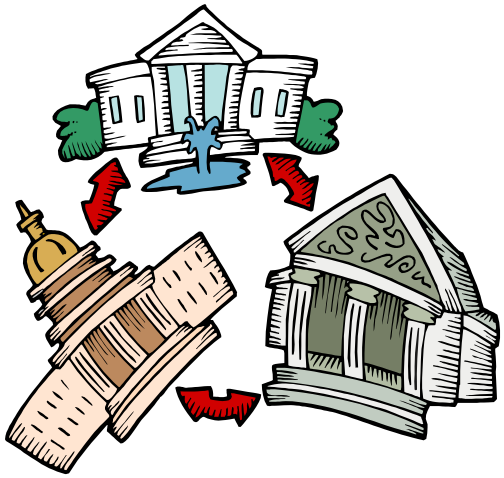
- THSteps Legislative Basis and funding
- THSteps administration
- THSteps goals
- Medical home
- Program services
- Medically necessary services
- Program eligibility
- Client notification of services
- Client access to services
- Confidentiality of records
- Client rights

THSTEPS is….

- A federally mandated health care program focusing on prevention, diagnosis and treatment.
  - Known in Texas as Texas Health Steps (THSteps).
  - Known nationally as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

Checkups and a Whole Lot More!

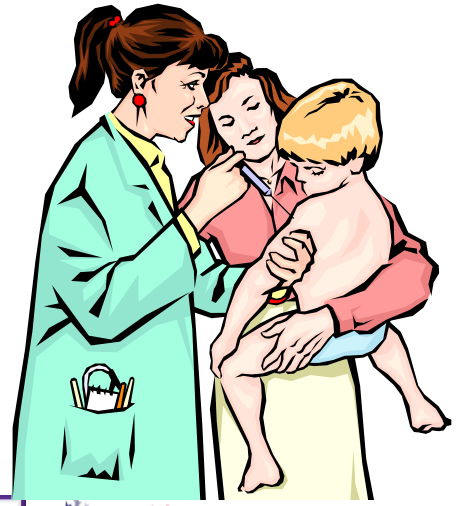
THSTEPS is....



- Jointly funded by state and federal funds
- Administered by HHSC/DSHS
- Serves children from birth through age 20.
- A true partnership

What are THSteps Program goals?

- Detect and treat medical and dental concerns for eligible Medicaid clients.
- Provide continuing preventive health care to infants, toddlers, children, adolescents, and young adults.



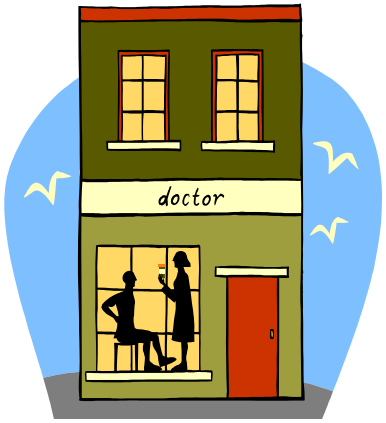
What are THSteps Program goals?

- Provide appropriate case management.
- Link clients with PCP to establish a Medical Home.
- Link clients with providers for preventive and on-going care.

How does THSteps help meet these goals?

- Expanding client awareness of available services
- Encourage increasing client use of preventive health services.
- Recruiting and retaining a qualified provider pool

What is a Medical Home?

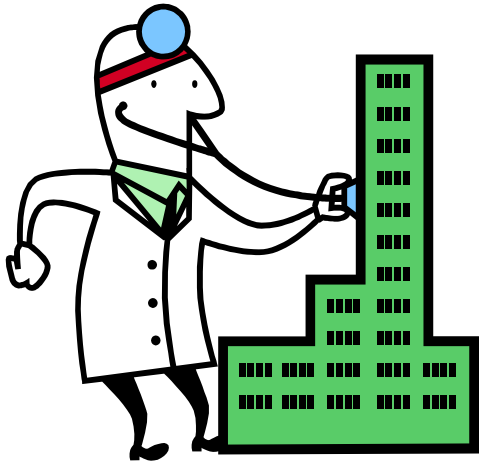


A Medical Home is a respectful partnership between a child, the child's family, and the child's primary health care setting. A Medical Home is **family centered** health and dental care that is accessible, continuous, comprehensive, coordinated, compassionate, and culturally competent. THSteps promotes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

How does someone use THSteps services?

- Apply for services
- Become eligible for services
- Receive Medicaid Identification Form 3087
- Receive outreach and informing from the THSteps Partnership
- Client chooses to access services and makes/keeps provider appointments.

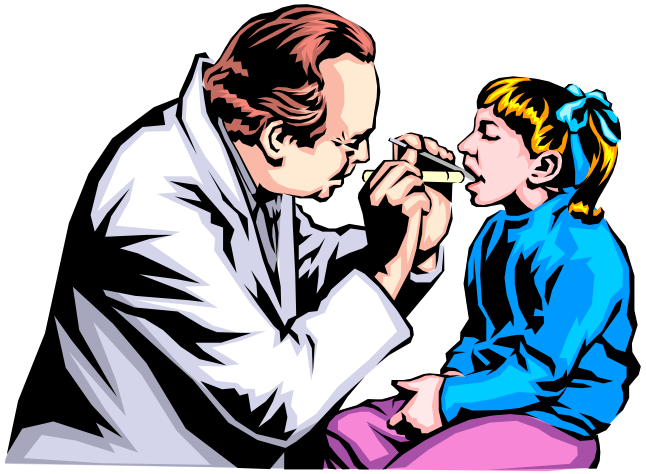
How does someone use THSteps services?



- Providers then provide the client services and bills for Medicaid covered services (as appropriate)
- Provider then receives 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.

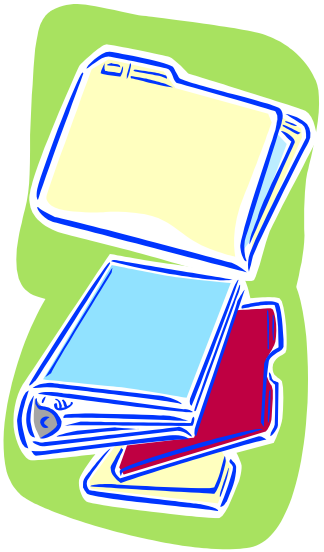
How does someone use THSteps services?

- 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.



Confidentiality of records

- Information about the diagnosis, evaluation, or treatment of a client with Medicaid coverage is usually confidential information that the provider may disclose only to authorized people.
- 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.



Client Rights

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

- to receive medical/dental/case management services;
- to receive information following a medical/dental examination;
- to full participation in the development of the treatment plan and the process of giving informed consent;
- to freedom from physical, mental, emotion, sexual, or verbal abuse or harm from the provider or their staff; and
- to freedom from overly aggressive treatment in excess of that required to address documented medical necessity.

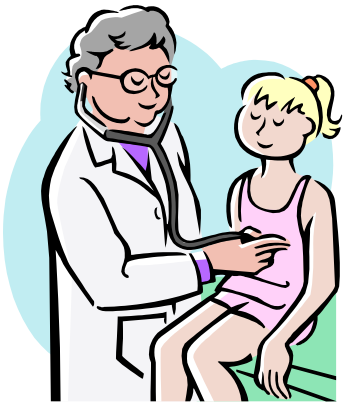
Module 2- THSteps Medical Checkups

Objectives

- 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

THSteps Medical Checkups

- Based on the American Academy of Pediatrics (*modified to meet federal requirements)*
- AAP Comprehensive assessment
- Purpose
  - Early detection of health problems
  - Offer guidance on a child's growth development



Medical Checkups for Infants, Children and Adolescents

- Schedule in TMPPM and TMPPM-THSteps contains all components due at each age
- Notes if test is required, risk based or to complete if not completed at earlier visit

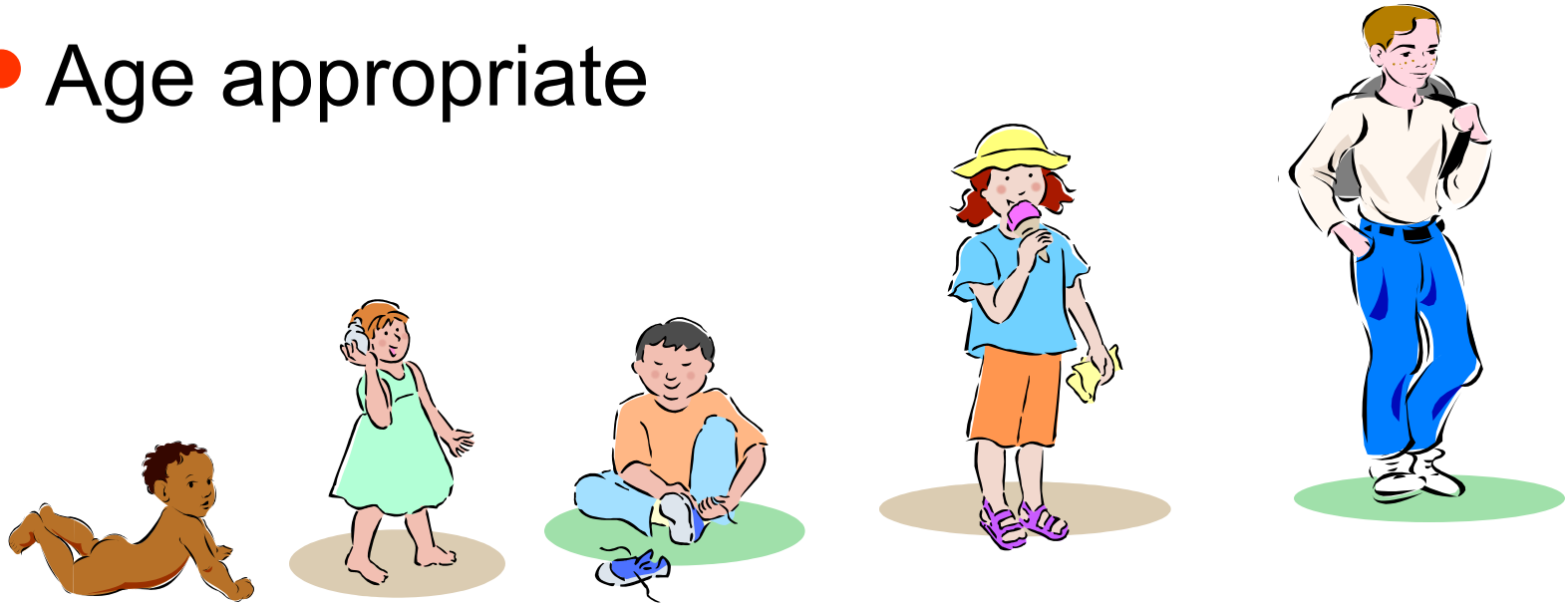
Medical History

- Initial
  - Family medical
  - Neonatal (if less than 5 years of age
  - Physical and mental health
  - Developmental
  - Immunization
  - Nutrition
  - Review of body systems
  - Medical behavioral risk for adolescents

- Return visits (specific for child's age)

Physical

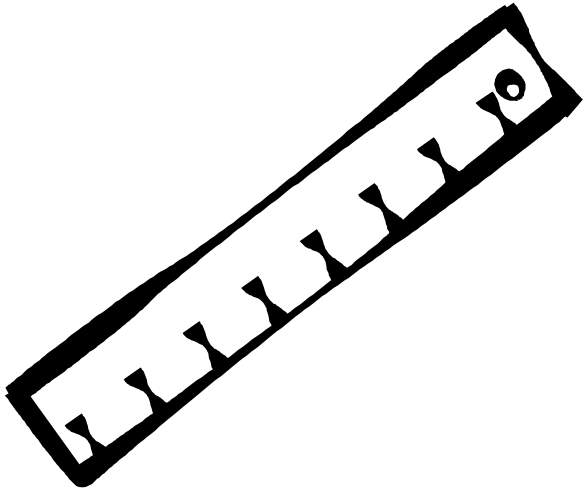
- Complete unclothed physical at each visit
- Age appropriate



Nutritional Assessment

- Questions about dietary practices
- Review of diet (quality and quantity)
- Measurements
- Laboratory screening for anemia

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

- Each visit (up to an including the sixth year check up)
- Physicians, nurse practitioners, physician assistants
  - A standardized developmental screen for a child between 9 through 12 months of age, 18 through 24 months of age, and every other year thereafter.
  - if a parent expresses concern about the child's developmental progress.
  - Developmental screening at all other visits to include a review of milestones

Developmental (*continued*)

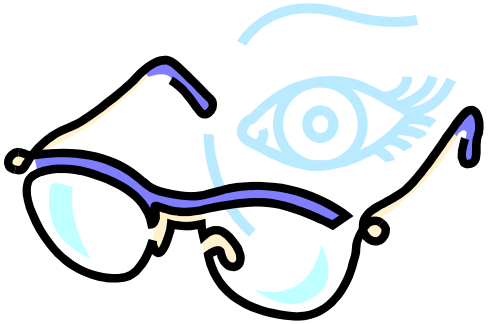
- Registered nurses
- Standardized observational tests
  - Between 9 and 12 months
  - Between 18 – 24 months
  - Any first visit thereafter in no record of testing
  - When parent expresses concern
- Standardized questionnaire at all other visits up to an including the sixth year checkup
- All providers: observation, school progress and neurological assessment age 7 years and older

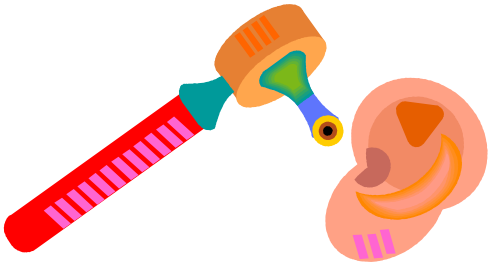
Mental Health

- Feelings
- Behavior
- Social interaction
- Thinking
- Physical problems
- Other, including substance abuse
- Optional tools for interview and referrals
- Confidentiality
- Referrals

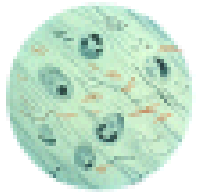
Other Components of a Medical Checkup

- Sensory Screening
  - Vision-Module 8
  - Hearing screening- Module 7





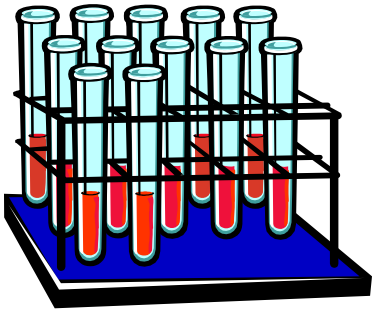
Tuberculosis Screening



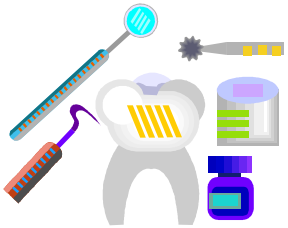
- Based on prevalence in community
- Low risk
  - Questionnaire at age 1 and yearly there after
  - Administer skin test if risk factor noted or providers discretion
- High risk
  - Administer skin test at age 1 year, once between 4 – 6 years and 11 – 16 years, or at provider's discretion
  - Questionnaire at all other visits

Other Components of a Medical Checkup

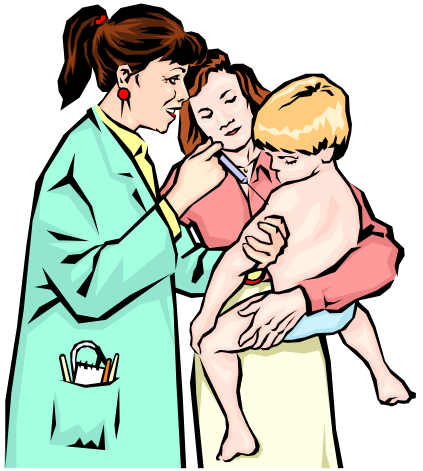
- Laboratory Screening & Tests- Module 4



- Dental Assessment- Module 5



Other Components of a Medical Checkup



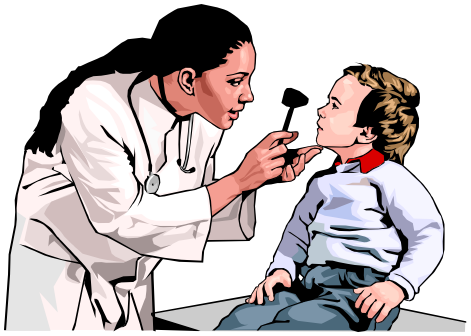
- Immunizations-Module 3
- Must not refer to the Health Department or other agency
- Must assess immunization status at each visit

Health Education/Anticipatory Guidance

- Based on the age of the client
  - Developmental expectations
  - Dental health
  - Sleep
  - Nutrition
  - Lead poisoning
  - Healthy lifestyles/practices
  - Accident and disease prevention

Medical Checkup Periodicity Schedule

- Based on AAP
- Modified to meet federal requirements or coordinate with other state programs and clients' needs
- 2 weeks, 2, 4, 6, 9, 12, 15, 18, 24 months
- Yearly after age 3

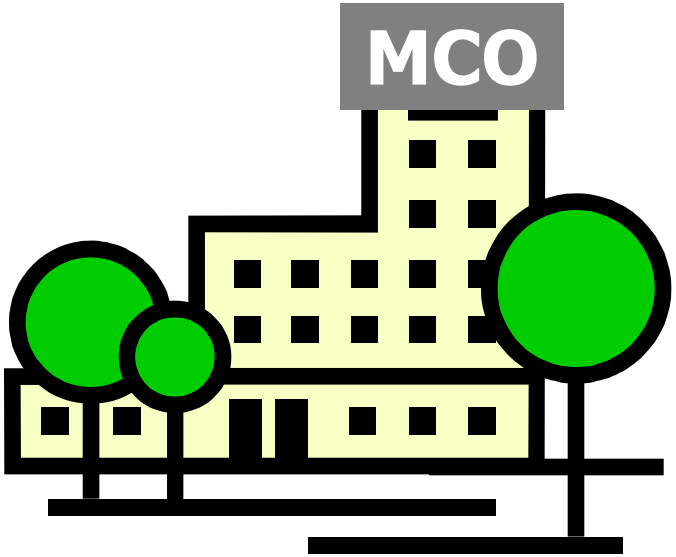


Provider Types

- Physicians
- Health care providers of facilities
- A Family or Pediatric Nurse Practitioner
- Certified Nurse Midwife (restricted)
- Women's Health Care Nurse Practitioner (restricted)
- Adult Nurse Practitioner (restricted)
- Physician's Assistant

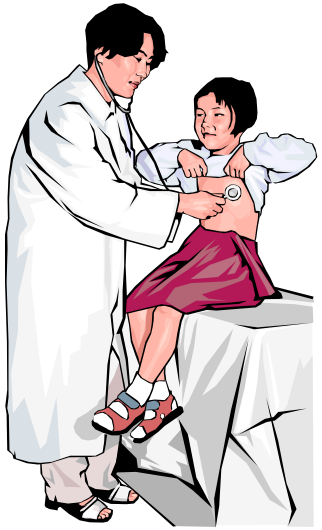
Reimbursement

- Negotiated with Managed Care Organization
- All components are included



Referrals for Medicaid Covered Services

- Diagnosis and treatment, including medically needed services
- Dental
  - Age 1 year and every 6 months
  - Parents may self refer
- Family planning/Genetics
- ECI
- PACT



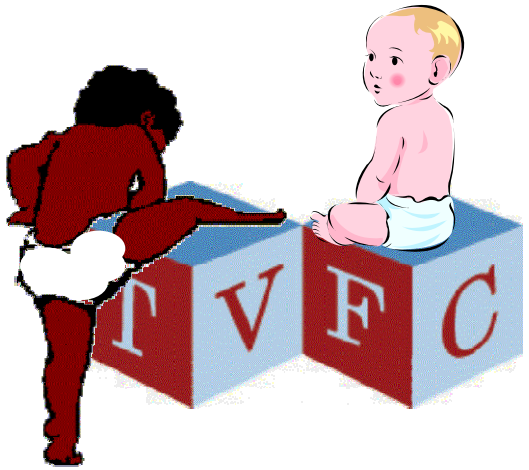
MODULE 3- Immunizations

Objectives

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

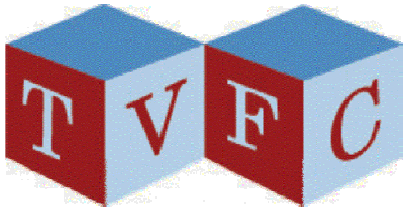
Texas Vaccines for Children Program

- TVFC is a federally and state funded program that provides vaccines free of charge to enrolled providers.
- These free vaccines are administered to TVFC eligible children.



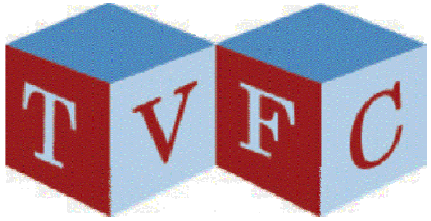
Who can enroll in TVFC?

- TVFC requires a signed enrollment form for providers to participate in program.
- MD, DO, NP, CNM, PA can sign the enrollment.
- What do providers have to do to receive free TVFC vaccine?
  - Update enrollment paperwork annually
  - Screen patients for TVFC eligibility
  - Report vaccine usage to the state
  - Monitor and record refrigerator and freezer temps
  - Yearly educational visit



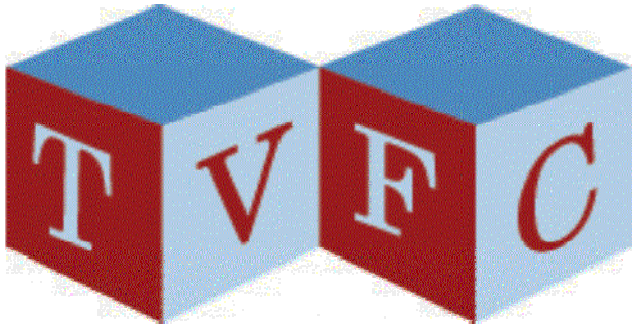
What children are eligible for TVFC?

- All children birth thru 18 who are
  - Medicaid
  - CHIP
  - Uninsured
  - Alaskan Natives or American Indians
  - Underinsured
    - Have insurance but does not cover vaccinations
    - Has insurance but family can not afford deductibles or co-pays



Provider Reimbursement

- Medicaid and CHIP children can not be charge any out of pocket expense.



Recommended Vaccines

- TVFC offers all ACIP routinely recommended vaccines.
- In January of each year CDC releases an updated Recommended Childhood and Adolescent Immunization Schedule that can be found at www.cdc.gov/nip/recs/child-schedule-color-print.pdf

DEPARTMENT OF HEALTH AND HUMAN SERVICES • CENTERS FOR DISEASE CONTROL AND PREVENTION

Recommended Childhood and Adolescent Immunization Schedule UNITED STATES • 2006

Vaccine ▼ Age ▶	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	24 months	4–6 years	11–12 years	13–14 years	15 years	16–18 years
Hepatitis B[1]	HepB	HepB		*HepB*[1]	HepB				HepB Series					
Diphtheria, Tetanus, Pertussis[2]			DTaP	DTaP	DTaP		DTaP			DTaP	Tdap	Tdap		
Haemophilus influenzae typeb[3]			Hib	Hib	*Hib*[3]	Hib								
Inactivated Poliovirus			IPV	IPV	IPV					IPV				
Measles, Mumps, Rubella[4]						MMR				MMR	MMR			
Varicella[5]						Varicella			Varicella					
Meningococcal[6]							Vaccines within broken line are for selected populations		MPSV4		MCV4		MCV4	MCV4
Pneumococcal[7]			PCV	PCV	PCV	PCV			PCV		PPV			
Influenza[8]					Influenza (Yearly)				Influenza (Yearly)					
Hepatitis A[9]									HepA Series					

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2005, for children through age 18 years. Any dose not administered at the recommended age should be administered at any subsequent visit when indicated and feasible. Indicates age groups that warrant special effort to administer those vaccines not previously administered. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective ACIP statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at www.vaers.hhs.gov or by telephone, 800-822-7967.

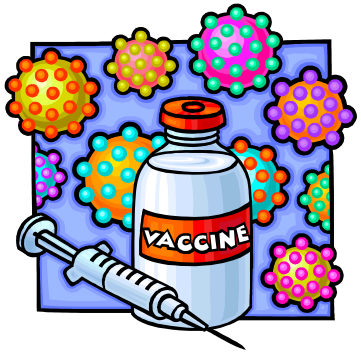
Range of recommended ages | Catch-up immunization | 11–12 year old assessment

Vaccines available through TVFC

- Hep B
- DTaP, DT, Td, Tdap
- Hib
- IPV
- MMR
- Var (now the child will be required to have a second dose)
- PCV7
- Hep A (recommended for individuals 12 months of age and older)
- Flu
- Rotavirus vaccine
- Meningococcal Conjugate vaccine (MCV4)
- Combination vaccines (DTaP-Hep B-IPV, Hep B-Hib, MMRV)

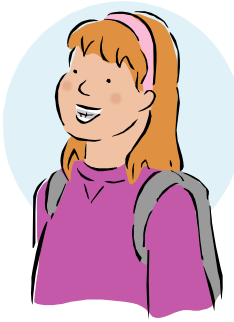
New Vaccines

- DSHS added several new vaccines with in 2006 :
  - Rotavirus (3 dose series administered at 2,4 and 6 months)
  - MMRV (combination of MMR and varicella)
  - MCV4 (meningococcal conjugate vaccine)
  - Tdap (Td with pertussis containing component)



Recent ACIP Recommendations

- Human papillomavirus vaccine (HPV) has been recommended for females 11-12 years of age



- A booster dose of varicella has been recommended for children 4-6 years.

ImmTrac

- Repository of immunization histories for many Texas children
- Parental consent is required
- Consolidates and safely stores immunization records
- Helps ensure a child's immunizations are up-to-date
- Can offer reminder when a vaccine is due
- A FREE service

ImmTrac
Texas Immunization Registry

Contact Information

- ImmTrac
  - Call: 800.252.9152
    Email: ImmTrac@dshs.state.tx.us
    Write to: DSHS Immunization Branch
    1100 West 49th St.; Austin, TX 78756
- Immunization
  - Susan Belisle, RN, BSN,
    Call:(512) 458-7111 ext 3802
    Susan.belisle@dshs.state.tx.us

Amy Schlabach

512-458-7111 x6496

Amy.Schlabach@dshs.state.tx.us

MODULE 4-
Laboratory Procedures

Objectives

- Required laboratory procedures
- Laboratory testing
- Laboratory supplies

Required Laboratory Procedures

Laboratory screening procedures are a federal/state required component of a THSteps medical checkup.

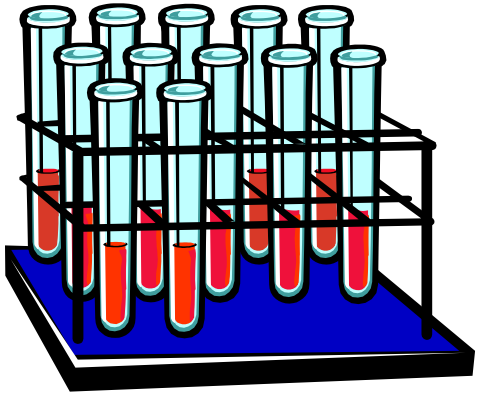
- Laboratory screening is done in accordance with the age and frequency specified on the THSteps medical periodicity schedules.
- Laboratory specimen collection is done at the time of the client's medical checkup by the THSteps medical checkup provider.

August 18, 2006

THSteps Medical Checkup Laboratory Testing

THSteps medical checkup for infants and children requires (when specified) laboratory testing for:

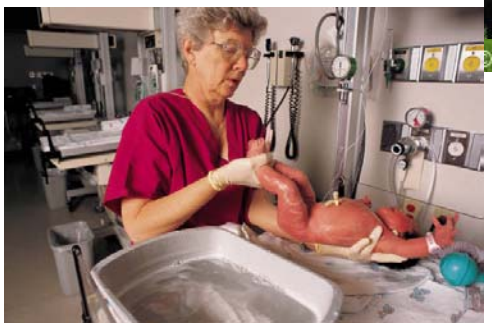
- Newborn screening conditions (PKU, GALT, CH, CAH, Sickle Cell Disease),
- Hemoglobin type,
- Cholesterol/lipid Profile,
- Total Hemoglobin
- Glucose, and
- Lead.



Current Legal Requirements

Texas law requires newborns to be screened for:

- PKU,
- Other heritable diseases, and
- Hypothyroidism.

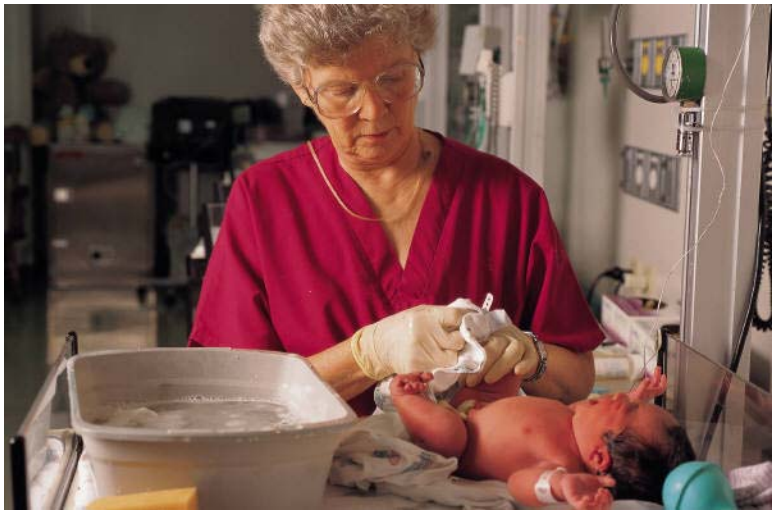


New Legal Requirements

Newborn Screening panel will increase from 5 disorders currently screened for to 27 as recommended by the American College of Medical Genetics (ACMG).

Some examples are:

- Maple Syrup
- MCAD
- Biotinidase.



Legal Testing Requirements

- 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.

THSteps Medical Checkup-Testing

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 the Pap Screens, for required medical checkup laboratory screening tests (performed as part of a medical checkup for infants/children/adolescents), to the DSHS Laboratory Services Section in Austin, Texas.

Department of State Health Services

Laboratory - THSteps

PO BOX 149163

Austin, Texas 78714-9803

1-888-963-7111





Texas Health Steps

TEXAS Department of State Health Services

Exception to Lab Testing

- Pap smears are submitted to the Cytology Laboratory at the Women's Health Laboratories in San Antonio, Texas.

  Women's Health Laboratories

  2303 S.E. Military Dr. Bldg. 533, Suite #1

  San Antonio, TX 78223-3597

  1-888-440-5002

Reimbursement

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

- Reimbursement for a THSteps medical checkup covers laboratory specimen collection.
- There are new laboratory forms that must be completed in their entirety!

Laboratory Results

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

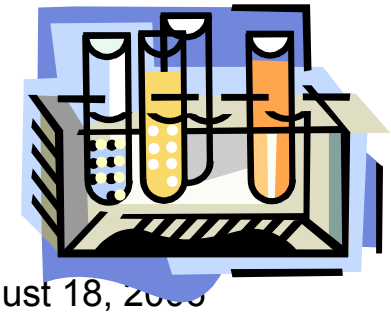
Laboratory Supplies

The DSHS Austin laboratory or the Women's Health Laboratory (for pap smears) will provide 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)

Laboratory Supplies *(Continued)*

- Gen-Probe collectors
- Mailing containers with pre-paid postage labels
- Newborn screen specimen collection wall chart
- Newborn screen collection procedures – video (loan)
- THSteps laboratory procedures – video (loan)
- **http://www.dshs.state.tx.us/lab/MRS_forms.shtm#supplies**



DSHS Laboratory

1-888-963-7111*

Clinical Chemistry Laboratory
(512) 458-7680

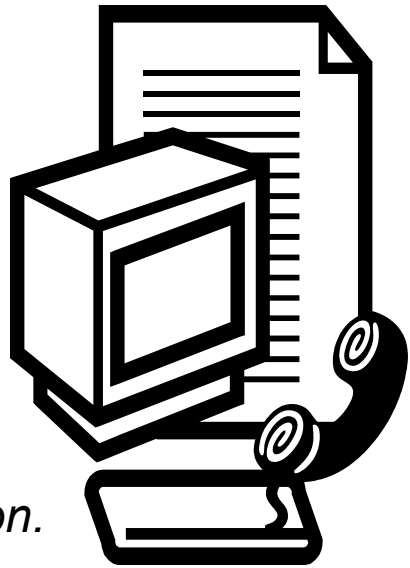
Newborn Screening Laboratory
(512) 458-7333

Specimen Submission
(512) 458-7598

Billing Information
(512) 458-7318 x3819
Ask for Accounts Receivable

Lab Reporting
(512) 458-7578 THSteps (EPSDT) Results
(512) 458-7533 fax

Specimen Collection Supplies
(512) 458-7661 THSteps (EPSDT)/ Newborn Screening
(512) 458-7672 fax



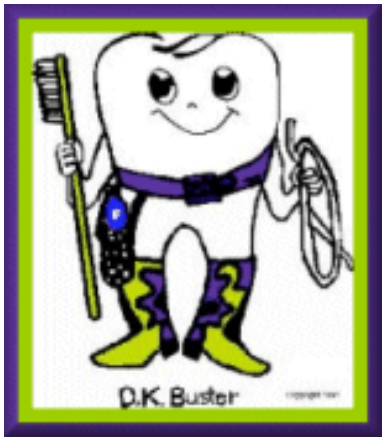
** For toll free calls, dial top number and then enter the extension.*

MODULE 5-THSteps Dental Checkups and Treatment Services

Objectives

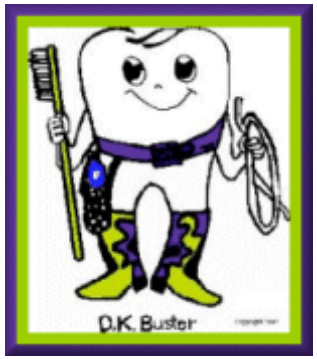
The information covered in this module is a review of the following:

- 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



Background

THSteps is a comprehensive program addressing medical, dental and case management needs. The medical checkup by the physician 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.



Dental Services

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

Dental Services

Treatment Services

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

Dental Services

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.

Dental Periodicity

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.

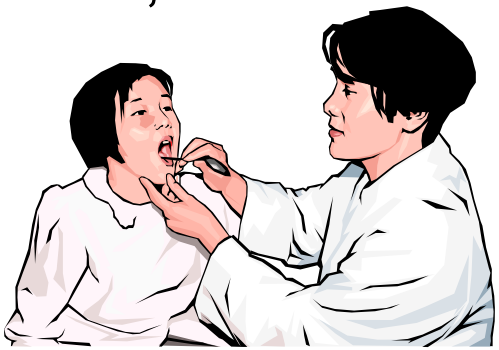




Exceptions to Periodicity

Payment is made for dental checkups that are exceptions to the dental checkup periodicity (every 6 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.



Provider Participation

Requirements

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.

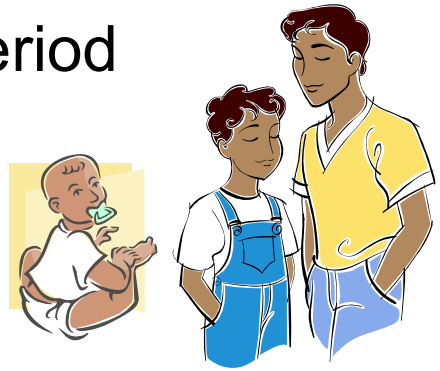
Client Eligibility

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

Parental Accompaniment

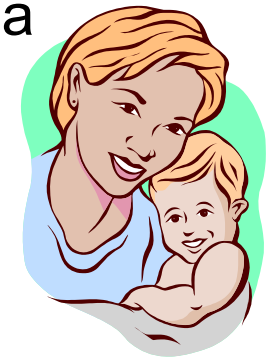
In order for a provider to be reimbursed for services to a child younger than age 15, the child must be accompanied by the parent, guardian, or other authorized adult at all dental visits. **Exceptions** are school health clinics, Head Start programs, and childcare facilities if the clinic, program, 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.



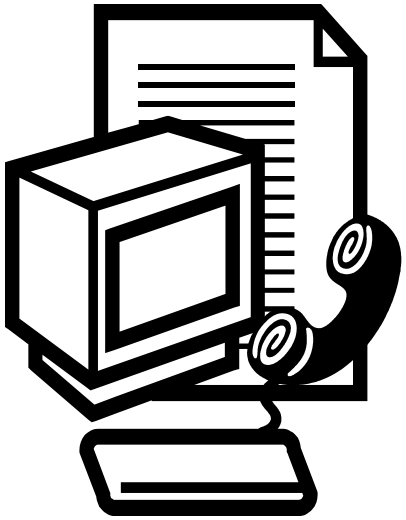
Informed Consent/Standards of Care

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/risk)
- Need for administration of sedation or anesthesia (including risks)
- Full explanation of the treatment plan



Complaints



Complaints from any source regarding dental services are:

- received by THSteps program staff
- received by Texas Access Alliance (TAA) through toll free phone line, 1-877-847-8377.

The complainant is notified in writing that their complaint has been received and is being referred as appropriate for follow-up/investigation. Complaints received at THSteps are documented and tracked to monitor frequency, volume, and trends.

MODULE 6-
Newborn Screening Program (NBS)

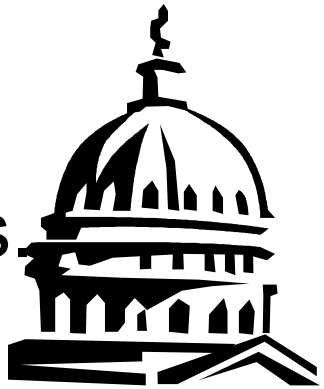
Objectives

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

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

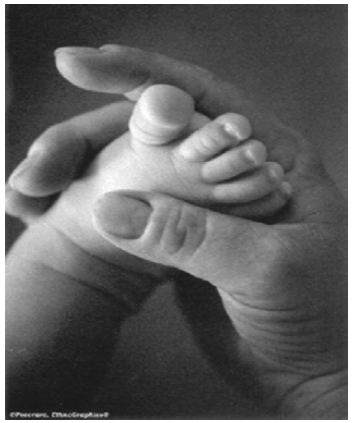
Statutes for Newborn Screening Program

- HB 790 Requires DSHS to implement an expanded panel of screens recommended by American College of Genetics as funding allows.
- Chapter 33 of Health and Safety Code and TAC 37.51 provide details.



NBS Follow-Up Goals

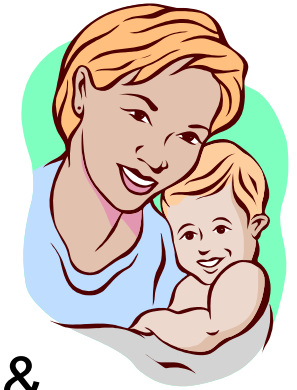
- Each baby born in Texas receives two newborn screening tests.
- All infants with an abnormal screen receive prompt and appropriate confirmatory testing.
- All infants diagnosed with newborn disorders are maintained on appropriate medical therapy.



Achieving Goals Requires coordinated efforts of:

Healthcare providers: collecting, handling, labeling both specimens, follow-up testing, medical care, parent education, referral to specialty care.

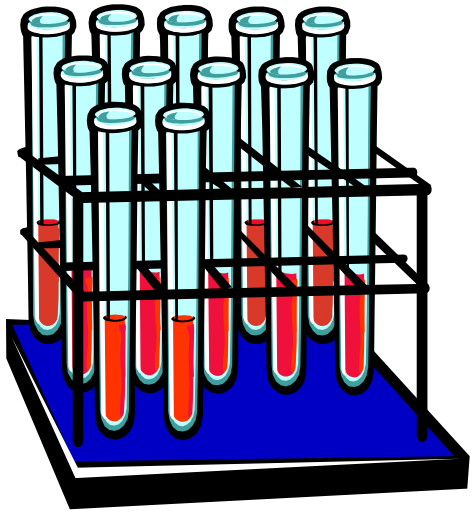
DSHS Laboratory: analyzing specimens, record keeping, quality control of lab methods and notifying providers and case managers of results.



Follow-up team: tracking abnormal screens & diagnosed cases, assisting in assuring appropriate medical care, serving as information resource for providers, parents and the public.

Disorders Currently Screened

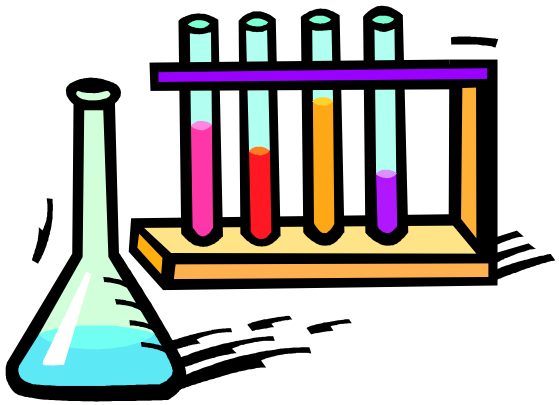
- Phenylketonuria (PKU)
- Galactose-1-phosphate uridyltransferase deficiency
- Sickling hemoglobinopathies, including sickle cell disease
- Congenital adrenal hyperplasia
- Hypothyroidism



Expanded Screening

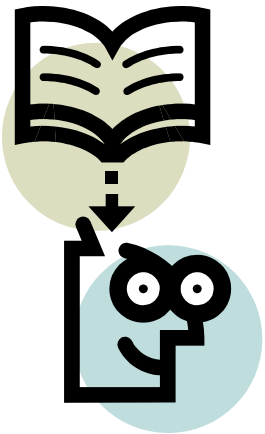
Includes the current disorders and the following:

- Amino acid metabolism disorders
- Organic acid metabolism disorders
- Fatty acid oxidation disorders
- Biotinidase deficiency



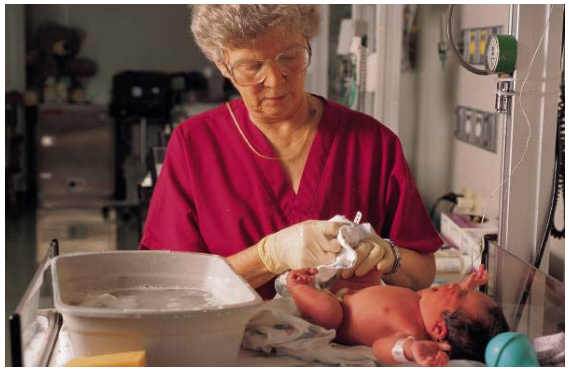
Information and Education

- Procedure Brochures available through NBS website
- Regular newsletter sent to submitters
- Onsite training provided by NBS educator
- Training module, slide show and further information available online
- Online CEU's will be available



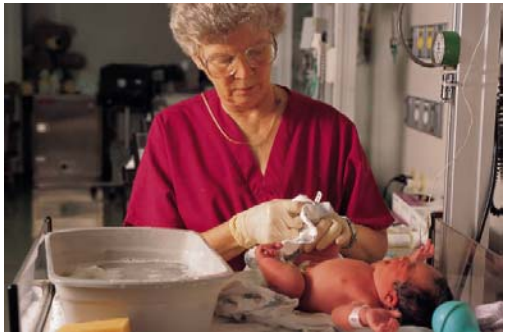
Current NBS Estimate

- Approximately 385,000 births a year
- Approximately 750,000 specimens a year collected
- Follow-up on approximately 12,000 abnormal screens a year
- Approximately 400 diagnosed cases per year



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



NBS Contacts

- David R. Martinez NBS Branch Manager
  (512) 458-7111 ext. 2216 davidr.martinez@dshs.state.tx.us
- Dr. Susan Tanksley Laboratory Branch Manager
  (512) 458-7111 ext 3102 susan.tanksley@dshs.state.tx.us
- Judy Chrisman NBS Educator
  (512) 458-7111 ext. 2682 judy.chrisman@dshs.state.tx.us
- Dr. Margaret Drummond-Borg Physician Consultant
  (512) 458-7111 ext. 2193 margaret.borg@dshs.state.tx.us
- Margaret Bruch LCSW Unit Manager
  (512) 458-7111 ext. 3045 margaret.bruch@dshs.state.tx.us

Resources

- http://genes-r-us.uthscsa.edu/
- www.marchofdimes.org (English)
- www.nacerano.org (Spanish)
- www.acmg.net (American College of Medical Genetics)
- www.dshs.state.tx.us/newborn/default.shtm
- http://www.dshs.state.tx.us/lab/nbs_about.shtm
- http://www.dshs.state.tx.us/lab/MRS_forms.shtm#supplies

BREAK

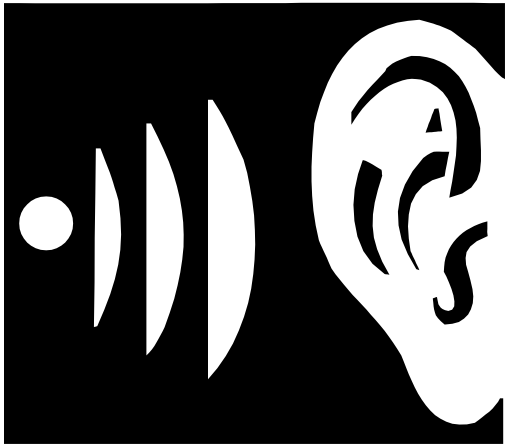
15 Minutes

MODULE 7- Hearing/PACT Services

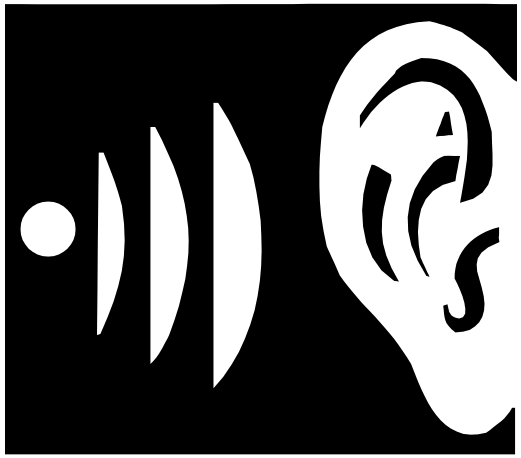
Objectives-

This module provides information about the following:

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



The Texas Early Hearing Detection and Intervention (TEHDI) program and the Program for Amplification for Children of Texas (PACT) are both administered by the Department of State Health Services.

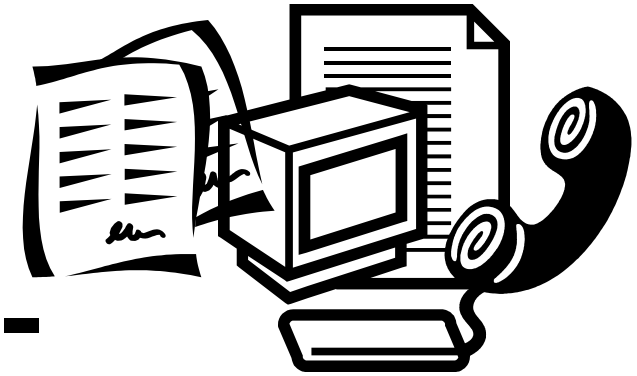


TEHDI Background-

- The newborn hearing screening law became effective 9-1-1999, 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.

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).

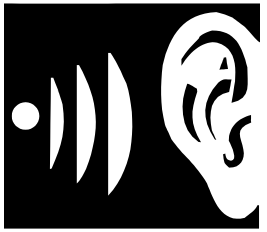


TEHDI Referrals-

- 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.

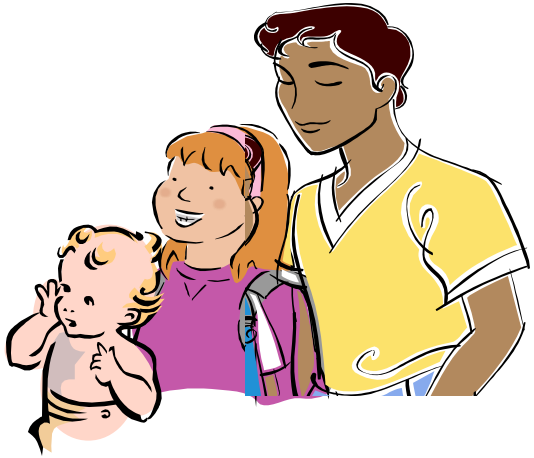


PACT Service Providers-

- 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.

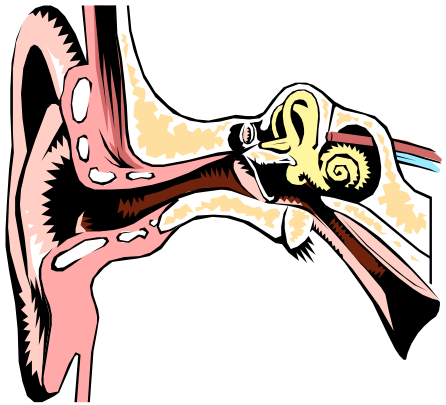
PACT Eligibility-



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

PACT Covered Services-

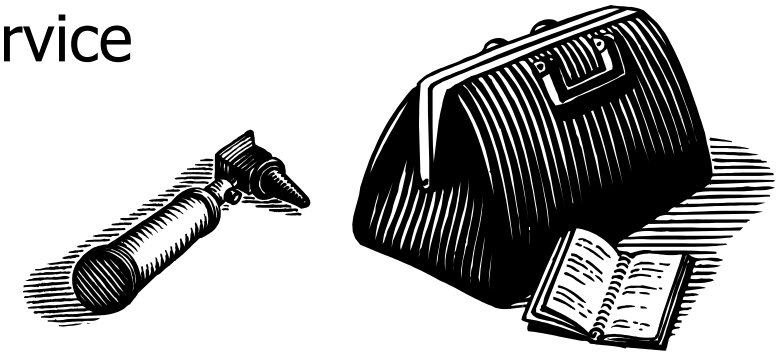


PACT hearing services include:

- 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

PACT Non-Covered Services-

- 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



Access to PACT Services-

To receive PACT services, clients must:

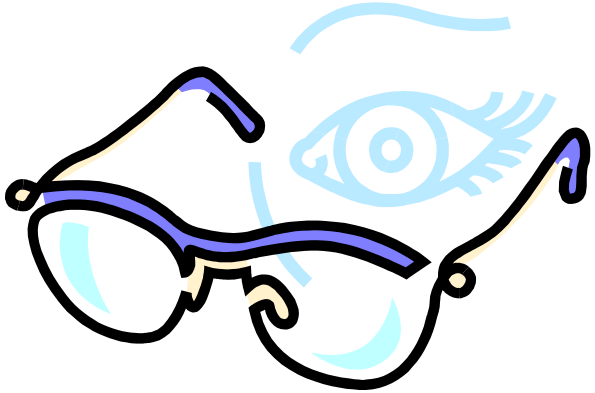
- Complete a PACT application and send it through a PACT provider
- Receive written approval for PACT services from DSHS
- Schedule an appointment with a PACT provider for services

MODULE 8-
Vision Services

Objectives-

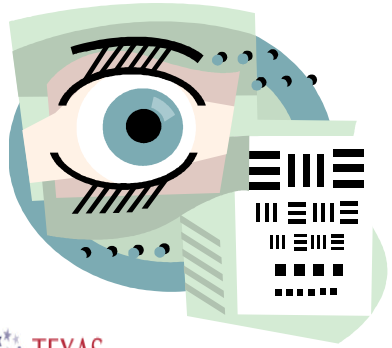
This module provides information about the following:

- **Vision screen**
- **Vision benefits**
- **Vision providers**
- **Training**
- **Screening requirements**



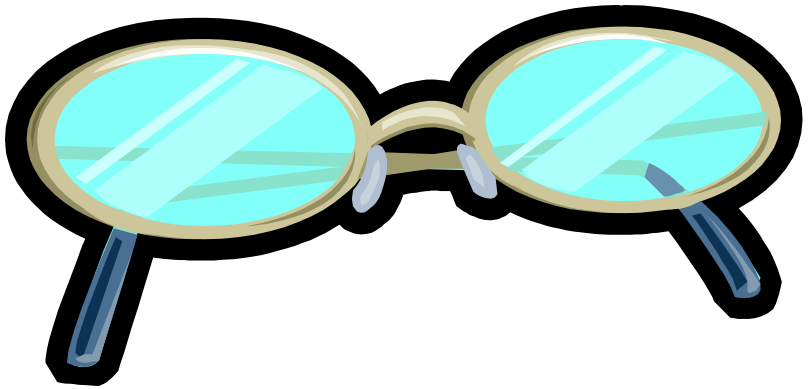
What is a THSteps Vision Screen?

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.

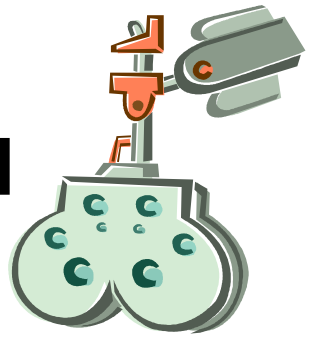


What Vision Benefits are available to children?

THSteps/Medicaid Services provide diagnosis and treatment for vision problems, including eyeglasses for defects in vision.



Benefits *(continued)*-



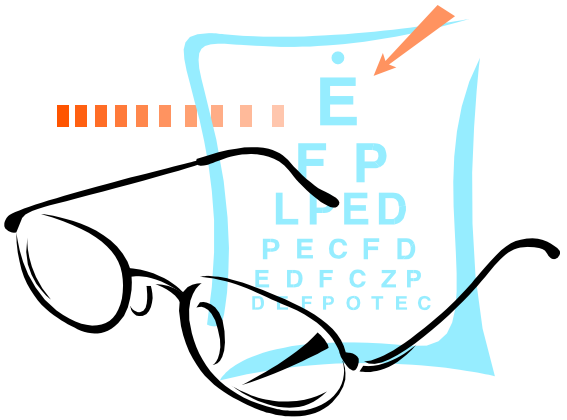
The following eye examination and eyewear services are available for THSteps clients:

- **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.**

Benefits *(continued)*-

Eyeglasses every 2 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.**



Who provides 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 (see Module –12, Managed Care, for information on STAR and STAR+PLUS).

Training-

- The DSHS Vision and Hearing Screening Program provides training workshops to certify vision screeners. These workshops cover the requirements for providing vision services.

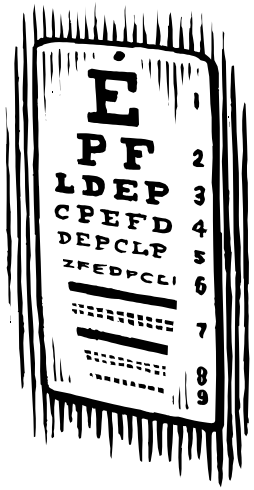
- Department staff or department -approved instructors of screening shall issue a certificate to individuals who successfully complete the department's vision screening course.

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 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.

Screening Requirements
(Continued)

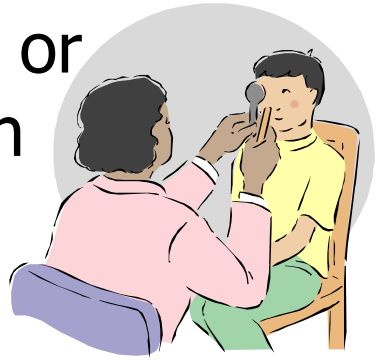
- A vision screener shall test distance acuity for both eyes with one of the following charts or a telebinocular instrument with a distance acuity test capability:
  - Sloan Letter Chart
  - Snellen Letter Chart
  - Snellen "Tumbling E" Chart
  - HOTV Crowded Test Set Certified screeners may screen children for vision problem for a period of five years.



Screening Requirements

(Continued)

- 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-

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

THSteps Outreach and Informing is a partnership

- Texas Access Alliance (TAA)
- State Agencies
- Community-Based Organizations
- Providers
- Managed Care Organizations

WHY?

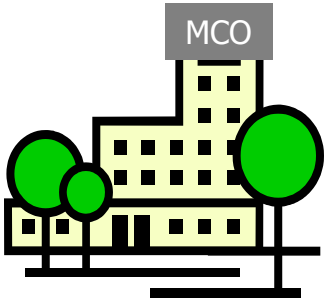
To provide information about Program services and benefits.

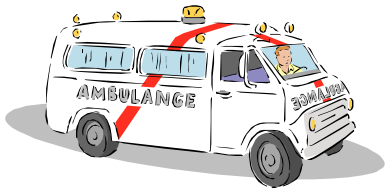
What information is conveyed?

- Information on THSteps Services
- Benefits of preventative medical and dental services.
- Where to get services
- How to get services

What information is conveyed?

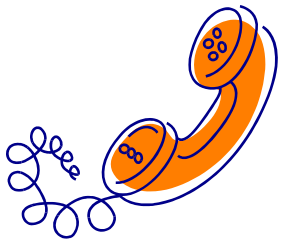
- Transportation scheduling assistance
- How to locate providers
- Reinforce Medical Home concept
- Appropriate use of emergency services

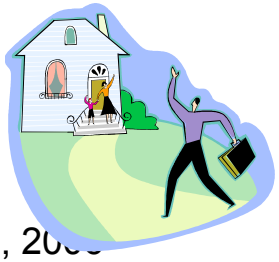




What methods are used?

- OES- face to face.
- TAA-
  - Face-to Face
  - Letters
  - Thru call centers
  - Home Visits





What other methods are used?

- Written materials
- Stuffers
- Due and overdue letters
- Oral group presentations

Outbound Calls to…

- Non-participants
- New Clients
- Health Care Organization Clients
- Pregnant and Parenting Teens
- Department of Family Protective Services

MODULE 10-
Case Management for Children and Pregnant Women (CPW)

Case Management for Children and Pregnant Women (CPW)

Case Management is a Term Widely Used in Different Contexts:

- Service Coordination
- Eligibility Work
- Care Coordination
- Case Coordination
- Administrative Case Management
- Case Work
- Comprehensive Case Management
- Discharge Planning

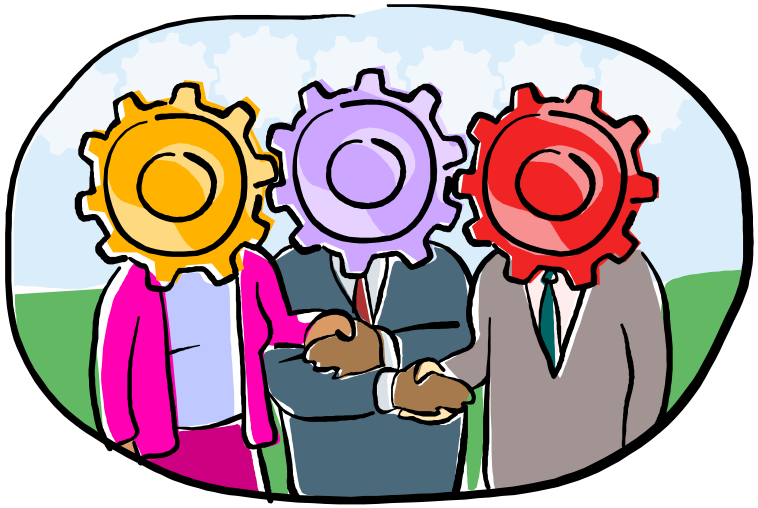
Children and Pregnant Women (CPW)

"Case Management for Children and Pregnant Women (CPW) will provide services to children with a health condition/health risk, birth to 21 years of age, and/or 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."

http://www.dshs.state.tx.us/caseman/default.shtm

Core Values

- Family Centered
- Community Based
- Culturally Sensitive
- Multidisciplinary
- Comprehensive
- Confidentiality



What Do Case Managers Do?

- Find out what families need
- Make plans to meet those needs
- Find services families need near where they live
- Teach families how to find and get the services they need
- Follow-up with families to make sure their needs have been met

Case Managers Assist With:

- Obtaining medical care / Locating a PCP
- Durable medical equipment
- Specialty referrals
- Education / School issues
- Developmental / Rehabilitative services
- Mental health services
- Transportation
- Housing
- Financial assistance (rent, utilities, clothing)
- Other community resources
- Information & referral
- Overcoming barriers to service
- Coordination of care
- Advocacy

Case Managers Have Skills In:

- Assessing needs, identifying challenges and family strengths
- Facilitating, coordinating and communicating
- Advocating
- Empowering
- Accessing services

Eligibility for CPW Services

- Eligible for Medicaid
- A child (birth through age 20) with a health condition or a health risk OR a pregnant woman with a high risk condition
- In need of services to prevent illness(es) or medical condition(s), to maintain function or slow further deterioration
- Want case management

Case Management Referrals

- Physician Referral
- Dentist Referral
- Other Agency Referral - Other agencies such as the Department of Family & Protective Services, community agencies or schools
- Self Referral - The client or other family members may request case management
- Outreach/Informing
- Managed Care Referrals

Referring Clients

It is important that clients have a choice of providers.

You can:

- Call 877-THSteps (877-847-8377)
  The Texas Health Steps Hotline

OR

- Go to the CPW website for a list of providers in your area.

http://www.dshs.state.tx.us/caseman/default.shtm

Referring Clients

- Case management providers also conduct outreach into the community.
- Case management providers may talk with physician and dental offices, health clinics, schools, WIC clinics and other community agencies about CPW services.
- Referrals can be made to these providers as long as client choice is assured (case management providers are also required to provide client choice at the initial contact with a potential client).

Information to Provide at Time of Referral

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

The Components of CPW Case Management Include:

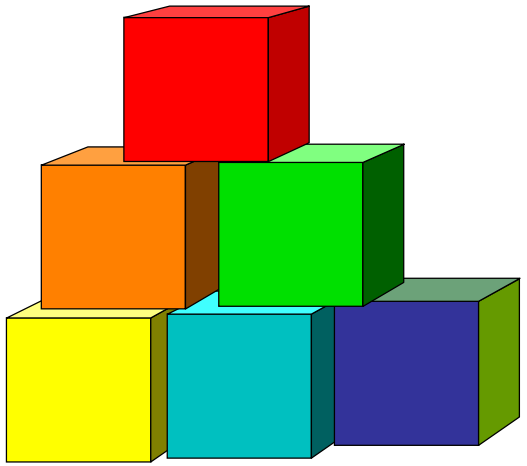
Intake

Comprehensive Visit

which includes:

- Family Needs Assessment
- Service Plan Development

Follow-up



Intake

- The Intake must be conducted with the client, parent or guardian.
- The Intake includes:
  - Collection of client demographics
  - Determination of client eligibility

Prior Authorization

- In order for a provider to be able to bill for services, visits must be prior authorized.
- Completed Prior Authorization Forms are faxed or submitted via an electronic web based system to DSHS.
- Requests are reviewed to determine eligibility for approval.

Prior Authorization *(Continued)*

- Responses to requests for prior authorization will be sent from DSHS to the provider within three working days.
- Other prior authorization information:
  - Current approval rate is 92%
  - Technical assistance is readily available for prior authorization questions

Comprehensive Visit –

Family Needs Assessment & Service Plan Development

Family Needs Assessment

- The Family Needs Assessment is an evaluation of all issues that affect the short and long term health of the eligible recipient and his or her family.
- Areas of Assessment:
  - Other agencies involved
  - Health status – client & family
  - Developmental/rehabilitative needs
  - Educational/vocational needs
  - Socioeconomic needs
  - Housing needs
  - Transportation needs
  - Psychosocial strengths/issues

Service Plan Development

Documentation of:

- the client needs,
- what action is to be taken and by whom,
- the time frame in which the need is to be addressed and
- when the task has been completed.

Follow-up

- Follow-ups (in person or by phone) are done to insure that the needs identified in the Service Plan are being met.

- Follow-ups include:
  - what needs have been addressed;
  - whether barriers to accessing services were addressed;
  - and evidence of problem solving with the client, parent or guardian when needs are not addressed.

CPW Service Providers

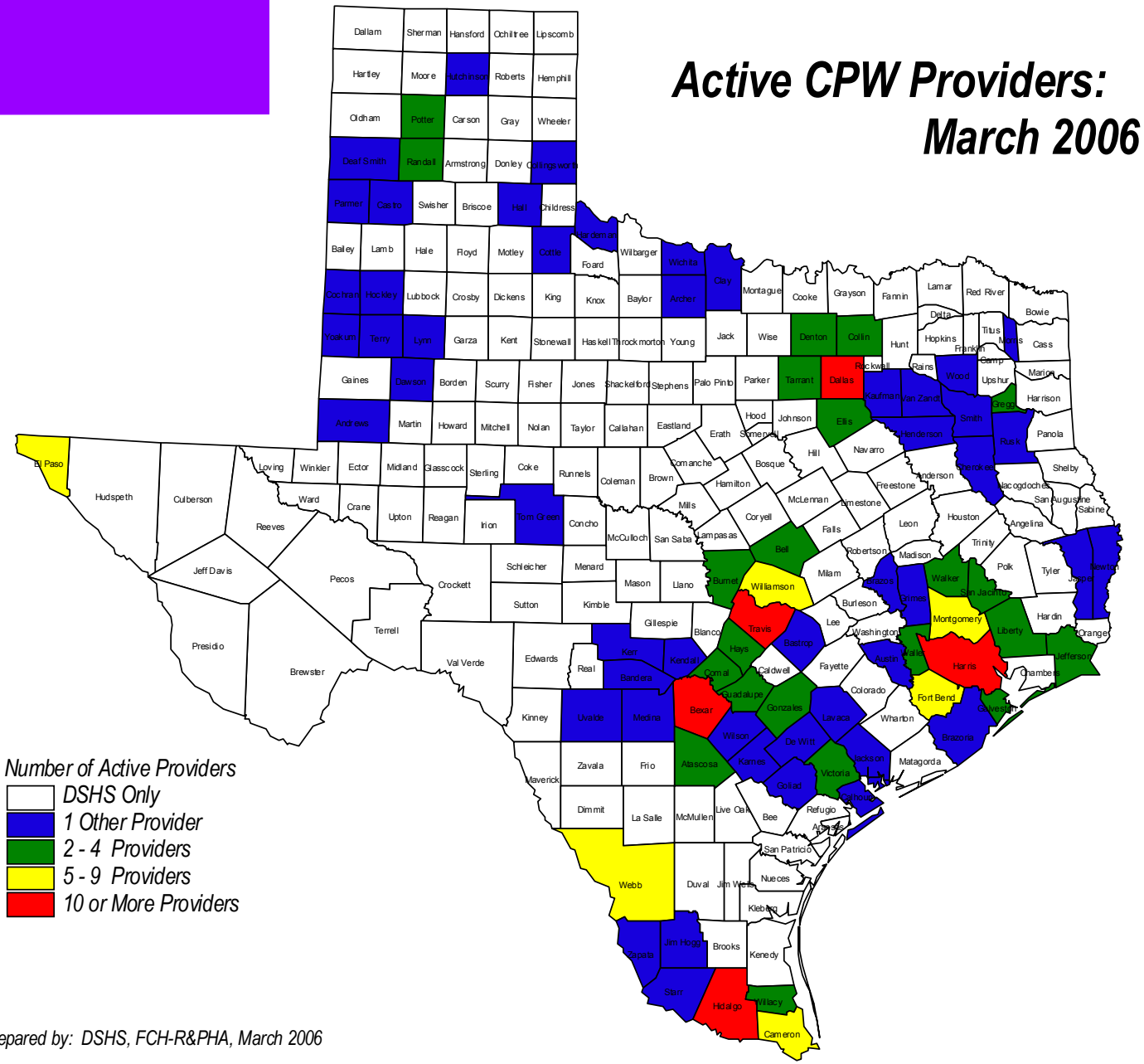
- Services are provided through approved private and public providers and DSHS Regional social work staff

- Providers range from small agencies, to health departments, to home health agencies, to hospitals, to schools and individual providers

CPW Service Providers *(continued)*

- Application approved by regional and central offices
- Enrolled with TMHP
- Case Managers
  - Social Workers licensed in Texas
  - Registered Nurses licensed in Texas
  - Education
  - Work experience
  - DSHS/CPW training at regional offices

Active CPW Providers: March 2006



Prepared by: DSHS, FCH-R&PHA, March 2006

Texas Health Steps

TEXAS Department of State Health Services

Becoming a CPW Provider

- Get an application from the Director of Social Work in the Regional Office of the Public Health Region area that you want to serve during a pre-planning session.

- Complete the application and submit it to the Director of Social Work for DSHS regional and central office review.

- If the application meets the requirements, you will receive a DSHS approval letter and instructions for how to get a claims administrator enrollment packet.

Becoming a CPW Provider *(Continued)*

- Enrollment forms must be submitted to the claims administrator to receive a Texas Provider Identifier Number and Individual Performing Provider Number (when applicable).

- Prior to providing and billing for services, you must attend the DSHS Regional Case Management Training.

CPW Case Management Regional Contacts

HEALTH SERVICES REGION 1
Pat Greenwood, MSSW, LMSW
(806) 655-7151; FAX (806) 655-0820

HEALTH SERVICES REGION 2/3
Crystal Womack, LMSW-AP
(817) 264-4589; FAX (817) 264-4592

HEALTH SERVICES REGION 4/5N
Peggy Wooten, LCSW
(903) 533-5256; FAX (903) 595-4706

HEALTH SERVICES REGION 6/5S
Raymond Turner, MA, LMSW-AP
(713) 767-3111; FAX (713) 767-3125

HEALTH SERVICES REGION 7
Eileen Walker, MS, LBSW
(254)-778-6744; FAX (254) 778-4066

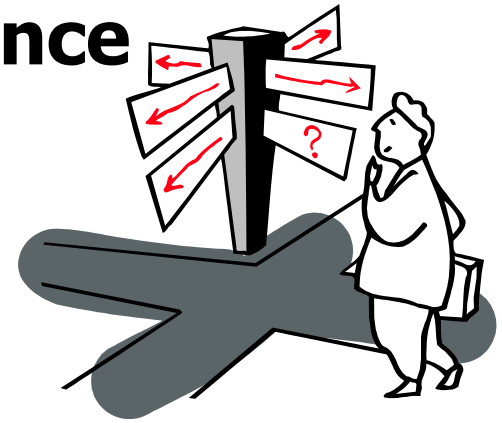
HEALTH SERVICES REGION 8
Vicky Contreras, LCSW
(210) 949-2155; FAX (210) 949-2047

HEALTH SERVICES REGION 9/10
Joanne Mundy, LSW
(432) 683-9492; FAX (432) 685-3637

HEALTH SERVICES REGION 11
Scott Horney, LCSW
(956) 423-0130; FAX (956) 444-3294

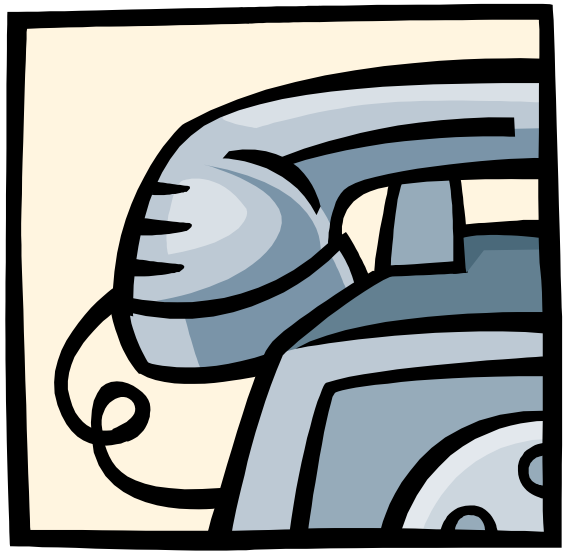
Support Available from Regional Staff

- Coordination of application process
- Training
- On going technical assistance



Support Available from Central Office Staff

- Assistance with TMHP and claims issues
- Technical assistance regarding prior authorizations
- Policy clarifications



DSHS Case Management Website

http://www.dshs.state.tx.us/caseman/default.shtm

- List of CPW Providers
- CPW Outreach Materials
- Training Schedule
- CPW Forms
- CPW Policies and Procedures
- Case Management Bulletins
- Information about Submitting Prior Authorization Requests via the Web

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

Objectives

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

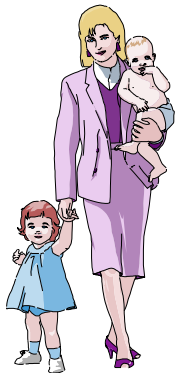
- Background
- Recognizing the unique needs of CPS involved children
- State and Federal Requirements for Medical and Dental Care
- Transition from Medicaid Managed Care to Fee for Service Medicaid for children who enter foster care
- Brief introduction to Medical Consent policies
- Eligible for all Medicaid services including CPW and Medical necessary services

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.

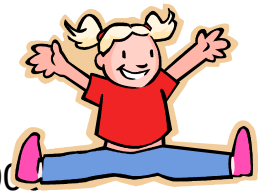
Recognizing the unique needs of CPS involved children -



- 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 children served in their own homes are enrolled in Medicaid.

Recognizing the unique needs of CPS involved children (Continued)-

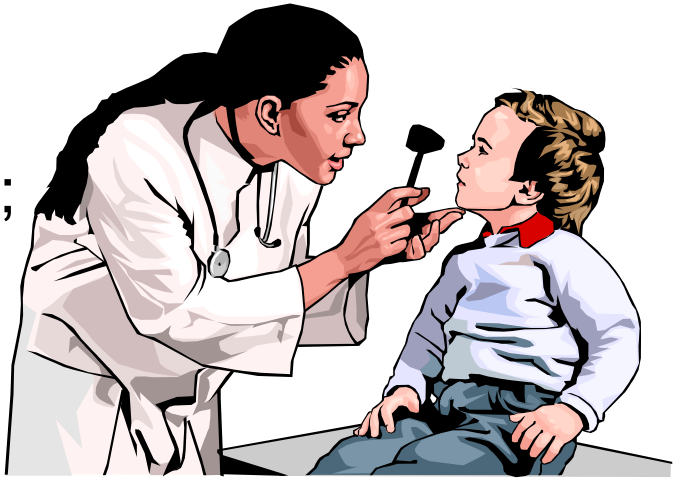
- Children in Substitute Care:
  - Each month approximately 1,400 children enter foster care across the state.
  - Age of children in foster care fiscal year 2005:
    - Birth through 2 years 21.8%
    - 3 to 5 years 14.6%
    - 6 to 9 years 17.1%
    - 10 to 13 years 18.6%
    - 14 to 17 years 26.1%
    - 18 to 20 years 1.8%



State and federal requirements for Medical and Dental Care

Exams required for state or federal foster care requirements are referred to in the Medicaid 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;



State and Federal Requirements for Medical and Dental Care *(Continued)*-

- annual well child check each year;
- dental exam scheduled within 30 days of admission and exam held within 90 days of admission; and
- dental exam every 6 months.

Transition -

Many children are enrolled in Medicaid at the time 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.

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.

DFPS Medical Consent Policies
(Continued)-

- 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 -

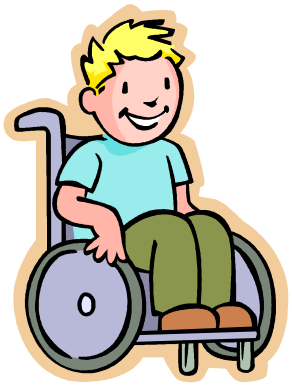
- All children in the managing conservatorship of DFPS are eligible for:
  - Medicaid,
  - Case Management for Children and Pregnant Women (CPW), and
  - medically necessary Services.
- Children in substitute care may be placed in foster care, kinship care, or pre-adoptive placements.

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

Objectives

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

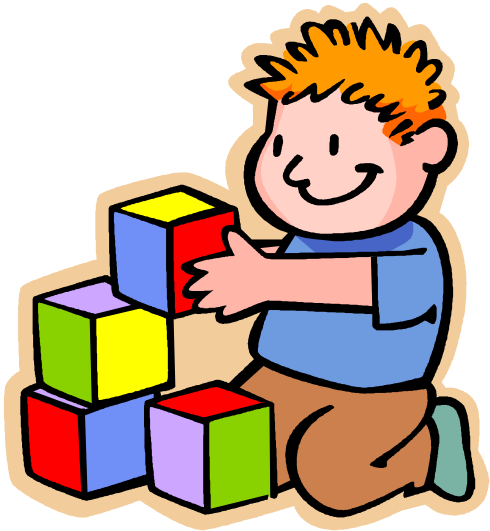
- Background
- Client Eligibility
- Benefits
- Service Limitations
- Provider Eligibility



Texas Medicaid Nursing and Personal Care Services Available In the Home:

- Private Duty Nursing, Home Health Care & Personal Care Services

Program Basics



Mandatory vs. Optional

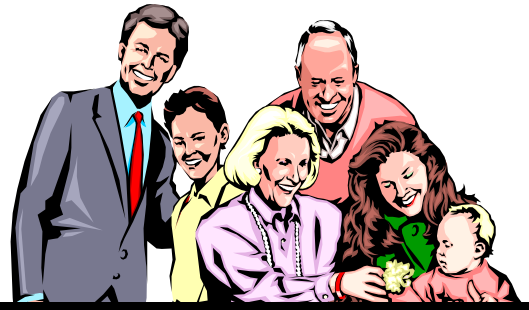
Mandatory

- Federal law requires that all state Medicaid programs cover certain services for clients.
- Home health care: mandatory.

Optional

- States may choose to provide optional services specified by federal law.
- Private duty nursing & personal care: optional.

Age & Eligibility



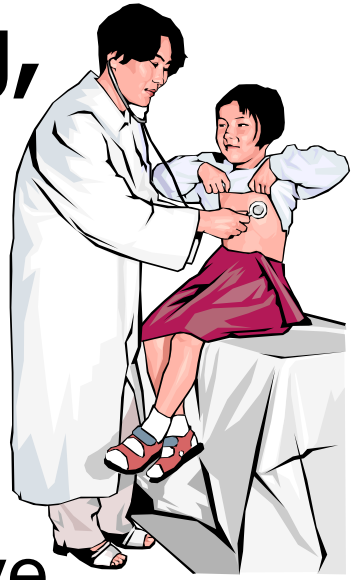
Program	< 21	21-64	65+
Private Duty Nursing	X		
Home Health Care	X	X	X
Personal Care Services	X	X	X

HHSC or DADS?

- The Health and Human Services Commission administers the Private Duty Nursing and Home Health Care programs for Medicaid clients.
- The Department of Aging and Disability Services administers multiple personal care services programs utilized by Medicaid clients.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) & Comprehensive Care Program (CCP)

Early and Periodic Screening, Diagnostic, and Treatment



- EPSDT enacted in 1967 in response to high rejection rates among military draftees due to childhood illnesses.
- EPSDT mission is to provide preventive and primary health and dental care to <21 Medicaid clients prior to health problems becoming chronic or irreversible.
- Texas Health Steps (THSteps) is the Texas EPSDT program.

Comprehensive Care Program

- Omnibus Reconciliation Act of 1989 (OBRA 89) expanded EPSDT services.
- OBRA 89 required states to offer all health care services available under Title XIX (Medicaid Act), mandatory and optional, to EPSDT clients, if medically necessary.
- In Texas, the expanded EPSDT benefit is known as CCP. For <21 population, CCP waives benefit limits imposed on adults, e.g., DME supplies.
- Private duty nursing (PDN) is available to Medicaid <21 clients through CCP.

Private Duty Nursing (PDN)

Who receives PDN?

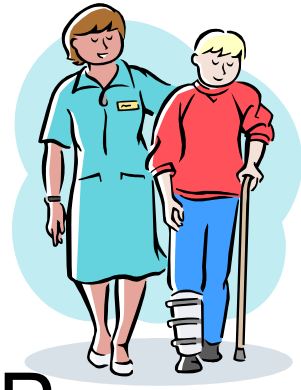
- Medicaid <21 clients entitled to all medically necessary PDN or home health skilled nursing services (HHSN).
- HHSN may be authorized instead of PDN if client nursing needs can be met on per visit basis.

What are Medically Necessary Nursing Services?

- Requested services are defined as nursing by Texas Nursing Practice Act.
- Services will correct or ameliorate client's disability or physical or mental illness or condition.
- No third party resource exists to assume financial responsibility for services.

Who Can Provide PDN?

- Licensed and certified home health service agencies.
- Independent RNs and LVNs.
- All must enroll with Medicaid and provide PDN through THSteps-CCP.



PDN Reimbursement

- Providers must bill in 15-minute increments
- Home health agencies must use HCFA-1450 (UB-92) claim form.
- Independent nurses must use CMS-1500 claim form.
- Independently enrolled nurses can bill a maximum of 16 hours per day.
- A single nurse can care and bill for more than one client in a single setting under certain conditions.

PDN Benefits and Limitations

- PDN is provided as a benefit to clients who meet medical necessity criteria and need continuous skilled care beyond what can be provided through standard Medicaid home health services.
- PDN provides skilled nursing care, caregiver training, and education intended to optimize client health status and outcomes.
- PDN cannot be authorized to provide respite care, childcare, activities of daily living, housekeeping, or comprehensive case management.

PDN Eligibility Criteria

Client must:

- Be under 21, eligible for Medicaid & CCP;
- Meet medical necessity criteria for PDN;
- Receive prior authorization from State or TMHP;
- Have a PCP;
- Require care beyond standard HHSN; and,
- Have a primary caregiver in home, and have an alternative caregiver or plan to provide care if primary caregiver unable to care for client.

PDN Place of Service

- PDN is authorized on basis of providing the care in client's home.
- Services may follow client to primary/ alternate caregiver' home, nurse provider's home, client's school, or daycare.
- All places of services must be able to support client's health and safety needs.

PDN Amount and Duration

- Amount and duration of PDN, as well increases and decreases in PDN, will depend on:
  - frequency of skilled nursing interventions;
  - complexity and intensity of client's care;
  - stability and predictability of client's condition; and
  - identified problems, goals and progress toward goals.

PDN Authorization Process

- Provider must submit the following documentation to TMHP-CCP for initial and subsequent authorizations:
  - THSteps-CCP PA Request Form;
  - Physician's Plan of Care; and,
  - Nursing Addendum to Plan of Care (Incl. 24 hour schedule of client care).
- 60-day initial authorizations.
- 4-6 month authorization extensions.

Home Health Services

Texas Medicaid Home Health Services Encompass the Following:

- home health skilled nursing (HHSN);
- home health aide visits;
- physical therapy visits;
- occupational therapy visits;
- DME; and,
- expendable medical supplies for use in client residence.

HHSN: Who Provides?

- HHSN must be provided by a Medicaid-enrolled home health agency.
- HHSN must be provided by an RN or LVN.
- Home health agencies can provide HHSN on part-time or intermittent basis.
- Part-time = nursing services provided any number of days.
- Intermittent = nursing services are not provided daily, and less than 8 hours per day.

HHSN: Referral & Authorization

- A client can be self-referred, physician-referred, or family can request an assessment.
- After assessment, the home health agency must call TMHP-HH and answer questions related to client's condition and medical necessity within 3 business days of the start of care.
- HHSN services are prior authorized by TMHP-HH. HHSN requests for <21 clients that are not authorized by THMP-HH will go to TMHP-CCP for possible authorization as PDN or HHSN through CCP.

HHSN: Referral & Authorization (Cont'd)

- All medically necessary nursing will be approved as PDN or HHSN.
- Authorization for HHSN lasts for 60 days.
- The home health agency must create and retain a physician–signed plan of care (POC) as part of the client's medical record.
- The POC must be updated every 60 days.

HHSN: Reimbursement

- Home health agencies can bill up to 2.5 hours per visit nurse or home health aide, and up to 3 visits per day.
- Billable home visits may include:
  - teaching client/family how to administer care;
  - supervising home health aides and others;
  - teaching client/family injection methods; and,
  - teaching client/family diabetes care and insulin injection

Personal Care Services

DADS Programs

- DADS currently administers 10 Community Care entitlement and waiver programs that provide personal care services to Medicaid and non-Medicaid clients.
- Community Care Medicaid Entitlement Services include:
  - Primary Home Care;
  - Community Attendant Services; and,
  - Day Activity and Health Services

Community Care Medicaid Waiver Programs include:

- Community-Based Alternatives;
- Home and Community-Based Services;
- Community Living Assistance and Support Services;
- Deaf-Blind with Multiple Disabilities;
- Medically Dependent Children's Program;
- Texas Home Living; and,
- Consolidated Waiver Program.

Program Differences

- The waiver programs generally serve populations that do not qualify for Medicaid due to high incomes.
- Primary Home Care (PHC) in the entitlement programs category of is the only program geared toward providing in-home personal care services to a population enrolled in Medicaid.

PHC: Description

- Primary Home Care (PHC) is a non-technical, personal care service for persons whose chronic health problems impair their ability to perform activities of daily living.
- Personal attendants provide services to assist clients in performing tasks of daily living.
- In SFY 2004, PHC served an average of 57,000 clients per month. It is the largest community care program in Texas and one of the largest in US.
- In SFY 2004, clients received an average 16.4 hours per week.

PHC: Providers

An agency providing personal assistance services under PHC must do so under the Personal Assistance Services (PAS) category of Home and Community Support Services Agency Licensure.

PHC: Benefits and Limitations

Benefits:

- assignment of a personal services attendant to assist the client with the following tasks:
  - bathing
  - dressing
  - meal preparation
  - feeding/eating
  - exercise
  - Grooming
  - routine hair/skin
  - Care assistance with self-administered medication
  - toileting
  - transfer/ambulation
  - cleaning
  - laundry
  - shopping
  - escorting

PHC: Benefits and Limitations *(Continued)*

- Benefits
  - consumer directed services (CDS).
- Limitations
  - 50 hours per week;
  - client must have a medical need for benefit; and,
  - mental/behavioral/cognitive illness or impairment alone will not qualify for a client. Must have a co-existing medical condition

PHC Eligibility Criteria

- Financial eligibility determined by HHSC
  - Medicaid eligible.
  - can be of any age.
- Functional eligibility determined by DADS
  - functional assessment conducted by DADS field eligibility staff.
  - medical practitioner statement attesting to individual's medical condition causing a functional limitation for at least one personal care task.

MODULE 13- Medical Transportation Program

Objectives

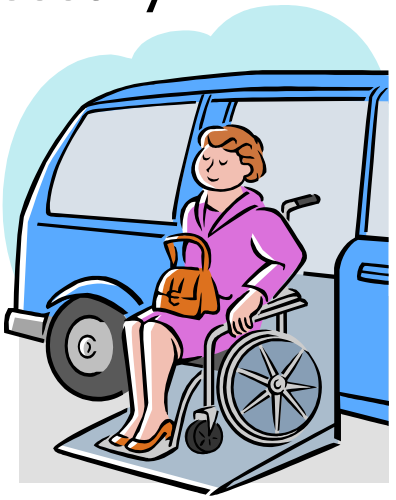
The information covered in this module is a review of the following:

- 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 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.



Program Eligibility

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 guidance on a child's growth and development.
- Have no other means of transportation to obtain Medicaid covered services.

Description of 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.
- Transportation through a mass transit provider
- Transportation by a commercial provider

Description of Services *(Continued)*

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

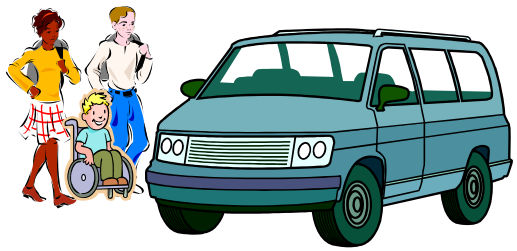
- Stays at lodging facilities
- Meal expenses for the client and one attendant
- Travel advances

Requests for Service

Medicaid clients can request services by calling MTP 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.
- at least 2 business days before the scheduled appointment for services within a county or a county adjacent to the resident county
- at least 5 business days before the scheduled appointment for services beyond the adjacent county

Required Information



The following information must be provided to the intake operator at the time of the call:

- Medicaid/CSCHN/Social Security number
- Name, address, and phone number, if available
- Name, address, and phone number of health care provider
- Purpose of the trip
- Affirmation that no other means of transportation are available
- Special Needs, wheelchair lift, or attendant need

Critical Same Day Service

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 Request

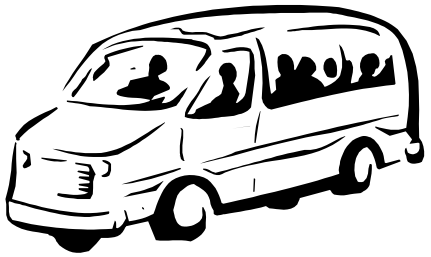
When cancellation of scheduled transportation is necessary, the client should notify MTP regional staff as soon as possible, at least one workday in advance of the scheduled service.

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
- 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
- Obtaining non-Medicaid covered services

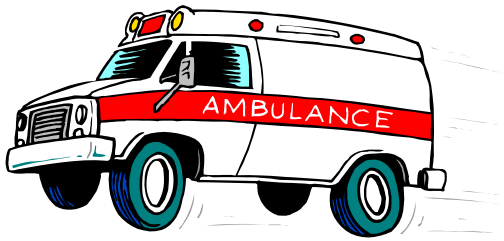
Ambulance Services

If a client has a severe disability and the use of an ambulance is the only appropriate means of transport, the provider may request prior authorization for non-emergency ambulance service. 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

For emergency ambulance transportation services, clients should call an EMS service (911).

***Between 8:00 a.m. to 500 p.m., Monday through Friday, CST in residential facilities.**



MODULE 14-
Alberto N. et al. vs. Albert Hawkins, et al.

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

Its Impact on Medicaid Policy

Origins of Lawsuit

- 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.

Origins of Lawsuit *(Continued)*

- 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:
  1. THSteps – CCP (HHSC)
  2. Medicaid Home Health Care Services (HHSC)
  3. Primary Home Care (DADS)

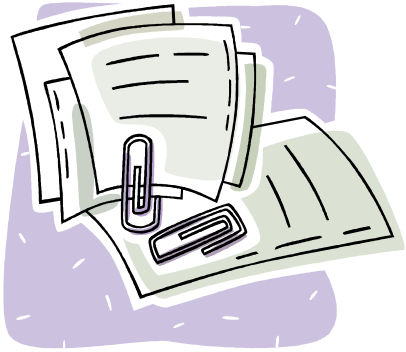
Mediation

- 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.

First Partial Settlement Agreement *(Continued)*



- 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.

Second Partial Settlement Agreement: 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.

Main Elements *(Continued)*

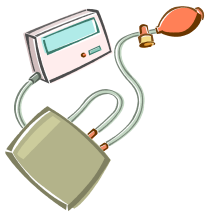
- HHSC will move personal care services for <21 population from DADS to HHSC to provide an improved opportunity for a continuum of care. Effective date of change: 9/1/2006.
- HHSC will convene a workgroup to advise the agency on the development of:
  - new criteria for authorizing personal care services for <21 Medicaid clients; and,
  - a comprehensive assessment that will be used by providers to authorize nursing services and personal care services.

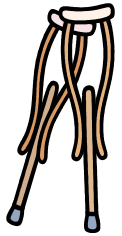
Immediate Impacts of Second Partial Settlement Agreement

- 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 care; and,
  - parent/guardian need to sleep, work, care for others

DME and Supplies Changes

- 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.



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.

Nursing Services *(Continued)*

- 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.

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.

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

Personal Care Services *(Continued)*

- **HHSC will convene a workgroup to advise on the 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.**

Additional Changes

- 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.

Workgroup Activities

- 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.

Workgroup Progress

- 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.

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 THSteps lawsuit, Consent Decree, and its impact on MCOs:

- Background
- Litigation Case Summary
- Consent Decree and MCOs

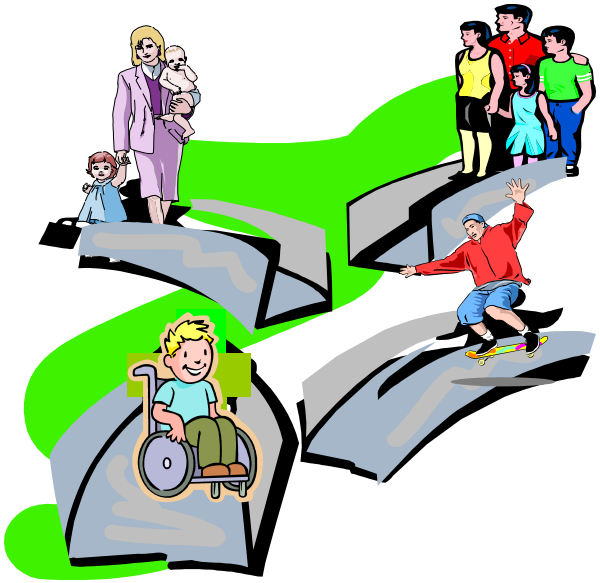
What is the lawsuit?

Frew vs. Hawkins is a class action suit filed in 1993 against the State of Texas alleging that Texas did not adequately provide Medicaid Early and Periodic Screening, Diagnosis and Treatment services. It was by a Consent Decree.

August 18, 2006

What are the major allegations?

- Medical and dental screens not timely provided.
- Ineffective Informing about benefits
- Inadequate Case Management Services
- Inadequate Medical Transportation Program
- Inadequate supply of providers



KEY DATES:

1993- Lawsuit filed

1996- Consent Decree Signed

2000- Hearing to Enforce the Consent Decree and findings of violations

2005- Hearing to Dissolve Consent Decree

2006 ??- Hearing regarding Corrective Action Plans

MCOs and Frew – General Consent Decree Issues

- outreach and informing
- medical and dental services
- transportation services
- training
- measuring outcomes/reporting

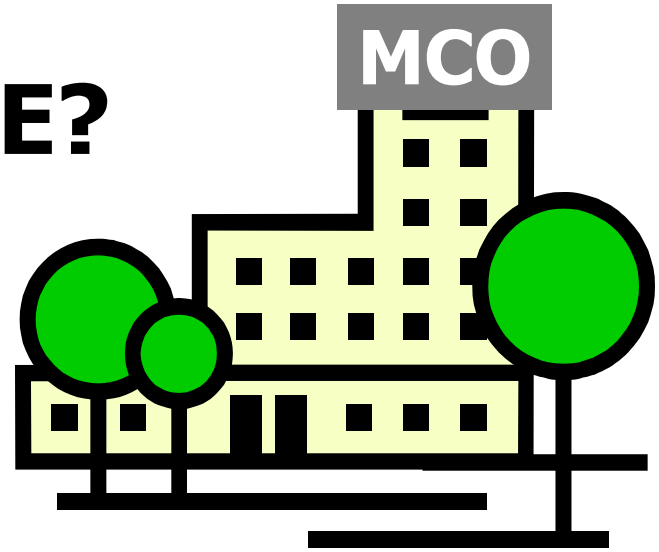




Consent Decree -MCO Specifics

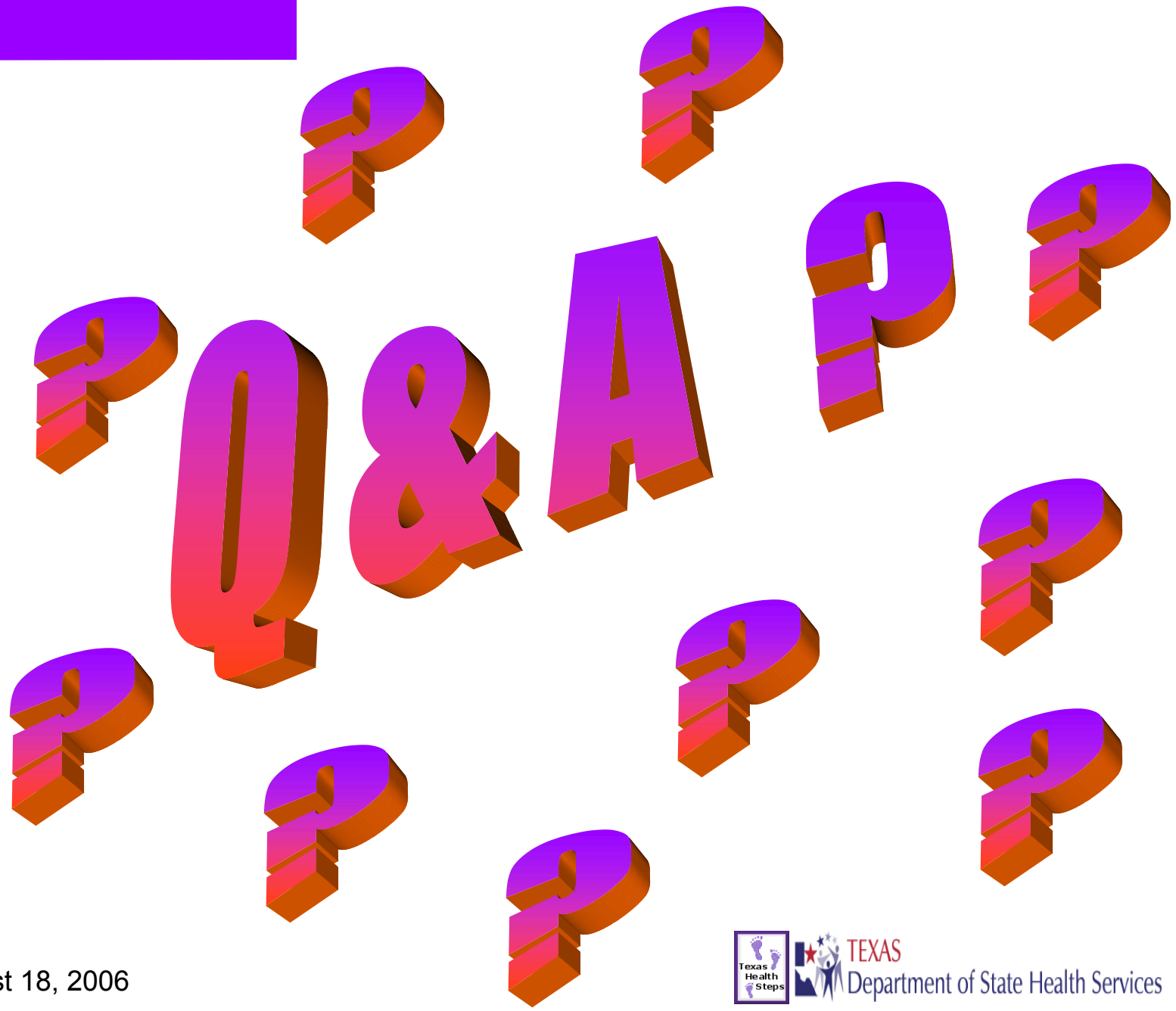
- Timely checkups, including within 90 days for new enrollees.
- Ability to challenge decisions
- Accelerate services to migrant farm workers.
- Appropriate provider training
- Adequate supply of providers

Frew and the FUTURE?



Corrective Action Plan MCOs?

- Timely Checkups
- Capacity to serve migrant farm workers
- Appropriate training of staff
- Plans to improve participation
- Reporting participation and outcome measures


Q&A

…for ALL that you do for our clients!!