

Ward - 4/19/02

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

FILED-CLERK
U.S. DISTRICT COURT
02 APR 19 PM 12:53
TEXAS EASTERN
BY *[Signature]*

ALBERTO N., ET AL.

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V.

CIVIL ACTION NO. 6:99CV459

DON A. GILBERT, ET AL.

**ORDER OF PARTIAL DISMISSAL AND
ORDER APPROVING, ADOPTING, AND INCORPORATING
PARTIAL SETTLEMENT AGREEMENT**

This action comes before the Court pursuant to the parties' Joint Stipulation of Voluntary Partial Dismissal (Docket #126). After consideration of the matter and being otherwise fully advised, it is hereby ORDERED and ADJUDGED that, as set forth in the Partial Settlement Agreement, the claims or issues related to (a) therapy services; (b) the provision of notice and an opportunity to request a fair hearing upon denial, reduction, or termination of a requested Medicaid benefit; (c) the adequacy of the written notices denying, reducing, or terminating a Medicaid benefit; (d) Medicaid fair hearing procedures; and (e) the contents of Medicaid fair hearing decisions, are hereby dismissed with prejudice.

It is further ORDERED that the Partial Settlement Agreement, attached hereto, is approved, adopted, and fully incorporated as this Court's order, and that the Court retain jurisdiction as provided for in the Agreement.

So ORDERED and SIGNED in chambers at ^{*Marshall*} ~~Tyler~~, Texas, on this 19 day of April,

2002.

T. John Ward

T. JOHN WARD
UNITED STATES DISTRICT JUDGE

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PARTIAL SETTLEMENT AGREEMENT

I. Parties to the Agreement

1. The parties to this Agreement are the Named Plaintiffs in *Alberto N., et al. v. Don A. Gilbert, et al.*, Civil Action No. 6:99CV459, United States District Court, Eastern District of Texas, Tyler Division: Alberto N., by his parents and next friends, Mr. and Mrs. N.; Alice F., by her next friend, Ms. K.; Keyaira R.-D., by her parent and next friend, Ms. D.; Kaitlyn C., by her parent and next friend, Ms. C.; Aaron D., by his parent and next friend, Ms. D.; Andrew M., by his parent and next friend, Ms. M.; Evan W., by his parents and next friends, Mr. and Mrs. W.; and Chelsea C., by her parent and next friend, Ms. C.; and the Named Defendants, Don A. Gilbert, in his official capacity as Commissioner of the Texas Health and Human Services Commission, Dr. Charles Bell, in his official capacity as the Deputy Commissioner of the Texas Department of Health, and James R. Hine, in his official capacity as the Commissioner of the Texas Department of Human Services.

II. General Provisions

2. It is expressly understood and agreed that all terms of this document are contractual and not merely recitals. The parties to this Agreement intend that this written document will incorporate the full terms and conditions of their agreement. It is also understood that the titles for each section of the document and all exhibits are part of the Agreement.

3. The parties acknowledge that this Agreement does not alter federal law and that such law and the terms of this Agreement will govern in any future action under this Agreement.

4. This Agreement applies to persons under the age of 21 years who are eligible to receive Early and Periodic Screening, Diagnosis, and Treatment (Texas Health Steps) benefits under the Texas Medical Assistance Program, established under Chapter 32, Texas Human Resources Code.

5. This Agreement is limited in scope to the issues raised in Plaintiffs' First Amended Complaint, filed in Civil Action No. 6:99CV459, and as described in paragraphs 51 and 52.

6. This Agreement is subject to the approval of the Attorney General, the Governor, and the Comptroller of the State of Texas. Defendants will make a good faith effort to obtain all necessary approvals by October 15, 2001.

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

III. Definitions

8. "Agency" means the Health and Human Services Commission and, when appropriate, the agency operating the relevant part of the Texas Medical Assistance Program.
9. "Contractor" means the health insuring organization, as that term is defined in 42 C.F.R. § 434.2, for the Texas Medical Assistance Program.
10. "Federal financial participation" means the federal government's share of a state's expenditures under the Medicaid program.
11. "Medicaid" means the Texas Medical Assistance Program established under the provisions of Chapter 32, Texas Human Resources Code, and subject to the requirements of Title XIX of the Social Security Act and its regulations.
12. "Notice" means a letter provided by the Agency to a Medicaid beneficiary under the age of 21 informing the beneficiary of any reduction, denial, or termination of a requested service, as described in 42 C.F.R. §§ 431.206 and 431.210.
13. "Policy" means all terms, criteria, guidelines, and standards that inform Agency action.
14. "Therapy" means occupational therapy, physical therapy, and services for individuals with speech, hearing and language disorders, as those terms are defined in 42 C.F.R. § 440.110.

IV. Resolution as to Certain Claims

A. Notice

15. Specific notice must be provided upon a determination by the Agency reducing, denying, or terminating a requested Medicaid service. The basis for such a determination will be limited to either not medically necessary or because federal financial participation is not available.
16. The notice informing the Medicaid beneficiary of a reduction, denial, or termination of a requested service because there is no federal financial participation for the requested service shall: (a) state that this is the basis; (b) contain an explanation of the basis for the Agency's decision, applying the state or federal law to the individual's particular request; and (c) cite the particular federal law that prohibits federal financial participation for the requested service.
17. All notices required under this Agreement pursuant to paragraph 16 must contain—
 - (a) The dates, type, and amount of service requested;
 - (b) A statement of what action the Agency intends to take (i.e., a reduction, denial, or termination of services);
 - (c) The basis for the intended action;

- (d) An explanation of the basis for the Agency's decision, applying the state and/or federal law to the individual's particular request;
- (e) A cite to the particular federal law that prohibits federal financial participation for the requested service;
- (f) A toll free number for the individual's use in seeking additional information regarding the intended action, for requesting help understanding the notice, and for requesting a fair hearing;
- (g) Information about accessing medical case management; and,
- (h) An explanation of --
 - (1) The individual's right to a fair hearing;
 - (2) The number of days and date by which the fair hearing must be requested;
 - (3) The individual's right to represent himself or herself, or use legal counsel, a relative, friend, or other spokesman;
 - (4) The right to either a written, telephonic, or in-person hearing;
 - (5) The right to examine, at a reasonable time before the date of the hearing, the contents of the case file and any and all documents to be used by the Agency at the hearing; and,
 - (6) The circumstances under which services will be continued if a hearing is requested.

18. The notice informing the Medicaid beneficiary of a reduction, denial, or termination of a requested service, based on a determination that the requested service is not medically necessary, shall (a) state that this is the basis; (b) contain an explanation of the medical basis for the Agency's decision, applying the Agency's policy or the accepted standards of medical practice to the individual's particular medical circumstances; and (c) cite the particular state and federal law that supports, or the change in state or federal law that requires, the intended action.

19. All notices required under this Agreement pursuant to paragraph 18 must contain--
- (a) The dates, type, and amount of service requested;
 - (b) A statement of what action the Agency intends to take (i.e., a reduction, denial, or termination of services);
 - (c) The basis for the intended action;
 - (d) An explanation of the medical basis for the Agency's decision, applying the Agency's policy or the accepted standards of medical practice to the individual's particular medical circumstances;
 - (e) A cite to the particular state and federal law that supports, or the change in state or federal law that requires, the intended action;
 - (f) A toll free number for the individual's use in seeking additional information regarding the intended action, for requesting help understanding the notice, and for requesting a fair hearing;
 - (g) Information about accessing medical case management; and,
 - (h) An explanation of --

- (1) The individual's right to a fair hearing;
- (2) The number of days and date by which the fair hearing must be requested;
- (3) The individual's right to represent himself or herself, or use legal counsel, a relative, friend, or other spokesman;
- (4) The right to either a written, telephonic, or in-person hearing;
- (5) The right to either examine, at a reasonable time before the date of the hearing, the contents of the case file and any and all documents to be used by the Agency at the hearing; and
- (6) The circumstances under which services will be continued if a hearing is requested.

20. When a request for prior authorization is submitted to the Agency or its contractor with incomplete specific documentation/information: the Agency or its contractor will return the request to the Medicaid provider with a letter describing the documentation that needs to be submitted, or when possible, the Agency or its contractor will contact the Medicaid provider by telephone and obtain the information necessary to complete the prior authorization process. If the documentation/information is not provided within sixteen (16) business hours of its request to the Medicaid provider, a letter will be sent to the Medicaid beneficiary explaining that the request cannot be acted upon until the documentation/information is provided, along with a copy of the letter sent to the Medicaid provider describing the documentation/information that needs to be submitted. If the documentation/information is not provided to the Agency or its contractor within seven days (7) of its letter to the Medicaid beneficiary, a notice will be sent to the Medicaid beneficiary informing the beneficiary of its denial of the requested service due to the incomplete documentation/information, and providing the beneficiary an opportunity to request a fair hearing. Notwithstanding the above, the Agency shall require its contractor to modify these procedures as necessary to improve the prior authorization process. The Agency shall notify Plaintiffs' counsel thirty (30) days prior to the implementation of any such changes.

21. Notices must substantially conform to the sample notices attached as Exhibit A.

22. All notices required under this Agreement must be written at a sixth grade reading level with the exception of citations, medical terms, policy, or law.

23. Within six (6) months of the effective date of this Agreement, the Agency shall require its contractor to implement the terms of paragraphs 15 through 22.

B. Fair Hearings

24. The Agency's fair hearing system must meet the due process standards set forth in Goldberg v. Kelly, 397 U.S. 254 (1970), and any additional standards specified in 42 C.F.R. §§ 431.200-250.

25. Hearing decisions must be based exclusively on evidence introduced and received at the hearing and must meet the standards specified in 42 C.F.R. § 431.244. This requirement will be reduced to writing and will be part of the training and guidance materials provided to all Agency hearing officers.
26. Because fair hearings must be based exclusively on evidence introduced and received into evidence at the hearing, hearing officers are prohibited from engaging in ex parte communications relating to matters to be adjudicated. This prohibition will be reduced to writing and will be part of the training and guidance materials provided to all Agency hearing officers.
27. If the fair hearing decision sustains the Agency action reducing, denying, or terminating a requested service on the basis that there is no federal financial participation, the decision must contain an explanation of the basis for the hearing officer's decision, applying the state and federal law to the individual's particular request.
28. If the fair hearing decision sustains the Agency action reducing, denying, or terminating a requested service on the basis that the service is not medically necessary, the decision must contain an explanation of the medical basis for the hearing officer's decision, applying the Agency's policy or the accepted standards of medical practice to the individual's particular medical circumstances.
29. All hearing decisions must substantially conform to the sample hearing decision attached as Exhibit B.
30. Within thirty (30) days of the date of the fair hearing decision, the Agency will redact all confidential information from the decision and make it available to the public.

C. Therapy

31. The parties agree that no limitations exist for the provision of medically necessary physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders, for which federal financial participation is available. The Agency shall approve medically necessary physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders, except where federal financial participation is not available.
32. The Agency shall provide medically necessary physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders if there is or will be progress made towards a goal, as supported by documentation from the prescribing physician and the treating therapist. Therapy goals include improving function, maintaining function, or slowing the deterioration of function.
33. The Agency will revise the Medicaid Provider Procedures Manual to conform with the policies described in paragraphs 31 and 32 of this Agreement. The Manual revisions will also include a description of the documentation that must be submitted by the prescribing physician and

treating therapist, when seeking authorization for therapy services. The Agency will provide Plaintiffs' counsel with a copy of these revisions for review and comment prior to publication in the Medicaid Provider Procedures Manual. Any corrections or clarifications will be made in subsequent Texas Medicaid Bulletins.

34. Within ninety (90) days of the effective date of this Agreement, the Agency will publish an explanation of the policies described in paragraphs 31 and 32 of this Agreement in the Texas Medicaid Bulletin. The text to be published in the Bulletin will be provided to Plaintiffs' counsel for review and comment at least fourteen (14) days prior to the publication deadline.

35. The Agency will publish an explanation of the policies described in paragraphs 31 and 32 of this Agreement in the 2002 Medicaid User's Guide. This information will also be highlighted in a letter to be included with the Medicaid User's Guide. The User's Guide and the text of the letter will be provided to Plaintiffs' counsel for review and comment at least fourteen (14) days prior to the publication deadline.

V. Additional Terms and Provisions

A. Medicaid User's Guide and Hotline

36. The Agency will update and improve the Medicaid User's Guide on an annual basis.

37. The Agency will make reasonable good faith efforts to provide beneficiaries who contact its contractor's toll-free Medicaid Hotline with consistent, detailed information regarding the following: (a) the intended action; (b) the basis for the intended action; (c) the procedure for requesting a fair hearing; and (d) accessing medical case management services.

B. Training

38. The Agency will train its relevant staff concerning all requirements of this Agreement within ninety (90) days of its effective date.

39. The Agency will require its contractor to train its relevant staff concerning all requirements of this Agreement within ninety (90) days of its effective date.

40. The Agency will approve the contractor's curriculum and verify that the training has been conducted for all relevant staff.

41. The Agency will provide copies of all training materials to Plaintiffs' counsel prior to the training sessions.

42. Plaintiffs' counsel may observe one (1) Agency training and one (1) contractor training conducted pursuant to this Agreement.

C. Reporting

43. The parties acknowledge the importance of mutual communication during the implementation of the terms of this Agreement. To ensure effective and timely communication regarding the changes to the state's Medicaid programs necessitated by this Agreement, the Agency or its counsel shall submit three (3) written status reports to Plaintiffs' counsel. These status reports shall provide detailed information as to all activities undertaken to fully implement the terms of this Agreement. The reports shall be provided according to the following schedule: ninety (90) days, one hundred and eighty (180) days and three hundred and sixty (360) days after the effective date of this Agreement.

44. For a period of two (2) years after the effective date of this Agreement, the Agency or its counsel shall submit to Plaintiffs' counsel quarterly reports concerning the following Medicaid services for EPSDT beneficiaries: private duty nursing services; home health skilled nursing visits; durable medical equipment and supplies; and occupational therapy, physical therapy and services for individuals with speech, hearing and language disorders. These reports shall identify the number of: requests for prior authorization; approvals of prior authorization requests; modifications of prior authorization requests; and denials of prior authorization requests. Agency expenditures for the identified services shall also be reported to Plaintiffs' counsel on a quarterly basis or as the data is typically reported in the regular course of business. These reports will be provided to Plaintiffs' counsel within fourteen (14) days from the date that the information from the previous quarter becomes available.

D. Monitoring and Verification

45. Each quarter, the Agency will provide Plaintiffs' counsel with copies of the following notices:

- (a) denials on the basis of no federal financial participation: all notices, not to exceed two hundred (200);
- (b) denials and reductions of therapy services: thirty percent (30%), or two hundred (200), whichever is less;
- (c) denials and reductions of all other services on the basis of no medical necessity: two hundred (200).

46. The notices described in (b) and (c) above will be selected randomly. All notices will be redacted, and will be provided for a period of two (2) years beginning six (6) months from the effective date of the Agreement.

E. Effective Date, Adoption and Approval of the Agreement by the Court

47. This Agreement is effective as of the date of the Court's approval and adoption of the Agreement.

F. Incorporation, Jurisdiction, and Enforcement

48. It is the intention of the parties that the Agreement be fully incorporated into an order of the Court and that the Court have exclusive jurisdiction over all matters relating to enforcement of the Agreement. This Agreement neither adds to nor subtracts from the court's jurisdiction.

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

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

G. Dismissal of Certain Claims

51. Within thirty (30) days of the effective date of this Agreement, the parties will file with the Court a Joint Stipulation of Voluntary Dismissal, in accordance with Rule 41(a) of the Federal Rules of Civil Procedure. The Stipulation will dismiss with prejudice claims related to:

- (a) therapy services;
- (b) the provision of notice and an opportunity to request a fair hearing upon denial, reduction, or termination of a requested Medicaid benefit;
- (c) the adequacy of the written notices denying, reducing, or terminating a Medicaid benefit;
- (d) Medicaid fair hearing procedures; and
- (e) the contents of Medicaid fair hearing decisions.

52. The above provision and the Joint Stipulation of Voluntary Dismissal does not apply to the following issues:

- (a) the obligation to provide notices to parents or legal guardians of beneficiaries under the age of 18;
- (b) the continuation of prior-authorized services pending appeal;
- (c) the authority of hearing officers;
- (d) private duty nursing services;
- (e) personal care services; and
- (f) durable medical equipment and supplies.

H. Attorneys' Fees, Costs, and Expenses

53. Within fourteen (14) days of the effective date of the Agreement, Plaintiffs will submit to Defendants a request for reasonable attorneys' fees, costs, and expenses. Defendants will respond to this request within sixty (60) days of receipt. Within sixty (60) days of an agreement on fees,

Defendants will seek the approval of the Attorney General, the Governor, and the Comptroller of the State of Texas and, once approved, will forward a check made payable to Advocacy, Inc., 7800 Shoal Creek Blvd., Suite 171-E, Austin, Texas 78757. If the parties cannot agree on the amount of attorneys' fees, or the required approvals are not obtained, Plaintiffs may petition the Court for an award of reasonable attorneys' fees, costs, and expenses.

I. Counterparts

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

J. Binding

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

K. Execution of Agreement

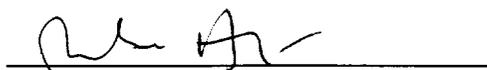
56. Counsel for Defendants represent that they have been fully authorized by their clients to enter into and execute this Agreement, under the terms and conditions contained herein.

SIGNED on the dates indicated below:



MARYANN OVERATH
State Bar No. 00786851

Date: 3/13/02



PETER HOFER
State Bar No. 09777275

Date: 3/13/02

ADVOCACY, INCORPORATED
7800 Shoal Creek, Suite 171-E
Austin, Texas 78757
Tel. (512) 454-4816



MAUREEN O'CONNELL
State Bar No. 00795949

Date: 3/13/02

SOUTHERN DISABILITY LAW CENTER
1006 Elm Street
Austin, Texas 78704
Tel. (512) 474-9093

ATTORNEYS FOR PLAINTIFFS

JOHN CORNYN
Attorney General of Texas

HAROLD G. BALDWIN
First Assistant Attorney General

JEFFREY S. BOYD
Deputy Attorney General for Litigation

TONI HUNTER
Chief, General Litigation Division



EDWIN N. HORNE
State Bar No. 10008000
Assistant Attorney General
P.O. Box 12548, Capitol Station
Austin, Texas 78711
Tel. (512) 463-2120

Date: 3/13/02

ATTORNEYS FOR DEFENDANTS

NAMED PLAINTIFFS:



PATRICIA N. [redacted]
Parent and next friend of Plaintiff Alberto N.

Date: 03/14/02

Maria K [REDACTED]
MARIA K [REDACTED]
Next friend of Plaintiff Alice F.
Date: 3-27-02



RITA D. [redacted]
Parent and next friend of Plaintiff Keyaira R.-D.
Date: 3/14/02


KATHY C. [redacted]
Parent and next friend of Plaintiff Kaitlyn C.
Date: 3/14/02


MARIE D. [redacted]
Parent and next friend of Plaintiff Aaron D.
Date: 3-14-02

Karen M. [REDACTED]
KAREN M. [REDACTED]
Parent and next friend of Plaintiff Andrew M.

Date: 3/17/02


Allen W. 

ALLEN W. 
Parent and next friend of Plaintiff Evan W.

Date: 3/14/02


Chava W. 

CHAVA W. 
Parent and next friend of Plaintiff Evan W.

Date: 3/14/02



PATRICIA C. [redacted]
Parent and next friend of Plaintiff Chelsea C.

Date: 3-20-02

**PARTIAL SETTLEMENT AGREEMENT
EXHIBIT A**

EXHIBIT A: SAMPLE NOTICE LETTER FOR DENIAL OF SERVICES - NO FFP

July 1, 2001

Address to: Medicaid beneficiary

Copy to: Requesting provider

Dear Medicaid Beneficiary:

Request: Family Living, Inc. has requested prior authorization to provide you the following service(s):

12 hours per day of home health services for the period of July 15, 2001 through September 15, 2001.

Date of request: June 25, 2001

Response to request: Denied

Reason: This request is denied because Family Living, Inc., the home health agency identified as the provider of these services, does not meet the surety bond requirements required by federal law. Because Family, Living, Inc. does not meet the surety bond requirements, federal financial participation is not available and Texas Medicaid cannot authorize the services.

In order to receive these services you must choose a provider that meets the requirements of the Medicaid program. You may obtain a list of Medicaid providers by contacting 1-[xxx-xxx-xxxx].

[Insert the following if it makes sense in the context of the denial. It does not make sense in the context of this particular sample.] Your provider has been sent a copy of this letter. You may want to discuss this decision with your provider to make sure your provider submitted all of the documents necessary to support your request.

Legal basis for this decision:

42 C.F.R. § 441.16

Texas Human Resources Code § 32.024(e)

Fair hearing: If you want to discuss this decision or if you want to ask for a fair hearing, you can contact us free of charge at 1-[xxx-xxx-xxxx]. An explanation of your right to a fair hearing is on the other side of this letter.

Additional assistance: If you need assistance in obtaining medical care, you may be eligible for medical case management services. For more information about medical case management, you may contact the THSteps Outreach and Information Hotline, free of charge at 1-877-THSTEPS (1-877-847-8377).

EXHIBIT A: SAMPLE NOTICE LETTER FOR DENIAL OF SERVICES

July 1, 2001

Address to: Medicaid beneficiary

Copy to: Requesting provider

Dear Medicaid Beneficiary:

Request: Acme Medical Supplies has requested the following medical nutritional product:

9-5081X Ensure, powder, 420 gram, 60 day supply

Date of request: June 25, 2001

Response to Request: Denied

Reason: Texas Health Steps policy 40.4.3.6 states that medical nutrition products must be prescribed by a physician and be medically necessary. To show that this product is medical necessary, documentation must include:

- * Identification of a metabolic disorder requiring a nutritional product or
- * Indication that part or all nutritional intake is through a tube or
- * Explanation of the medical condition that requires a medical nutritional product.

Documentation submitted by your provider indicates that you do not have a metabolic disorder and that you do not have any nutritional intake through at tube. Documentation submitted by your provider indicates that you have a daily caloric intake of 1800 calories, without nutritional supplements. This is an age appropriate diet and your provider did not submit information explaining why you need this medical nutritional product to supplement your daily diet.

Your provider has been sent a copy of this letter. You may want to discuss this decision with your provider to make sure your provider submitted all of the documents necessary to support your request.

Legal basis for decision:

42 U.S.C. § 1396d(r)(5).

Texas Health Steps policy 40.4.3.6

Fair hearing: If you want to discuss this decision or if you want to ask for a fair hearing, you can contact us free of charge at 1-xxx-xxx-xxxx,. An explanation of your right to a fair hearing is on the other side of this letter.

Additional assistance: If you need assistance in obtaining medical care, you may be eligible for medical case management services. For more information about medical case management, you may contact the THSteps Outreach and Information Hotline, free of charge at 1-877-THSTEPS (1-877-847-8377).

EXHIBIT A: SAMPLE NOTICE LETTER FOR DENIAL OF SERVICES

July 1, 2001

Address to: Medicaid beneficiary

Copy to: Requesting provider

Dear Medicaid Beneficiary:

Request: Acme Therapy has requested prior authorization to provide you speech-language pathology services for the following time period: July 15, 2001 through January 15, 2001.

Date of request: June 25, 2001

Response to request: Denied

Reason: Texas Health Steps policy 40.4.12.3 states that to request an extension of services, the documentation should include a current physician signature, a summary statement of measurable progress made during the treatment period, and documentation indicating new treatment goals and anticipated measurable progress for the next treatment period. Therapy goals include improving function, maintaining function or slowing the deterioration of function.

Documentation submitted by your provider indicates that you have met all of the therapy goals related to your use of the Dynavox and does not include any new goals. Additionally, documentation submitted by your provider does not state that you require speech therapy services to maintain your current ability to use the Dynavox.

Your provider has been sent a copy of this letter. You may want to discuss this decision with your provider to make sure your provider submitted all of the documents necessary to support your request.

Legal basis for decision:

42 U.S.C. § 1396d(r)(5).

Texas Health Steps policy 40.4.12.3

Fair hearing: If you want to discuss this decision or if you want to ask for a fair hearing, you can contact us free of charge at 1-xxx-xxx-xxxx. An explanation of your right to a fair hearing is on the other side of this letter.

Additional assistance: If you need assistance in obtaining medical care, you may be eligible for medical case management services. For more information about medical case management, you may contact the THSteps Outreach and Information Hotline, free of charge at 1-877-THSTEPS (1-877-847-8377).

EXHIBIT A: SAMPLE PAGE 2 FOR ALL NOTICES

**YOU HAVE A RIGHT TO A FAIR HEARING
IF YOU DO NOT AGREE WITH THIS DECISION**

You must ask for a fair hearing within **90 days** from the date of this letter. If you do not ask for a fair hearing before [insert date], you will lose your right to a fair hearing.

Your rights in a fair hearing are:

- The right to represent yourself, or have a lawyer, relative, friend, or other person represent you;
- Before the date of the hearing, you have the right to see your case file and all of the documents that are to be used by the agency at the hearing. The documents to be used at the hearing will be sent to you before the hearing;
- The right to either a telephone or in-person hearing;
- You can also ask us to conduct the hearing using written documents only - you would not have to participate in person.
- The right to accommodations for a disability, including interpreter services.
- The right to request a language interpreter.

A fair hearing is an informal process. If you do ask for a fair hearing, you will get another letter telling you where and when the hearing will take place. The letter will also explain what will happen at the hearing, and your rights at, and after, the hearing.

You can call us to talk about this letter, even if you are not sure you want a fair hearing. You can call us free of charge at [toll free number], Monday to Friday, 8:00 a.m. to 5:00 p.m. This is the same telephone number you should call if you want to ask for a fair hearing, and if you need to request an accommodation for a disability, or interpreter services. You can also write us at the National Heritage Insurance Company (NHIC) Client Notification Office at:

[NHIC contact information]

**PARTIAL SETTLEMENT AGREEMENT
EXHIBIT B**

DOCKET NO. _____

BEFORE THE
HEALTH & HUMAN SERVICES COMMISSION
CUSTOMER RELATIONS SERVICES

IN THE MATTER §
 §
 § FAIR HEARING DECISION
PETITIONER'S NAME §
 §

ON [date], [Petitioner's name], Petitioner, appeared [in person/by telephone] before the undersigned Hearing Official to appeal the [denial/termination/reduction] of [prior authorization/services] by [Responsible Entity—e.g., NHIC, HMO, etc.]. A fair hearing was conducted to resolve the appeal and is designated by the docket number and style above. This document, and any exhibits, attachments, or evidence appended or incorporated by reference to this document, represent the Decision and Order of the Health and Human Services Commission (HHSC) in the matter identified above.

DRAFT

I. INTRODUCTION

A. Legal Authority

The fair hearing was conducted under the authority provided by [statutes and regulations].

B. Purpose of Fair Hearing

The purpose of the fair hearing was to determine whether the [denial/reduction/termination] of [prior authorization/services] by [Responsible Entity—e.g., NHIC, HMO, etc.] was erroneous or whether a request for prior authorization was acted upon with reasonable promptness.

C. Statement of the Issue

The issue raised in this hearing is whether NHIC correctly reduced Petitioner's occupational therapy from twice a week to once a week.

II. PROCEDURAL HISTORY

[Provide, in separately numbered paragraphs, a concise description of the procedural history of the case, e.g.:

- *When the request for authorization was filed, by whom, and when;*
- *Provide the same information for the request for fair hearing;*
- *Provide a description of the basics of the fair hearing, including—*
 - *Date and time of the fair hearing;*

- *Whether the fair hearing was conducted in person or by telephone;*
- *The names of—*
 - *The Petitioner's designated representative(s) (if any);*
 - *The representative(s) (if any) of the Responsible Entity; and*
 - *Any third parties present at and participating in the fair hearing.*
 - *NOTE: If third parties are present and are neither the designated representatives of the Petitioner, the program, or the Responsible Entity, consult with HHSC Legal to determine the need to obtain a waiver of confidentiality from the Petitioner.]*

Sample language follows:

1. On May 15, 2001, the Acme Rehabilitation Center submitted a request for prior authorization to provide Petitioner, _____ two sessions of occupational therapy per week for the time period June 1, 2001, through August 31, 2001. The National Heritage Insurance Company ("NHIC"), the contracted claims administrator for the Medicaid program, denied the request for two sessions per week but authorized one session per week. NHIC sent a notice of the denial to Petitioner dated May 20, 2001, stating that the "requested services are not medically necessary because the goals described in the documentation submitted by your provider can be met with one therapy session per week." A copy of the Notice is appended to this Decision and Order as Exhibit 1.
 2. On May 23, 2001, Petitioner's grandmother, Ms. _____, requested a fair hearing. Petitioner's request is appended to this Decision and Order as Exhibit 2.
 3. An in-person hearing was convened in Austin, Texas, at 10:00 a.m., on June 25, 2001. The record was held open for written statements from the parties until July 5, 2001. The record was closed on July 6, 2001.
 4. Appearances on behalf of Petitioner were:
 - Ms. _____, grandmother of _____
 - Cornelius Wyley, M.D., _____'s physician
 - Pamela Fox, OTR, _____'s occupational therapist.
- Appearances on behalf of Agency were:
- Ms. Virginia Ness, R.N., NHIC representative.

5. Petitioner and NHIC presented evidence at the fair hearing. This evidence is identified in Exhibit 3, which is appended to this Decision and Order.

III. SUMMARY OF EVIDENCE

[Describe, in separately numbered paragraphs, the relevant evidence, as required by 42 C.F.R. § 431.244, including reference to the list of exhibits accepted on behalf of Petitioner and the Responsible Entity and any additional submissions obtained at the hearing.]

Sample language follows:

A. Evidence on behalf of NHIC.

1. Ms. Virginia Ness, R.N., NHIC representative, testified that she reviewed the documentation submitted by Acme Rehabilitation Center in support of its request for prior authorization and that, in her opinion, the goals described in the documentation could be met with the provision of one therapy session per week.
2. Ms. Ness, R.N., also testified that the provider failed to submit information regarding the percentage of appointments kept during each six-month period and an assessment of family involvement in therapy.

B. Evidence on behalf of Petitioner

1. Petitioner's grandmother, Ms. _____ testified that _____ is nine years old and has been receiving two sessions per week of occupational therapy for the past five years. Ms. _____ testified that the purpose of the therapy is to help her granddaughter increase her fine motor skills and maintain her flexibility.
2. Petitioner's physician, Dr. Wyler, testified that _____ has a diagnosis of cerebral palsy with spastic quadriplegia resulting in apraxia, hypotonicity of musculature, and poor motor coordination. Dr. Wyley testified that he prescribed two sessions per week of occupational therapy so that _____ can meet the goals outlined in her therapy plan.
3. Petitioner's occupational therapist, Ms. Fox, OTR, described the goals in _____'s therapy plan and explained why, in her opinion, _____ requires two sessions per week of occupational therapy in order to meet these goals. Ms. Fox testified that, given Petitioner's age and the severity of her contractures, one therapy session per week will not allow Petitioner to sufficiently increase her fine motor skills or decrease her hypotonicity.

IV. RELEVANT AUTHORITIES

[Identify the relevant or applicable state or federal statute, federal regulation, administrative rule, program guidance (e.g., Texas Medicaid Provider Procedures Manual, Medicaid Bulletin)]

A. Pertinent Federal Regulations

B. Pertinent State Law and Administrative Rules

C. Pertinent Medical Policy and/or Procedure

V. FINDINGS OF FACT

The Hearing Official has carefully considered all of the credible and available evidence in this matter, and on that basis, makes the following findings of fact:

1. The NHIC denial notice was mailed to Petitioner on May 20, 2001. The denial notice failed to indicate the agency policy or the accepted standard of medical practice on which the denial was based.
2. Petitioner's grandmother, Ms. _____, made a timely request for a fair hearing on May 23, 2001.
3. Petitioner is an eligible Medicaid beneficiary under the age of 21.
4. Petitioner is nine years old and lives with her grandmother. She has a diagnosis of cerebral palsy with spastic quadriplegia resulting in apraxia, hypotonicity of musculature, and poor motor coordination.
5. Dr. Wyley is a pediatrician who has specialized in treating children with physical disabilities for the past 12 years. He has been Petitioner's treating physician for six years.
6. Ms. Fox is a Texas licensed occupational therapist and has been an occupational therapist for 15 years. Ms. Fox has been Petitioner's treating occupational therapist for four years.
7. Acme Rehabilitation Center is a Medicaid provider enrolled in the Texas Medical Assistance Program.
8. Petitioner began receiving occupational therapy at the age of four. Treatment goals have been directed at addressing muscle tone, postural control, praxis and bi-lateral coordination.
9. Petitioner has been receiving occupational therapy twice a week for five years and, while she has made some progress, she continues to show significant weaknesses in her overall fine motor skills.
10. Petitioner's current occupational therapy goals are to:
 - (a) improve visual motor skills;
 - (b) increase upper limb speed and dexterity;
 - (c) improve balance between flexor and extensor musculature;
 - (d) increase motor planning abilities;
 - (e) enhance quality of movement; and

- (f) increase functional shoulder, arm, and hand control.
11. Ms. Ness, R.N., NHIC representative, did not explain a medical basis, applying the agency policy or the accepted standard of medical practice, for her opinion that Petitioner's treatment goals can be achieved with the provision of one therapy session per week.
 12. Petitioner requires occupational therapy in order to improve and maintain fine motor functioning.
 13. Petitioner requires two sessions per week of occupational therapy in order to achieve the goals set out in her therapy plan.

VI. CONCLUSIONS OF LAW

Based on findings of fact and applicable policy, the Hearing Official concludes that:

1. The Agency's denial notice, dated May 20, 2001, was legally deficient because it failed to identify the agency policy or the accepted standard of medical practice on which the denial was based.
2. Ms. _____ timely filed this appeal pursuant to 1 TAC § 357.5(d).
3. 42 U.S.C. § 1396r(5) and 25 TAC § 33.132 require the Texas Medical Assistance Program to provide all medically necessary services for which federal financial participation is available to Medicaid beneficiaries under the age of 21.
4. The Agency has the burden of demonstrating that NHIC correctly reduced Petitioner's occupational therapy services.
5. Occupational therapy is a benefit of the Texas Medical Assistance Program for Medicaid beneficiaries under the age of 21. Texas Medicaid Provider Procedures Manual, 40.4.6.
6. Federal regulations define occupational therapy as services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and provided to a beneficiary by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment. 42 C.F.R. § 440.110.
7. Texas Medicaid medical policy authorizes occupational therapy when documentation submitted by the beneficiary's treating physician and occupational therapist establishes treatment goals to improve function, maintain function, or slow the deterioration of function. Texas Medicaid Provider Procedures Manual, 40.4.6.
8. The percentage of appointments kept during each six-month period and an assessment of family involvement in therapy are not eligibility criteria for occupational therapy.

9. Petitioner meets the eligibility criteria for occupational therapy. Texas Medicaid Provider Procedures Manual, 40.4.6.
10. The Agency failed to offer sufficient evidence to support its decision denying two sessions per week of occupational therapy to Petitioner. 1 TAC § 357.21.
11. The decision to deny two therapy sessions per week was erroneous and is reversed. 42 U.S.C. § 1396r(5); 25 TAC § 33.132; Texas Medicaid Provider Procedures Manual, 40.4.6.

Date

[Fair Hearing Official's name]
Fair Hearing Official

DRAFT

DRAFT
Exhibit 1
Notice of Denial

Exhibit 2
DRAFT
Request for Fair Hearing

DRAFT
Exhibit 3
Fair Hearing Exhibits

Fair Hearing Exhibits

1. Evidence presented by Petitioner:
 - a. Dr. Wyley's' prescription for occupational therapy for _____, dated May 10, 2001.
 - b. Occupational therapy evaluation and treatment plan for _____, dated May 12, 2001, Acme Rehabilitation Center.
 - c. Occupational therapy evaluation and treatment plan for _____, dated May 5, 2000, Acme Rehabilitation Center.
 - d. Occupational therapy evaluation and treatment plan for _____, dated April 30, 1999, Acme Rehabilitation Center.
 - e. Occupational therapy evaluation and treatment plan for _____, dated May 1, 1998, Acme Rehabilitation Center.
 - f. Brown, F.F., O.T., "Addressing Fine Motor Skills for Young Children with Cerebral Palsy," Journal of Pediatric Occupational Therapy, August, 1998.
 - g. Curriculum Vitae, Samuel Wyley, M.D.
 - h. Curriculum Vitae, Pamela Fox, OTR
 - i. _____'s Medicaid Identification card.
2. Evidence presented by NHIC
 - a. NHIC denial notice, dated May 20, 2001
 - b. Case notes, Virginia Ness, R.N., NHIC
3. Post-hearing documents, if any
 - a. Petitioner's written statement, dated July 1, 2001
 - b. NHIC's written statement, dated July 1, 2001

DOCKET NO. _____

BEFORE THE
HEALTH & HUMAN SERVICES COMMISSION
CUSTOMER RELATIONS SERVICES

IN THE MATTER
OF
PETITIONER'S NAME

§
§
§
§
§

ORDER OF THE
HEALTH AND HUMAN SERVICES COMMISSION

Based on the findings of fact and conclusions of law, NHIC is directed to grant prior authorization for two therapy sessions per week for _____ for the period June 1, 2001, through August 31, 2001.

Signed in Austin, Travis County, Texas, on this _____ day of June 2001.

DRAFT

Jane Roe, RN.
Hearing Official
Health and Human Services Commission

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

ALBERTO N., by his parents and next §
friends, Mr. and Mrs. N.; ALICE F., §
by her next friend, Ms. K; §
KEYAIRA R.-D., by her parent and §
next friend, Ms. D.; KAITLYN C., §
by her parent and next friend, Ms. C; §
AARON D., by his parent and next §
friend, Ms. D; ANDREW M., by his §
parent and next friend, Ms. M.; §
EVAN W., by his parents and next §
friends, Mr. and Mrs. W.; CHELSEA C., §
by her parent and next friend, Ms. C.; §
on behalf of themselves and others §
similarly situated; and TASH §

Plaintiffs, §

VS. §

CASE NO. 6:99CV459 §

ALBERT HAWKINS, in his official capacity §
as Executive Commissioner of the Texas §
Health and Human Services Commission; and §
JAMES HINE, in his official capacity as §
Commissioner of the Texas Department §
of Aging and Disability Services, §

Defendants §

SECOND PARTIAL SETTLEMENT AGREEMENT

INTRODUCTION

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

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

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

1. DEFINITIONS

- 1.1 “**Agency**” means the Health and Human Services Commission and, when appropriate, the agency operating the relevant part of the Texas Medical Assistance Program.
- 1.2 “**Beneficiary**” means any individual under the age of 21 years who has been determined eligible to participate in the Early and Periodic Screening, Diagnosis, and Treatment program (currently known as Texas Health Steps), established by the Texas Medical Assistance Program.
- 1.3 “**Contractor**” means the entity with which the Agency contracts to administer prior authorization of the categories of benefits encompassed by this Agreement, pursuant to the requirements of 42 C.F.R. Part 434. Currently, the Contractor for the Texas Medical Assistance program is ACS State Healthcare.
- 1.4 “**Day**” means a calendar day, unless otherwise noted herein.
- 1.5 “**DME list**” refers to any and all lists of DME the Agency has, or may develop, to expedite the prior authorization or approval process.
- 1.6 “**Durable medical equipment (DME)**” includes medical supplies, equipment, and appliances, as these terms are used in 42 C.F.R. § 440.70(b)(3) and further defined in 1 TAC § 354.1031(11)-(12). To the extent the Agency defines items of DME or describes the purpose of items of DME in policy, guidelines, and manuals, it will do so consistent with applicable law, the definitions and descriptions generally accepted by health care practitioners, and generally accepted standards of medical practice. The Agency will define items of DME, or describe their purpose, in a manner that does not exclude medically necessary DME.
- 1.7 “**Home Health Skilled Nursing services**” are nursing services, as described by the Texas Nursing Practice Act and its implementing regulations, that are authorized when a Beneficiary requires nursing services that can be met on a per-visit basis. Home Health Skilled Nursing services may be provided to meet acute needs or on an on-going basis to meet chronic needs, and may be provided on consecutive days. The Agency will identify the maximum length of a Home Health Skilled Nursing visit and the permissible number of visits per day. Once identified, this temporal component will be incorporated into the definition of “Home Health Skilled Nursing services.” Until the Agency identifies the temporal component, as an interim measure, they will not deny requests for 28 hours or more per week of Private Duty Nursing services on the basis that the services could be provided through Home Health Skilled Nursing services.

- 1.8 **“Medicaid”** means the Texas Medical Assistance Program established under the provisions of Chapter 32, Texas Human Resources Code, and subject to the requirements of Title XIX of the Social Security Act and its regulations.
- 1.9 **“Medicaid Managed Care Organizations”** means any entity with which the Agency contracts, pursuant to the requirements of 42 C.F.R. Part 438, that provides Medicaid-funded services to individuals who fall within the definition of Beneficiary in paragraph 1.2.
- 1.10 **“Medical Director”** means the Contractor’s Medical Director or Associate Medical Director/Director of Children’s Services.
- 1.11 **“Notice”** means a letter provided by the Agency to a Beneficiary informing the Beneficiary of any reduction, denial, or termination of a requested service, as described in 42 C.F.R. §§ 431.206 and 431.210.
- 1.12 **“Nurse Reviewer”** means any nurse who is employed by the Agency or its Contractor to make prior authorization determinations for the Medicaid benefits and services encompassed by this Agreement.
- 1.13 **“Nursing services”** as described by the Texas Nursing Practice Act and its implementing regulations, include observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings of a Beneficiary who has a disability or chronic health condition or who is experiencing a change in normal health processes. Nursing services also include the supervision of delegated nursing tasks. Tex. Occ. Code § 301.002 (Vernon 2004).
- 1.14 **“Other Contractors”** means any entity with which the Agency contracts, pursuant to the requirements in 42 C.F.R. Part 434, that provides information to beneficiaries or providers, enrolls beneficiaries, monitors quality of services, or provides case management services, related to the categories of benefits encompassed by this Agreement.
- 1.15 **“Parent/Guardian”** means the person or persons lawfully charged with the duty of taking care of the Beneficiary, and includes biological parents, adoptive parents, foster parents, guardians, and individuals court-appointed as managing conservators.
- 1.16 **“Personal Care Services”** are support services provided to Beneficiaries who require assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health related functions due to physical, cognitive, or behavioral limitations related to their disability or chronic health condition. ADLs include, but are not limited to, eating, toileting, grooming, dressing, bathing, transferring, maintaining continence, positioning, and mobility. IADLs include, but are not limited to, personal hygiene, meal preparation, grocery shopping, light housework, laundry, communication, transportation, and money management. Health related functions include, but are not limited to, medication

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

- 1.17 **"Policy"** means all written terms, criteria, guidelines, and standards that guide the actions of the Agency and its Contractor, related to the categories of benefits encompassed by this Agreement.
- 1.18 **"Private Duty Nursing services"** are nursing services, as described by the Texas Nursing Practice Act and its implementing regulations, that are authorized when the Beneficiary requires more individual and continuous care than is available from Home Health Skilled Nursing services. Private Duty Nursing services are available only through the EPSDT program. 42 C.F.R. § 440.80.
- 1.19 **"Provider"** means a Medicaid-enrolled individual or entity that provides the Medicaid benefits and services encompassed by this Agreement.

2. CORE REQUIREMENTS

All Medically Necessary Services

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

Amount, Duration, and Scope of Services

- 2.4 The Agency will authorize all requested medically necessary Private Duty Nursing services that are required to meet all of the Beneficiary's Private Duty Nursing needs over the span of time the needs arise, as the needs occur over the course of a 24-hour day. 42 U.S.C. § 1396d(r)(5).
- 2.5 The Agency will authorize all requested medically necessary Personal Care Services that are required to meet all of the Beneficiary's personal care needs over the span of time the needs arise, as the needs occur over the course of a 24-hour day. 42 U.S.C. § 1396d(r)(5).
- 2.6 The Agency will not establish or apply an absolute cap on the amount of DME available to Beneficiaries. To the extent that the Agency establishes quantity guidelines on DME for administrative convenience, the listed quantities must not be arbitrary and must be sufficient to meet typical use by children with disabilities and other chronic health conditions. 42 U.S.C. §§ 1396d(r)(5), 1396a(a)(17), 1396a(a)(10)(B); 42 C.F.R. § 440.230(c).
- 2.7 The Agency will not establish or apply an absolute cap on the frequency of replacement of DME available to Beneficiaries. 42 U.S.C. §§ 1396d(r)(5), 1396a(a)(10)(B); 42 C.F.R. § 440.230(c).
- 2.8 The Agency will not establish or apply a cap on the amount of medically necessary nursing or personal care services available to Beneficiaries. 42 U.S.C. §§ 1396a(a)(10)(B), 1396a(a)17, 1396d(r)(5); 42 C.F.R. § 440.230(c).

Diagnosis Based Denials Prohibited

- 2.9 The Agency will not arbitrarily deny or reduce the amount, duration, or scope of DME to a Beneficiary solely because of diagnosis, type of illness, condition, or functional limitations that are unrelated to the medical necessity of the item.
- 2.10 The Agency will not arbitrarily deny authorization of nursing services or reduce the number of requested hours of services based solely upon the diagnosis, type of illness, or condition of the Beneficiary. 42 U.S.C. §§ 1396a(a)17, 1396d(r)(5); 42 C.F.R. § 440.230(c).
- 2.11 The Agency will not arbitrarily deny authorization of personal care services or reduce the number of requested hours of services based solely upon the diagnosis, type of illness, or condition of the Beneficiary. 42 U.S.C. §§ 1396a(a)(10)(B), 1396a(a)17, 1396d(r)(5); 42 C.F.R. § 440.230(c).

Reasonable Promptness

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

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

- 2.13 Requests for medically necessary Home Health Skilled Nursing services, Private Duty Nursing services, or Personal Care Services will be prior authorized with reasonable promptness to ensure timely access to these Medicaid benefits. For purposes of this Agreement, prior authorization determinations for Home Health Skilled Nursing services, Private Duty Nursing services, or Personal Care Services will be completed by the Agency or its Contractor within three (3) business days of receipt of a complete request. 42 U.S.C. § 1396a(a)(8); 42 C.F.R. §§ 435.930, 441.56(e).
- 2.14 With the advice of the workgroup described in paragraph 7.1, the Agency will review and, if necessary, revise or establish policies and procedures for retroactive authorization of medically necessary DME, Home Health Skilled Nursing services, Private Duty Nursing services, and Personal Care Services, for Beneficiaries experiencing an urgent medical need.

Prior Authorization Tools, Grading Scales, and Processes

- 2.15 The Agency will make available all DME lists to Beneficiaries and Providers. Each DME list will prominently include a statement that the list is not exhaustive, and that other categories and items of DME not identified are available to Beneficiaries when medically necessary.
- 2.16 The Agency will make available to Beneficiaries and Providers all DME criteria and a description of the prior authorization process for DME, including a description of the process for obtaining items of DME not specifically identified in any DME list. 42 U.S.C. § 1396a(a)(43)(A).
- 2.17 The Agency will make available to Beneficiaries and Providers all processes, tools, and grading scales used to prior authorize nursing services and personal care services, by publishing them on the Agency's website and in the *Texas Medicaid Provider Procedures Manual*. When prior authorizing nursing or personal care services, the Agency and its Contractor will use only tools, grading scales, and processes made available to Beneficiaries and Providers. 42 U.S.C. § 1396a(a)(17); 42 C.F.R. § 431.18; Due Process Clause of the 14th Amendment to the United States Constitution.

Services to be Provided in the Most Integrated Setting Appropriate

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

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

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

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

3. DURABLE MEDICAL EQUIPMENT

Criteria for DME

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

Scope of Coverage of DME

- 3.2 The Agency will regularly update Medicaid coverage of DME to reflect available technology and current standards of medical practice.
- 3.3 To the extent that the Agency maintains lists of DME, such DME lists will not exclude categories of, or specific items of, DME.

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

4. NURSING SERVICES

Criteria for Nursing Services

- 4.1 The Agency and its Contractor will authorize nursing services when:
- (a) the prior authorization request is complete, as described in paragraph 4.7;
 - (b) the requested services are nursing services as defined by the Texas Nursing Practice Act and its implementing regulations;
 - (c) the requested services correct or ameliorate the Beneficiary's disability or physical or mental illness or condition; and
 - (d) there is no third party resource, as described in the *2004 Texas Medicaid Provider Procedures Manual*, section 1.5.3, financially responsible for the requested services.
- 4.2 Nursing services correct or ameliorate the Beneficiary's disability or physical or mental illness or condition when the services improve, maintain, or slow the deterioration of the Beneficiary's health status.
- 4.3 When a Beneficiary's medical needs have not decreased, as documented by the prior authorization request, the Agency and its Contractor will not deny or reduce the amount of nursing services on the basis that the Beneficiary's condition or health status is "stable" or has not changed.

Prior Authorization Process for Nursing Services

- 4.4 The Agency will authorize nursing services, either through Home Health Skilled Nursing services or Private Duty Nursing services, based upon a plan of care, which includes the physician's orders and is supplemented by a service plan, a Title XIX form (if required), and any additional materials submitted by the Provider to support medical necessity for the requested service. The plan of care is established and periodically reviewed by the treating physician in consultation with home health agency staff and the Beneficiary's Parent/Guardian. The Agency and its Contractor may also consider any relevant records to which they are legally entitled. 42 C.F.R. § 484.18.
- 4.5 The Agency and its Contractor will utilize licensed nurses (Nurse Reviewers) to make prior authorization determinations for nursing services. These nurses must act within their scope of practice as established by the Texas Board of Nurse Examiners.

- 4.6 When reviewing requests for nursing services, the Agency and its Contractor will apply the definitions of these services as set forth in paragraphs 1.7, 1.13, and 1.18 of this Agreement.
- 4.7 The Agency or its Contractor will review requests for nursing services to confirm that: (a) the Beneficiary's current diagnosis, functional status, and condition are clearly and consistently described throughout the documentation; (b) the treatment is described consistently throughout the documentation; and (c) an explanation has been provided as to how the requested nursing services correct or ameliorate the Beneficiary's disability or physical or mental illness or condition. If any of this information is missing, the Agency or its Contractor will follow the procedure for Incomplete Requests described in paragraph 20 of the Partial Settlement Agreement effective April 19, 2002.
- 4.8 For complete requests, the Agency or its Contractor will determine whether: (a) the requested services are nursing services as defined by the Texas Nursing Practice Act and its implementing regulations; (b) the Beneficiary's nursing needs could be met on a per-visit basis through Home Health Skilled Nursing services; and (c) the requested services correct or ameliorate the Beneficiary's disability or physical or mental illness or condition. When the Agency or its Contractor determine that the requested services are not nursing services, they will then determine whether the documentation may support a request for personal care services.
- 4.9 The Agency or its Contractor will authorize Private Duty Nursing services when: (a) the request is complete, as described in paragraph 4.7; (b) the requested services are nursing services as defined by the Texas Nursing Practice Act and its implementing regulations; (c) the explanation is sufficient to support that the requested services correct or ameliorate the Beneficiary's disability or physical or mental illness or condition; (d) the Beneficiary's nursing needs cannot be met on a per-visit basis through Home Health Skilled Nursing services; and (e) there is no third party resource, as described in the *2004 Texas Medicaid Provider Procedures Manual*, section 1.5.3, financially responsible for the services.
- 4.10 The Agency or its Contractor will authorize Home Health Skilled Nursing services when: (a) the request is complete, as described in paragraph 4.7; (b) the requested services are nursing services as defined by the Texas Nursing Practice Act and its implementing regulations; (c) the explanation is sufficient to support that the requested services correct or ameliorate the Beneficiary's disability or physical or mental illness or condition; (d) the Beneficiary's nursing needs can be met on a per-visit basis; and (e) there is no third party resource, as described in the *2004 Texas Medicaid Provider Procedures Manual*, section 1.5.3, financially responsible for the services.
- 4.11 The Nurse Reviewer may deny authorization for nursing services when: (a) the request is incomplete; (b) the information in the request is inaccurate or inconsistent as described in paragraph 4.7 or does not provide an explanation as to how the requested services correct or ameliorate the Beneficiary's disability or physical or mental illness or condition; or (c) the

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

- 4.12 Only Nurse Reviewers acting within the scope of their license may make a preliminary determination that the requested nursing services do not correct or ameliorate the Beneficiary's disability or physical or mental illness or condition.
- 4.13 Prior to denying or reducing nursing services on the bases described in paragraph 4.11, or prior to making a preliminary determination that the requested services do not correct or ameliorate the Beneficiary's disability or physical or mental illness or condition, the Agency or its Contractor will contact the nursing services Provider and/or the treating physician to determine whether additional information or clarification can be provided that would allow for the authorization of the requested nursing services.
- 4.14 When the Agency or its Contractor determines that the requested nursing services are not nursing services and that the documentation may support authorization of personal care services, the notice denying the nursing services will describe the basis for this determination, in accordance with paragraph 18 of the Partial Settlement Agreement effective April 19, 2002. The notice will include template language briefly describing the Personal Care Services benefit and where and how to request prior authorization for Personal Care Services. The template language to be used is as follows:
- “The medical information received may support authorization of Personal Care Services. Personal Care Services are support services provided to Medicaid Beneficiaries under 21 years of age who require assistance with activities of daily living and health related functions because of a physical, cognitive, or behavioral limitation related to their disability or chronic health condition. For more information and to find out how to obtain Personal Care Services for a Medicaid Beneficiary under 21 years of age, you should contact [the appropriate agency].”
- 4.15 When the Agency or its Contractor determines that the services requested do not support a request for Private Duty Nursing services because the services could be provided on a per-visit basis through Home Health Skilled Nursing services, the notice denying the Private Duty Nursing services will describe the basis for this determination, in accordance with paragraph 18 of the Partial Settlement Agreement effective April 19, 2002. The notice will include template language briefly describing the Home Health Skilled Nursing services benefit and where and how to request prior authorization for Home Health Skilled Nursing services. The template language to be used is as follows:

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

- 4.16 When the Nurse Reviewer makes a preliminary determination that the requested nursing services do not correct or ameliorate the Beneficiary’s disability or physical or mental illness or condition, and additional information or clarification from the nursing services Provider and/or the treating physician does not change this preliminary determination, the Nurse Reviewer will forward the request and all documentation related to the request to the Contractor’s Medical Director for review. The Medical Director will determine whether the requested nursing services correct or ameliorate the Beneficiary’s disability or physical or mental illness or condition.
- 4.17 If the Medical Director determines that the requested nursing services correct or ameliorate the Beneficiary’s disability or physical or mental illness or condition, the Medical Director will authorize the services. If, however, the Medical Director determines that requested nursing services do not correct or ameliorate the Beneficiary’s disability or physical or mental illness or condition, the Medical Director will call and confer with the Beneficiary’s treating physician prior to making a final determination.
- 4.18 If a request for nursing services is denied or reduced on the basis that requested services do not correct or ameliorate the Beneficiary’s disability or physical or mental illness or condition, the notice to the Beneficiary of this determination will describe why the requested nursing services do not correct or ameliorate the Beneficiary’s disability or physical or mental illness or condition, as provided in paragraphs 18 and 19 of the Partial Settlement Agreement effective April 19, 2002.
- 4.19 When the Medical Director denies a request for nursing services and the Beneficiary requests a fair hearing, the Medical Director must attend the fair hearing and provide testimony describing why the requested services do not correct or ameliorate the Beneficiary’s disability or physical or mental illness or condition. 42 C.F.R. § 431.242.

5. PERSONAL CARE SERVICES

Development of the Personal Care Services Benefit

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

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

- 5.2 The policies and procedures for the Personal Care Services benefit, developed by the Agency with the advice of the workgroup described in paragraph 5.1, must:
- (a) conform to the terms and conditions of this Agreement;
 - (b) promote the well-being of the child in the context of his or her family and the community; and
 - (c) require the authorization decision to take into account:
 - (1) the Parent/Guardian's need to sleep, work, attend school, and meet their own medical needs;
 - (2) the Parent/Guardian's legal obligation to care for, support, and meet the medical, educational, and psycho-social needs of their other dependents;
 - (3) the Parent/Guardian's physical ability to perform the personal care services; and
 - (4) whether requiring the Parent/Guardian to perform the personal care services will put the Beneficiary's health or safety in jeopardy.
- 5.3 To ensure effective and timely communication regarding the development of the policies and procedures necessary to establish and implement the Personal Care Services benefit, beginning with the effective date of this Agreement, the Agency or its counsel will submit a written status report to Plaintiffs' counsel every one hundred twenty (120) days until the policies and procedures are finalized. The status reports will include the working draft of policies and procedures developed to establish and implement the Personal Care Services benefit, current at the time the status report is due. Plaintiffs' counsel will provide the Agency with their comments to the draft policies and procedures within fifteen (15) business days of receipt of each status report.

Criteria for Personal Care Services

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

Prior Authorization of Personal Care Services

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

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

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

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

- 7.1 The Agency will convene a workgroup, which will include, but not be limited to, Providers, relevant professional groups, including associations of home health care Providers, and a representative for Plaintiffs, to advise the Agency as to the development of the service plan forms that will be used by Providers to request authorization for nursing services and Personal Care Services. The service plan forms to be used for nursing services will be developed by September 1, 2005; the comprehensive service plan forms to be used for nursing and Personal Care Services, which will include the new Personal Care Services criteria, will be developed by September 1, 2006. At a minimum, the service plan forms will require a description of:
- (a) the Beneficiary's disability or chronic health condition and the support needs related to the disability or chronic health condition;
 - (b) the necessary nursing interventions, clinical observation, assessment, evaluation, and on going exercise of nursing judgment;
 - (c) any non-nursing supports, including durable medical equipment, therapy services, and personal care services;
 - (d) an explanation as to how the requested services correct or ameliorate the

- Beneficiary's disability or physical or mental illness or condition, including an explanation of the frequency of the requested service;
- (e) the time periods during which the nursing services and other non-nursing supports are required by the Beneficiary, as they occur over the course of a 24-hour day, and a 7-day week (the description of the time periods during which nursing services are required will include an estimation of the amount of time it takes to provide the particular nursing interventions, as well as the span of time over which the nursing interventions, clinical observation, assessment, evaluation, and the exercise of nursing judgment are necessary);
 - (f) a contingency plan for the provision of services when unanticipated events prevent the regular Provider from providing services or when the need for services occurs intermittently and at indeterminate times;
 - (g) the Parent/Guardian's ability to perform the nursing services as part of a contingency plan; and
 - (h) the amount of nursing services, if any, that the Parents/Guardians are willing to provide to the Beneficiary.

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

- 7.2 To the extent that the Agency or its Contractor uses forms to review requests for prior authorization for nursing services and Personal Care Services, the forms must be consistent with the service plan forms described in paragraph 7.1. Should the Agency choose to use forms to review requests for prior authorization for nursing services and Personal Care Services, the same group described in paragraph 7.1 will advise the Agency as to the development of these forms, and the forms will be developed by the same deadlines. The forms to be used by the Agency and its Contractor to review requests for nursing services and Personal Care Services may not be designed or applied, in any manner, contrary to the terms and conditions of this Agreement. Once developed, the forms to be used by the Agency and its Contractor to review requests for nursing services and Personal Care Services will replace the then-current forms used for this purpose.
- 7.3 The Agency will provide any new forms developed pursuant to paragraphs 7.1 and 7.2 to Plaintiffs' counsel for review and comment at least one month prior to the date on which the forms are to replace the then-current forms. Plaintiffs will provide comments to the Agency within fifteen (15) business days of receipt of these documents.
- 7.4 Once new forms have been developed pursuant to paragraphs 7.1 and 7.2, the Agency and its Contractor will not use the "private duty nurse reviewer assessment tool," the Form 2060, the Community Care Assessment Tool, or any other tool or instrument that calculates the amount of time it takes to perform particular nursing or personal care tasks rather than

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

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

8. CHANGES TO POLICIES, GUIDELINES, AND MANUALS

Durable Medical Equipment

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

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

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

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

Nursing Services

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

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

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

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

9. TRAINING

- 9.1 The Agency will train, or cause to be trained, its relevant staff, including Office of the Inspector General staff, and the relevant staff of its Contractor, the Managed Care Organizations, and Other Contractors, as to the requirements of this Agreement, in a timely fashion based on established protocols, but not later than one hundred eighty (180) days after the development of any new policies. Training will begin within sixty (60) days of the effective date of this Agreement and be completed by April 1, 2008.
- 9.2 The Agency will include in the curriculum regularly offered to Providers the requirements of this Agreement, and the new policies to be developed in accordance with this Agreement, in a timely fashion based on established training protocols.
- 9.3 The Agency will provide Plaintiffs' counsel a schedule of all upcoming training dates. The Agency will provide copies of all training materials to Plaintiffs' counsel prior to their initial use for training. Plaintiffs' counsel may observe three (3) trainings of their choice.

10. QUALITY ASSESSMENT

Durable Medical Equipment and Supplies

- 10.1 Beginning with the fourth quarter of Fiscal Year ("FY") 2005, and until the publication of the 2007 *Texas Medicaid Provider Procedures Manual*, the Agency will review, quarterly, one hundred fifty (150) DME reduction or denial notices, so as to identify the changes necessary to conform DME policies to the terms and conditions of this Agreement, including, but not limited to, the medical necessity standard described in paragraph 3.1. The Agency will provide Plaintiffs' counsel with copies of these notices by the forty-fifth (45th) day of the subsequent quarter. The provision of these notices to Plaintiffs' counsel will satisfy the Agency's obligation to provide an equal number of notices pursuant to paragraph 45(c) of the Partial Settlement Agreement effective April 19, 2002.
- 10.2 Beginning with the publication of the 2007 *Texas Medicaid Provider Procedures Manual* and for one year thereafter, the Agency will provide to Plaintiffs' counsel one hundred (100) DME reduction or denial notices each quarter, with fifty (50) notices selected from the Home

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

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

Nursing Services

- 10.4 Beginning ninety (90) days after the effective date of this Agreement, each quarter, the Agency will select sixty (60) requests for Private Duty Nursing services that resulted in denial or reduction of Private Duty Nursing services and provide to Plaintiffs' counsel copies of all documents related to each request, including, but not limited to:
- (a) all documents submitted in conjunction with the request for Private Duty Nursing services;
 - (b) all documents and forms used to make the prior authorization determination;
 - (c) all information considered by the Agency or its contractors in making the prior authorization determination;
 - (d) any notes generated by the Nurse Reviewer;
 - (e) any notes generated by the Medical Director; and
 - (f) the denial/reduction notice associated with each request.

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

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

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

Personal Care Services

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

11. NOTICE TO PROVIDERS AND BENEFICIARIES

Banner Message, *Texas Medicaid Bulletin*, Agency Websites

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

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

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

- 11.2 Within thirty (30) days of completion of the activities described in Section 5 of this Agreement, the Agency will publish a description of the Personal Care Services benefit as a banner message. Within sixty (60) days of completion of the activities described in Section 5 of this Agreement, the Agency will prominently post a description of the Personal Care Services benefit and all policies related to the Personal Care Services benefit on the websites of the Texas Health and Human Services Commission and the Texas Department of Aging and Disability Services. The Agency will publish a description of the Personal Care Services benefit and all policies related to the Personal Care Services benefit in the *Texas Medicaid Bulletin* (or any successor publication) in accordance with established time frames for submission of materials for publication, but no later than 60 days after the completion of the activities described in Section 5.
- 11.3 Within thirty (30) days of changes to the DME and nursing services benefits made pursuant to this Agreement, the Agency will publish a description of the changes as a banner message. Within sixty (60) days of changes to the DME and nursing services benefits made pursuant to this Agreement, the Agency will prominently post a description of the changes and all policies related to the changes on the websites of the Texas Health and Human Services Commission and the Texas Department of Aging and Disability Services. The Agency will publish a description of the changes and all policies related to the changes in the *Texas Medicaid Bulletin* (or any successor publication) in accordance with established time frames for submission of materials for publication, but no later than 60 days after the changes are made.
- 11.4 Within one hundred eighty (180) days of the effective date of this Agreement, the Agency will send the following notice, as an insert or part of an insert included in a regularly scheduled mailing, to all Beneficiaries under the age of 21 years:

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

12. RULEMAKING

- 12.1 The Agency agrees to propose, amend, withdraw, or repeal agency rules so that agency rules conform to the terms and conditions of this Agreement. The Agency will initiate the rulemaking process within forty-five (45) days of any action required by this Agreement that necessitates a rule to be promulgated, amended, withdrawn, or repealed.
- 12.2 For all rulemaking required by paragraph 12.1, the Agency will provide to Plaintiffs' counsel the draft of each proposed rule, amendment, or repeal when it is routinely provided to the members of the Medical Care Advisory Committee.

13. APPROVAL OF AGREEMENT BY STATE OFFICIALS

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

14. CONTINUING JURISDICTION AND ENFORCEMENT

- 14.1 It is the intention of the parties that the Agreement be approved, adopted, and fully incorporated into an order of the Court, and it is agreed and stipulated that the United States District Court for the Eastern District of Texas will retain exclusive jurisdiction over all matters relating to the enforcement of the Agreement and attorneys' fees. This Agreement may be enforced until July 1, 2009.
- 14.2 The Parties agree that Plaintiffs will amend the Complaint to add TASH, an organizational plaintiff, for purposes of enforcing the terms of this Agreement.

15. EFFECTIVE DATE OF THE AGREEMENT

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

16. COMPLIANCE DISPUTES ARISING UNDER THIS AGREEMENT

- 16.1 In the event that any party fails to comply with any part of this Agreement, the party alleging noncompliance may seek enforcement of the Agreement in the United States District Court for the Eastern District of Texas. Prior to seeking enforcement, absent an emergency, the party alleging noncompliance will provide notice to the opposing party and will give them thirty (30) days to correct the alleged noncompliance.
- 16.2 Failure by a party to enforce any provision of this Agreement will not be construed as a waiver of the party's right to enforce other provisions of the Agreement.

17. DISMISSAL OF CERTAIN CLAIMS

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

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

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

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

18. ATTORNEYS' FEES, COSTS, AND EXPENSES

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

19. SEVERABILITY

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

20. MODIFICATION

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

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

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

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

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

21. COUNTERPARTS

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

22. BINDING

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

23. EXECUTION OF AGREEMENT

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