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

LINDA FREW, et al.	§	
	§	
Plaintiffs,	§	
	§	CIVIL ACTION NO. 3:93CV65
v.	§	
	§	
MICHAEL MCKINNEY, et al.	§	
	§	
Defendants.	§	

CONSENT DECREE

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INTRODUCTION

1. According to the 1990 United States Census, about 5,672,537 Texans are under the age of 21. Roughly 1.5 million of them (more than 20%) receive Medicaid and are eligible for Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefits. The number of recipients should increase in future years because of federally required eligibility expansions.

2. EPSDT is intended to provide comprehensive, timely and cost effective health services to indigent children and teenagers who qualify for Medicaid benefits. Check ups are the cornerstone of the program. They assess recipients' health, provide preventive care and counselling (anticipatory guidance) and make referrals for other needed diagnosis and treatment.

42 U.S.C. §§ 1396a(a)(43); 1396d(r). Recipients are entitled to both medical and dental check ups on a regular schedule. About 48% of recipients received at least one medical check up in fiscal year 1994 (FY94), according to reports Defendants filed with the United States Department of Health and Human Services.

3. Recipients are also entitled to all needed follow up health care services that are permitted by federal Medicaid law. 42 U.S.C. § 1396d(r).

4. Given the large number of recipients in Texas, improvements to the EPSDT program should improve the lives of many indigent youth. The program also has the potential to improve the overall health of the Texas population, because the percent of young Texans who receive EPSDT benefits is large and increasing. The likelihood that these young Texans will be healthy children and grow into healthy adults increases if the Texas EPSDT program functions properly. To achieve this end, recipients and the adults responsible for them must be effectively informed about EPSDT and its benefits. Further, young recipients should receive proper health care.

5. The Texas EPSDT program can be improved. Indigent EPSDT recipients are more likely to receive adequate health care when the EPSDT program

* enhances the availability of health care services,
* eliminates barriers that have the effect of preventing access to services, and
* more effectively informs recipients that services are available and important to their current and future health.

6. To address the parties' concerns, to enhance recipients' access to health care, and to foster the improved use of health care services by Texas EPSDT recipients, the

parties agree and the Court orders Defendants to implement the following changes and procedures for the Texas EPSDT program:

7. TEXAS DEPARTMENT OF HEALTH REORGANIZATION The Texas Department of Health (TDH) is the agency that administers EPSDT. TDH has reorganized its administrative structure to better administer the program. Senior management staff are responsible for the EPSDT program in each of TDH's 8 regions. In each region, a senior manager is ultimately responsible for EPSDT. Other functions of the management team include a) community relations and outreach and b) provider relations.

8. Further, the TDH State EPSDT office has reorganized to better administer the program. Before TDH assumed responsibility for EPSDT on September 1, 1993, only about 6 staff members at the State office of the Texas Department of Human Services were directly involved in running the EPSDT program. TDH's EPSDT Division now employs 25 staff. Currently, the Division is divided into 2 units: a) Program and Policy Development and b) Operations. Obviously, the policy unit develops policies and procedures for the program. The operations unit supervises and evaluates work performed in the regions.

9. Further, by July, 1996, TDH will develop the capacity to conduct epidemiologic studies of the EPSDT population to determine if the program is improving recipients' health.

INFORMING AND OUTREACH

10. Information about the EPSDT program is important so that recipients can fully utilize EPSDT services, including medical and dental check ups.

11. The parties agree to and the Court orders the following changes to the Texas EPSDT program, policies and procedures to effectively inform recipients about the EPSDT program:

12. The process of informing recipients about EPSDT involves several components, including:

* written information of various types,
* face to face oral informing by Texas Department of Human Services (TDHS) eligibility workers during interviews to determine eligibility for Medicaid benefits,
* oral outreach by outreach units when recipients a) request further information, b) miss medical and/or dental check ups, or c) when requested by health care providers,
* coordinated efforts with other agencies, and
* media efforts.

13. For the purposes of informing and outreach, "recipient" means an EPSDT recipient and/or the adult responsible for the recipient's health care, as appropriate. Further, it is encouraged but not required that other family members be included in informing efforts when appropriate.

14. Information about EPSDT must be relevant to recipients' needs. Information must also be reasonably interesting and presented in a manner that is sensitive to EPSDT recipients' many different cultural backgrounds. It will also be presented in a positive

and timely way that encourages recipients to understand and use services fully. Finally, information must be presented in a manner that is convenient to recipients.

SIMPLIFICATION OF TERMS

15. Program Name Many recipients do not understand the terms "Early Periodic Screening Diagnosis and Treatment" or "EPSDT." These terms do not give meaningful information about the purpose of the program. Defendants agree to delete or change the program's name by September 30, 1995. The new name will reflect the program's goals and readily identify it to recipients.

16. Periodic Check Ups Federal law requires the EPSDT program to provide periodic medical "screens" and dental "services." 42 U.S.C. § 1396d(r). Defendants call these services "medical screens" and "dental exams." Further, Defendants may implement a new program that involves "dental scans," which some dentists might consider to be "screens." To avoid confusion, the following terms in English and Spanish will be used:

* a medical or dental service provided in accordance with the periodicity schedules will be called a "check up/examen;"

* a dental service provided to encourage the timely use of dental check ups will be called a "dental scan/ inspeccion dental."

17. WRITTEN MATERIALS Defendants provide various forms of written materials to explain the EPSDT program and to encourage its use.

Reminder Letters Defendants agree to mail letters to recipients who are about to be due for a medical and/or dental check up. Defendants will mail the letters early in the month that the check up is due. But, Plaintiffs contend that this timing is not

effective in one instance - letters about dental check ups for 1 year olds. Many recipients do not know that 1 year olds need dental check ups. Also, there is a shortage of dentists who provide services to one year olds, so there is often a delay in scheduling appointments. So, Defendants will mail letters about the 1 year dental check up 2 months before the check up is due, i.e., when the recipient is 10 months old (except for recipients who lose eligibility at one year of age). This schedule will be implemented no later than January 1, 1996.

* Plaintiffs contend that in the past, the letters sent to recipients due for check ups were hard to understand and impersonal. For example, some letters did not specify which child in a family was due for what type of service. The letters only indicated that a child was due for some kind of service.

* Defendants will use letters that are effective and appropriate. They will be printed in English and Spanish. They will encourage the use of EPSDT services in a positive manner. Each letter will specify the name of the child who is due for a service and whether the child is due for a medical or a dental check up. The letters will also include information about the benefits of preventive care. The information will be appropriate to the age of the child who is due for a check up. The reason to include age appropriate information is to provide information that is relevant and interesting to encourage the recipient to fully use EPSDT services.

* When appropriate, the letters will vary by geographic area to provide information that is relevant to the different geographic areas of the state. The letters will also explain that services are free

of charge. They will offer help with transportation, locating a provider who is willing to serve Medicaid recipients and scheduling appointments. The letters will state the toll free telephone numbers that are available for assistance with transportation and scheduling.

Brochures and Fliers Defendants provide various brochures and fliers to recipients, applicants and community agencies where the EPSDT population may be found. Defendants will update the brochures and fliers to make them appropriate for use with the EPSDT population. Defendants will create age appropriate information for use by recipients of specific ages.

Medical Identification Card Every month, Medicaid recipients receive new Medical Identification cards (Form 3087). Exhibit 1.

* When the Texas Department of Human Services (TDHS) administered EPSDT, TDHS created "grids" on the Medical Identification cards. The purpose of the "grids" is to use Medical Identification cards to inform recipients and health care providers when medical and dental check ups are due. They are supposed to show when check ups are due or not due by use of "Y" to indicate "yes" and "N" to indicate "no." For example, a "Y" in the EPSDT medical column is intended to show that a medical check up is due. Conversely, an "N" in the EPSDT medical column is intended to show that a medical check up is not due. The EPSDT dental column is supposed to function the same way.

* But, Plaintiffs contend that the "grids" do not effectively inform some recipients that check ups are due. Some recipients believe that the "N" means that services are not available at all - not merely that a check up is not due.

* The parties have developed a proposed new card. Defendants will field test the new card by May 31, 1995 to determine which card more effectively informs recipients. The field testing will be conducted in a manner that is acceptable to Plaintiffs. Plaintiffs will submit their decision about the method of field testing to Defendants within 30 days of receipt. Plaintiffs will not unreasonably withhold approval. If the parties agree that the field tests show that the revised card is acceptable, the new card will be in use within 6 months. If the new design is not acceptable, another revision will be available for field testing by July 31, 1995.

18. This paragraph does not preclude the development of new Medicaid card formats in the future as contemplated by Paragraph 304.

19. TEXAS DEPARTMENT OF HUMAN SERVICES The Texas Department of Human Services (TDHS) interviews hundreds of thousands of applicants for Medicaid benefits every year. Eligibility workers almost always meet with the applicant in person.

20. In the past, the EPSDT program has relied upon eligibility workers to inform applicants about EPSDT. This process is now being improved. Eligibility workers will now be required to discuss EPSDT with applicants who apply for benefits on behalf of an EPSDT eligible person. Eligibility workers will provide information during initial eligibility interviews but not during subsequent interviews. The discussion will include at least the following elements:

* age appropriate information about the importance of preventive care for children of the ages in the applicant's household;

* information about medical and dental check ups and the full range of EPSDT services;

* information about how to call TDH toll free telephone numbers for help with a) transportation, b) locating a health care provider who is willing to provide services to EPSDT recipients and c) scheduling appointments for EPSDT services;

* information about the Medicaid Transportation Program including but not limited to a description of the gas reimbursement option;

* encouragement to request further oral outreach to provide more information and answer questions about EPSDT; and

* an offer of help from the TDHS office to arrange further outreach.

21. Eligibility workers will also provide an EPSDT brochure and a wallet card schedule of medical check ups to each applicant household. Exhibits 2, 3.

22. Eligibility workers will receive an outline of the subjects to be covered in each interview to guide the discussion of EPSDT. They will also receive training about how to discuss EPSDT, including instructions to follow the outline. The parties will agree on the contents of the outline by March 31, 1995.

23. Upon request, each TDHS office will provide assistance to help applicants to request further oral outreach by an outreach unit. See below. This assistance may include but is not limited to the use of a TDHS telephone to call the outreach unit to schedule a convenient appointment.

24. A Memorandum of Understanding between TDH and TDHS concerning the outreach process will be presented for Plaintiffs' approval by August 31, 1995 and to the Court by October 1, 1995. It will address all terms outlined in this agreement as well as a) training of TDHS eligibility workers to conduct EPSDT informing and b) the monitoring of TDHS' EPSDT informing process to determine its ongoing effectiveness.

25. OUTREACH UNITS But, information about EPSDT provided by TDHS eligibility workers will not be effective for all EPSDT recipients. Oral outreach units will provide outreach services when required.

26. An outreach unit is the entity responsible for oral outreach in a geographic area of Texas. An outreach unit can be either (a) an agency that contracts with TDH to provide oral outreach services or (b) TDH staff.

27. Defendants contemplate that contractors will provide outreach services in urban areas. TDH staff will provide outreach services where it is not practical or possible to contract for services.

28. A model request for proposals for contracted outreach units is attached. Exhibit 4.

29. All outreach units will begin to provide outreach services by September 1, 1995.

30. Outreach units will work cooperatively with others who serve EPSDT recipients to serve recipients effectively and efficiently.

31. Defendants will provide outreach services in all areas of the state. To the extent possible, these services will not be overlapping.

32. All outreach units will have sufficient staff and other reasonably necessary resources to handle their workload promptly and effectively.

33. Four groups of EPSDT recipients require oral outreach services by an outreach unit. They are a) recipients who request information beyond that provided by TDHS eligibility workers, b) recipients who miss medical check ups, c) recipients who miss dental check ups and d) recipients whose health care provider requests outreach.

34. Beginning on September 1, 1995, outreach units will provide oral outreach to all recipients who request information about EPSDT beyond that provided by TDHS eligibility workers.

35. Beginning on September 1, 1995, outreach units will provide oral outreach to all recipients who miss a medical check up that is due on or after July 1, 1995. "Due" means a medical check up that is due according to the current Texas EPSDT periodicity schedule, i.e.,

newborn	24 months	13 years*
1-2 weeks	3 years	14 years
2 months	4 years	15 years*
4 months	5 years	16 years
6 months	6 years	17 years*
9 months	8 years	18 years

12 months	10 years	19 years*
15 months	11 years*	20 years
18 months	12 years	* special teen check ups

For infants, outreach units will provide outreach to recipients aged 5 months and 11 months who have missed a medical check up, or more often at Defendants' option.

36. The different schedules for medical and dental check ups mean that recipients can miss the interim dental check ups even if they receive timely medical check ups. For example, between the ages of 6 and 10 years, recipients are due for medical check ups every 2 years. They are also due for dental check ups every 6 months.

37. Beginning no later than June, 1997, outreach units will provide oral outreach to all recipients who miss a dental check up that is due on or after April 1, 1997. "Due" means a dental check up that is due according to the Texas EPSDT periodicity schedule, i.e., starting at 1 year and continuing every 6 months.

38. Outreach units will use highly visual written materials about dental issues. The materials will include photographs of healthy mouths and common dental problems. Materials will be appropriate to the age of the recipients who receive outreach. Outreach will attempt to convince recipients that they can achieve dental health if they care for their mouths properly.

39. Beginning no later than June, 1997, oral outreach for missed dental check ups will continue in tandem with oral outreach upon request and for missed medical check ups.

40. Every month, Defendants will provide a current Outreach List to each outreach unit. The Outreach List will identify each recipient who requires oral outreach from the

outreach unit. The Outreach List will contain pertinent information to enable outreach workers to effectively assist recipients.

41. Beginning in August, 1995, Defendants will maintain a list of recipients for whom no medical check up bill has been received no more than 60 days after the check up was due. Beginning in May, 1997, Defendants will maintain a list of recipients for whom no dental check up bill has been received no more than 60 days after the check up was due.

42. Each month, outreach letters are mailed from Austin to newly certified recipients and recipients for whom bills for check ups have not been received within 60 days of their periodic eligibility month.

43. Further, TDHS will identify recipients who request information about EPSDT beyond that provided by TDHS eligibility workers. TDHS will provide the names of these recipients to Defendants promptly after the request is made. Defendants will include these names in outreach efforts.

44. Defendants will list the recipients who require outreach because of missed check ups in the geographic area served by each outreach unit. Each month, Defendants will provide these lists to outreach units.

45. Outreach files include the TDHS referral lists and the TDH lists of recipients who miss check ups.

46. Within 10 working days of receipt of the TDHS referrals each outreach unit will mail a written offer of outreach to each recipient identified on the lists. The written offer will encourage the recipient to request oral outreach in a manner that is convenient to the recipient. The written offer will state that the recipient actually has options about how and when to receive

oral outreach. The written offer will explain that the outreach unit provides oral outreach in several different ways, including a) at a location convenient to the recipient including the home, b) by telephone, c) at the outreach unit's office or other offices or d) in some geographic areas, in small group sessions. The written offer will also clarify that oral outreach will be provided at a time that is convenient for the recipient. The written offer may tentatively schedule an appointment for outreach services, but it will encourage the recipient to schedule another form, location or time for outreach if the recipient prefers.

47. Outreach units will provide outreach services as described in the above paragraph and elsewhere in this agreement.

48. Written offers of outreach will correspond to the reason that outreach is required.

49. Outreach units will keep current so that they can a) provide prompt outreach upon receipt of new Outreach Lists and b) properly manage their caseload of recipients who require outreach.

50. The purpose of oral outreach is to

* encourage EPSDT recipients to fully use EPSDT services; and

* assist recipients to overcome common barriers that prevent them from using EPSDT services.

51. Common barriers may include

* lack of a health care provider;

* communication problems (non-English speaker, no telephone);

* transportation problems;

* misunderstandings/lack of knowledge about Medicaid and/or EPSDT.

52. Oral outreach efforts will effectively inform recipients about EPSDT, including the schedule for medical and dental check ups as well as the full range of covered services. Oral outreach will also effectively inform recipients about the benefits of preventive health care, that services are free of charge, how to locate a provider who is willing to provide services to EPSDT recipients, how to schedule appointments and how to schedule transportation assistance.

53. When appropriate, outreach staff will help recipients to schedule appointments and/or transportation during the oral outreach session.

54. Oral outreach will use examples that are tailored to the recipient's age and needs so that information is relevant and interesting to the recipient. When a household includes several recipients of different ages, outreach will provide age appropriate information about each recipient when possible.

55. Oral outreach will also discuss the Medicaid Transportation Program as appropriate to the recipient's needs. It will explain how the Transportation Program can help each recipient given the recipient's current transportation resources. Oral outreach will also explain what other transportation options are available if the recipient's transportation resources change, for example, if the family loses their only car.

56. Oral outreach will be provided in a manner that is sensitive to recipients' ability to understand and process information. Appropriate language will be used. Sessions will be long enough to meet recipients' needs for information but not so long that they are

overwhelming or confusing. The length of sessions will necessarily vary from recipient to recipient.

57. Recipients may require oral outreach services more than once. For example, a recipient may receive oral outreach services after missing a medical check up. The recipient may also miss the next medical check up and require oral outreach again. The outreach unit's responsibility is to provide oral outreach again upon receipt of an Outreach List that again identifies the recipient.

58. Over time, the groups of recipients who require oral outreach should change. At first, many recipients will require oral outreach because of missed check ups or by request. But, if oral outreach works, the percent of recipients who miss check ups will decrease. Further, many of those who request oral outreach should have their questions answered. The groups of recipients who require oral outreach will increasingly be a) newly eligible recipients who have never received oral outreach, b) recipients who continue to misunderstand EPSDT or miss check ups and c) recipients who face new health care problems.

59. Outreach unit staff will not make child abuse or neglect reports because of a) failure to respond to an offer of outreach or b) failure to receive a medical or dental check up. The parties do not intend to preclude outreach workers from making a report if other sufficient evidence of child abuse or neglect exists.

60. Each month, the outreach unit will at a minimum report the following information to the EPSDT program:

a) the number of initial written offers of outreach mailed to recipients.

b) the number of requests for outreach by health care providers, See, page 29.

c) the number of recipients who did not respond to the initial written offer of outreach within 45 days;

d) the number of recipients who did not receive oral outreach within 45 days of receipt of the outreach lists;

e) the number of recipients who responded to the initial written offer of outreach and the number who requested each method of outreach;

f) the number of recipients who received each method of outreach; and

g) the number and status of recipients identified on earlier outreach lists who did not receive oral outreach in prior months and who requested services.

61. By September 1, 1996, Defendants will develop and implement a method that reports the number and percent of recipients who receive medical and/or dental check ups after receipt of oral outreach.

62. Defendants will train outreach unit staff. Either TDH EPSDT State Office staff or EPSDT Regional Office staff will provide this training. Training will be standardized so that outreach services are delivered effectively throughout the state. Training may also address uniquely local issues that vary across Texas. Training will address all issues raised in this settlement agreement that are relevant to outreach units.

63. The dental section of this agreement describes further outreach efforts. See, page 40-4.

64. Defendants may conduct other appropriate, aggressive outreach efforts to encourage recipients to use EPSDT services.

65. COORDINATED EFFORTS WITH OTHER AGENCIES In addition to the coordinated efforts between Defendants and TDHS described above, Defendants will work with the following agencies to effectively inform recipients and others about EPSDT:

Texas Department of Protective and Regulatory Services

Early Childhood Intervention

Texas Juvenile Probation Commission

Texas Department on Aging

Texas Commission on Alcohol and Drug Abuse

Texas Commission on the Blind

Texas Department of Mental Health/Mental Retardation

Texas Health and Human Services Commission

any other appropriate agency

66. Agency Handbooks Staff of other agencies can help their clients who are also eligible for EPSDT to understand and use EPSDT benefits. To do so, other agency staff must have accurate information about EPSDT.

67. Agency handbooks are important for staff because they provide a permanent source of information. But, handbooks are not effective if they are out of date.

68. Defendants will provide accurate information about EPSDT for inclusion in the handbooks of other agencies that serve EPSDT recipients. Defendants will update the information from time to time as appropriate.

69. Memorandums of understanding about handbook information between TDH, TDHS and TDPRS will be presented for Plaintiffs' approval by August 31, 1995 and to the Court by October 1, 1995.

70. Defendants will also provide handbook inserts to the following agencies and programs on an ongoing basis:

Early Childhood Intervention

Texas Juvenile Probation Commission

Texas Department on Aging

Texas Commission on Alcohol and Drug Abuse

Texas Commission on the Blind

Texas Department of Mental Health/Mental Retardation

Texas Health and Human Services Commission

any other appropriate agency

71. By September 1, 1995, the Commissioner of Health will write to the Commissioner of each agency to ask that the other agency include the information in the appropriate handbook. Defendants will follow up with each agency to be sure that the provided information is appropriate and in use.

72. TDH will encourage other agencies to use EPSDT brochures and will provide adequate supplies of brochures to requesting agencies.

73. MEDIA Defendants will arrange for and implement a marketing plan that encourages providers and recipients to participate in the EPSDT program. Defendants provided a copy of the Marketing Invitation for Bids to the Court in March, 1995.

74. This section does not preclude the development of outreach models to be used by managed care organizations as contemplated by Paragraph 304.

HEALTH CARE PROVIDERS

75. Defendants' efforts concerning providers involve

* recruitment of new providers to serve EPSDT recipients,

* retention of providers who currently serve EPSDT recipients and efforts to encourage them to increase the number of recipients they serve,

* training of providers and their administrative staff about how EPSDT works, and

* facilitating training for providers about clinical issues relevant to provision of services to recipients.

76. PRIVATE PRACTITIONERS: BACKGROUND Health care providers in private practice provide the vast majority of health care services to EPSDT recipients. As a result, the number of private practitioners who participate in Medicaid and EPSDT, and the quality of care that they provide, significantly influence the success of EPSDT in Texas.

77. PROVIDER ENROLLMENT Providers must apply to receive reimbursement for services to EPSDT recipients. By signing provider agreements with TDH, providers agree to follow Medicaid rules and accept Medicaid reimbursement as payment in full.

78. Providers must complete further paperwork to enroll to provide EPSDT medical or dental check ups. Only doctors and advanced nurse practitioners (ANPs) may enroll to conduct EPSDT medical check ups. ANPs have special training that allows them to provide

services to patients with specified illnesses and conditions, under protocols designed by collaborating physicians. They establish referral sources for patients whose conditions require services that are beyond their scope of practice or competence.

79. Under some circumstances, registered nurses (RNs) may also provide EPSDT medical check ups. RNs must have special training about how to assess the health of children and youth. Further, they may conduct EPSDT medical check ups only under the direct supervision of a physician. Unlike ANPs, RNs may not enroll independently to provide medical check ups. Also, unlike ANPs, RNs may not submit their own bills for EPSDT medical check ups. Instead, their supervising physician is responsible for billing.

80. Only dentists may conduct EPSDT dental check ups. They may be assisted by dental hygienists or dental assistants.

81. NUMBER OF PRIVATE PRACTITIONERS Nothing in federal law, Texas law or the Medicaid provider agreement requires private practitioners to serve a minimum number of EPSDT recipients. Providers may decline to serve EPSDT recipients or limit the number of recipients in their practice if they decide to serve the population at all.

82. In FY94, approximately 43,613 medical doctors provided direct services in Texas. At least 25,000 were Medicaid providers. Defendants believe that 25,000 understates the number of Texas physicians who accept Medicaid payments. Further, 7986 primary care practitioners accept Medicaid. Also, 5636 advanced nurse practitioners provide direct services in Texas. In December, 1994, 830 advanced nurse practitioners submitted Medicaid bills. Only 1840 doctors and advanced nurse practitioners are signed up to provide EPSDT medical check ups.

83. In FY94, 9172 dentists were licensed in Texas. About 17-1800 dentists billed Medicaid in the past 6 months.

84. Specialists generally do not provide medical check ups. Their role in the EPSDT arena is to provide needed follow up diagnosis and treatment to recipients.

85. PRIVATE PRACTITIONERS LIMIT SERVICES Further, Plaintiffs contend that most private practitioners who serve EPSDT recipients limit the number of recipients in their practice. TDH maintains data about the number of primary care physicians who are low volume providers (0-29 Medicaid recipients/quarter), mid-volume providers (30-99 Medicaid recipients/quarter) and high volume providers (100+ recipients/quarter). In the quarter that began in November, 1993 and ended in January, 1994, TDH reports there were

* 4641 low volume primary care physicians (0-29 recipients)
* 1422 mid-volume primary care physicians (30-99 recipients)
* 1923 high volume primary care physicians (100+recipients)

86. Plaintiffs contend that practitioners have different reasons for refusing to see Medicaid recipients or limiting the number that they will serve. The most common reasons are:

Reimbursement Issues: On average, Medicaid reimbursement rates are slightly less than 50% of physician's usual and customary charges.

Patient compliance: Some practitioners complain that Medicaid recipients are less likely than others to arrive for appointments at all, or on time. Some practitioners also complain that recipients do not follow health care instructions.

Paperwork, hassle and non-responsiveness: Some practitioners complain that Medicaid paperwork is too complex and that program administration does not respond to practitioners' problems or needs.

Swamping: Some practitioners argue that there is a shortage of providers to serve the Medicaid population. The shortage makes some providers reluctant to sign Medicaid agreements because they are afraid that they will be "swamped," i.e., they will end up serving the entire local Medicaid population with no help from other practitioners.

Provider attitudes: Some providers do not serve Medicaid recipients because they do not want "that kind" of patient in their offices. Whether based on race, ethnicity, socio-economic status or a combination of those factors, discrimination means that some providers do not serve the Medicaid population.

87. TEXAS DEPARTMENT OF HEALTH STAFF In addition to the corps of private practitioners who serve EPSDT recipients, TDH staff provide some services to the EPSDT population. Currently, TDH employs 304 public health nurses. In the first 11 months of FY93, TDH performed 50,492 EPSDT medical check ups.

88. An adequate corps of capable providers is necessary to provide recipients with adequate access to needed services. Assuring an adequate provider pool requires recruiting new providers, retaining current providers, encouraging current providers to increase the number of recipients that they serve and facilitating training so that providers can adequately meet recipients' needs.

89. Defendants do not agree with the facts as described by Plaintiffs. But, the parties agree and the Court orders as follows:

90. PAPERWORK SIMPLIFICATION Defendants have drafted a simplified form for EPSDT medical check ups. It will be in use no later than December 31, 1995 and possibly as early as September, 1995.

91. Defendants have created a new billing form for immunizations. It allows the tracking of recipients' progress toward completion of the full series of immunizations. The tracking system will be in place and running by January, 1996. This system will permit providers to promptly request up to date information about patients' immunization status.

92. ACCURATE REFERRAL LISTS Providers and recipients are frustrated when a recipient is referred to a provider who cannot actually meet the recipient's needs. For example, many dentists do not see children until they reach the age of 3, or even 5 years. It is not appropriate to refer 1 year olds to those dentists for initial EPSDT dental check ups.

93. Defendants will maintain updated lists of providers who serve EPSDT recipients. The lists will specify practitioners' practice limitations, if any. Defendants will provide to appropriate NHIC staff information about provider practice limitations and encourage NHIC to use the information.

94. AGENCY RESPONSIVENESS The reorganization of TDH is partly intended to improve responsiveness to providers' needs. Senior management staff in each of the 8 TDH regions will be responsible for provider relations. The number of staff assigned to this task may vary based upon the number of EPSDT recipients in each region. One responsibility

of TDH provider relations staff will be to work with providers who serve EPSDT recipients to reduce or eliminate problems that discourage providers from participating in the program.

95. NO SHOWS/MISSED CHECK UPS Recipients who do not show up for scheduled appointments frustrate providers. Providers cannot discharge their professional responsibilities toward recipients who do not come to the office. Further, missed appointments wreak havoc with providers' schedules and cost them money. Also, busy providers may feel that they are missing the opportunity to help another needy patient every time a recipient misses an appointment.

96. Outreach units will respond to providers' requests for assistance to encourage recipients to receive services when recipients a) miss appointments or b) are overdue for check ups. Defendants will inform providers that this service is available. Defendants will also explain to providers how to contact outreach units. Outreach units will begin to serve this function no later than September 1, 1995.

97. In addition, the parties believe that improvements in transportation and scheduling assistance will reduce the number of no shows. See page 57 et seq.

98. INDEXED REIMBURSEMENTS FOR MEDICAL CHECK UPS Annual cost of living adjustments that apply to reimbursement for other Medicaid services do not apply to the reimbursement rates for medical check ups. So, a separate indexing methodology is necessary to annually adjust reimbursement to providers for check ups.

99. By September 1, 1997, Defendants will implement a method to index the reimbursement rate for medical check ups in non-managed care areas. The indexing method will

cause the reimbursement to change in accordance with a methodology developed by TDH.

100. RECRUITMENT OF PROFESSIONAL SCHOOLS TO BE PROVIDERS Not all relevant professional schools in Texas are enrolled as Medicaid or EPSDT providers. A "relevant professional school" is one that trains professionals who could serve EPSDT recipients, i.e., medical schools, dental schools, nursing schools, advanced nurse practitioner programs, etc.

101. Recruitment of professional schools is important to the functioning of the EPSDT program for at least three reasons. First, the schools can provide services to recipients and increase access to services. Second, the schools can show their students that it is important and meaningful to serve EPSDT recipients. Third, the schools can show their students that it is possible to incorporate EPSDT recipients into a practice without creating serious problems for the practitioner.

102. By May 30, 1995, Defendants will make a complete list of all relevant professional schools in Texas that are not enrolled as EPSDT providers. By October 31, 1995, Defendants will complete innovative efforts to recruit all relevant professional schools to become EPSDT providers.

103. INTENSIFIED PROVIDER RECRUITMENT EFFORTS Additional staff are needed to intensify provider recruitment efforts. The new provider relations staff in the TDH regions will assist in this effort. Further, NHIC will increase its provider relations staff to 28 (previously 16) to increase recruitment efforts.

104. TRAINING PROVIDERS To adequately serve recipients, providers must understand how EPSDT works. They must also understand EPSDT recipients' needs. Further, Plaintiffs contend that some providers' attitudes toward Medicaid recipients should be improved.

105. Some training efforts may have the added benefit of recruiting new providers, retaining current providers and encouraging current providers to increase the number of recipients that they serve.

106. TDH regional provider relations staff will assist providers to receive high quality training about topics relevant to provision of services to EPSDT recipients. They will also assist providers and their administrative staff to receive training about the administration of the EPSDT program.

107. Training at Professional Schools Defendants will provide information and facilitate ongoing training about Medicaid and EPSDT at all relevant professional schools in Texas. "Relevant professional schools" include all schools that train health care providers who could serve EPSDT recipients. The purpose of this training will be to

* interest students in serving EPSDT recipients,
* inculcate in students a sense of ethical or social obligation to serve EPSDT recipients,
* show students how to apply to become Medicaid and EPSDT providers, and
* explain how the Medicaid and EPSDT programs work and how to get help with problems.

108. EPSDT Training Associated with Other High Caliber Training Defendants will make staff available to participate in ongoing training in conjunction with appropriate professional training. "Appropriate professional training" means training about issues that are relevant to the provision of services to EPSDT recipients, such as how to conduct a medical check

up for a teenager or how to conduct a dental check up for an infant. "Appropriate professional training" will also be of a high caliber to encourage providers to attend.

109. Training by Other Professional Organizations Defendants will make staff available to appropriate professional organizations for the provision of training about EPSDT. The training will address the administrative aspects of EPSDT and/or clinical issues that pertain to serving the EPSDT population.

110. Training by TDH and NHIC NHIC runs annual training seminars about EPSDT (medical and dental) and Medicaid. Historically, the seminars' purpose has been mostly to explain billing and address administrative problems. The seminars about the EPSDT dental program remain primarily seminars about billing. Training is conducted primarily by NHIC staff, who are not doctors or dentists. As a result, Plaintiffs contend that training has not been conducted at a level of sophistication that is appropriate or interesting for physicians, dentists or many nurses.

111. Defendants will facilitate annual NHIC training seminars about EPSDT for medical and dental check up providers. Trainers will include physicians and dentists who present information that is appropriate and interesting for their peers. Training will also address billing and administrative issues, including those that deter some providers from participating in EPSDT.

112. Training about Mental Health Services Defendants will facilitate training for professionals about the importance of and how to conduct mental health assessments for indigent children and youth. The training will further describe the recent expansions in Medicaid coverage of outpatient mental health services. These changes significantly reduce prior approval requirements for outpatient care by psychiatrists and psychologists. The changes further expand

the categories of mental health professionals who may receive reimbursement for services provided to Medicaid recipients. Social workers, licensed professional counsellors and advanced clinical practitioners may now be paid for serving Medicaid recipients.

113. But, Plaintiffs contend that many health care providers are not aware of the recent expansions of Medicaid coverage of mental health services. As a result, they may not make appropriate referrals for full mental health evaluations or treatment when medical check ups reveal potential mental health problems. Some professionals may not even conduct mental health assessments during medical check ups out of a now-mistaken sense of futility that there will be no source of mental health care if a problem is diagnosed.

114. Plaintiffs further contend that this failure of the EPSDT program to fully address mental health problems is particularly tragic because those problems are overrepresented among the poor.

115. Mental Health Screening Tool The Texas EPSDT program provides a mental health screening tool to EPSDT medical check up providers upon request. By January 15, 1996, Defendants will convene a panel of experts in child and adolescent mental health to evaluate the tool for validity and appropriateness for use in Texas. The evaluation will be completed by April 15, 1996 and any needed changes implemented by September 1, 1996.

116. Training about Services for Teenagers The number of teenagers who are eligible for Medicaid and EPSDT will increase dramatically in the coming years because of changes in federal Medicaid eligibility standards. But, Plaintiffs contend that there is a shortage of providers to serve this group. Partly, the problem is training. Many professionals are not aware of recent significant changes in professional standards for the provision of care to teens.

Accordingly, Defendants will facilitate training for professionals in the provision of EPSDT services to teenagers.

117. Training about New Issues As time goes by, new clinical issues will arise that are important to the provision of care to EPSDT recipients. Defendants will facilitate training in those areas.

118. Training about the Realities of EPSDT Recipients' Lives/ Cultural Sensitivity Plaintiffs contend that some health care providers have misconceptions about EPSDT recipients and their families. For example, some providers believe that all welfare families are large, when in fact the average size of AFDC families in Texas is 3 (1 parent, 2 children). Others believe that all welfare recipients are lazy cheats, when in fact many are trying to better their circumstances so that they can live without public assistance.

119. Plaintiffs further contend that misconceptions can cause providers to treat recipients disrespectfully and even with hostility. This poor relationship destroys the trust that is needed between doctor and patient. Further, it discourages recipients from returning for care except when they are sick and cannot do without. This further encourages some providers to believe that parents of EPSDT recipients are lazy or do not care about their children's health.

120. Defendants do not agree with all of the facts described by Plaintiffs. Nonetheless, Defendants will develop training modules designed to be included in other training programs about the realities of EPSDT recipients' lives to attempt to improve providers' attitudes toward recipients. These training materials will be provided to professional schools.

121. Training for Nurses TDH contracts with the University of Texas Health Sciences in San Antonio's School of Nursing, to provide training to TDH public health nurses.

A week long seminar trains TDH public health nurses to conduct medical check ups of EPSDT recipients and arrange appropriate referrals when needed.

122. TDH prepares training modules for use in the seminar. TDH will incorporate into the training modules information about

* the comprehensive nature of EPSDT services,
* provision of services for teenagers,
* mental health assessments, expansions in mental health services and how to make mental health referrals,
* cultural sensitivity, to discourage hostile attitudes about EPSDT recipients and their families among TDH nurses, and
* relevant new clinical issues as they arise.

123. Further, TDH will make this training seminar available for non-TDH nurses who wish to attend, as allowed by state law.

124. Training for Pharmacists Pharmacies play a vital role in the EPSDT program. They supply needed pharmaceuticals and medical supplies to recipients based upon prescriptions.

125. Plaintiffs contend that many pharmacists do not understand the broad range of products that EPSDT covers. For example, EPSDT covers over-the-counter medications if physicians prescribe them. Over-the-counter medications are sometimes the medication of choice. For example, benadryl used to be available only by prescription but now is available over-the-counter. It is often the medication of choice for allergies.

126. EPSDT also covers formula and diapers when medically necessary. Further, the program covers other supplies and equipment that are commonly sold in pharmacies.

127. Plaintiffs contend that when pharmacists do not understand EPSDT's broad coverage, they sometimes refuse to provide needed items to EPSDT recipients absent cash payment. Since many recipients cannot afford to make payment, they go without needed products. Others pay for products that EPSDT actually covers.

128. Defendants do not agree with the facts described by Plaintiffs.

129. By January 31, 1996, Defendants will implement an initiative to effectively inform pharmacists about EPSDT, and in particular about EPSDT's coverage of items found in pharmacies. The effort will include presentations at meetings of the Texas Pharmaceutical Association and other appropriate organizations, if possible, articles in the TPA newsletter, if possible, and at least one mail out to all pharmacists who participate in the Medicaid program. The mail out will be designed to attract pharmacists' attention, explain EPSDT coverage clearly and encourage pharmacists to provide the full gamut of covered pharmaceutical products to recipients as needed.

130. By July 31, 1996, Defendants will conduct a professional and valid evaluation of pharmacists' knowledge of EPSDT coverage of items commonly found in pharmacies. They will report the results of the evaluation to Plaintiffs by September 1, 1996. If the parties agree that pharmacists' understanding of the program is acceptable, Defendants will continue the initiative described above to inform pharmacists about EPSDT. If the parties do not agree, or if pharmacists' understanding is unacceptable, Defendants will conduct an initiative to

orally inform pharmacists about EPSDT's coverage. Plaintiffs will not unreasonably disagree about whether pharmacists' understanding is acceptable.

131. Training Scholarships When TDH sponsors training programs relevant to EPSDT, it will arrange scholarships to enable needy providers to attend.

132. "PUBLIC" PROVIDERS Many EPSDT recipients receive services from providers who work for governmental entities, such as local health departments or hospital districts. Large hospital districts in major urban areas are sometimes associated with publicly funded health science centers. Then, recipients receive some services from medical and other health professional students under the supervision of professors.

133. Other recipients receive services from non-profit agencies that receive public funds, such as migrant and community health centers, rural health centers and mental health clinics. Further, many teenaged girls who are EPSDT recipients receive services from family planning agencies, such as Planned Parenthood.

134. Public Providers: Barriers to Participation Plaintiffs contend that unique problems prevent public and semi-public agencies from participating fully in EPSDT.

* For example, the Bexar County Hospital District runs a large outpatient center near downtown San Antonio. The center's pediatric drop in clinic handles more than 50,000 visits each year. Most patients are indigent children; many are EPSDT recipients.

* An institutional barrier prevents the drop in clinic from conducting EPSDT medical check ups. Bexar County Hospital District has its own laboratory. The drop in clinic is set up to send specimens to that laboratory and to receive and

file test results when they are returned. The drop in clinic is not set up to send specimens to the TDH laboratory in Austin[1] or to file results when the Austin lab returns them by mail. So, the drop in clinic does not provide EPSDT medical check ups. Further, although the local laboratory can provide test results within 1 day, the Austin laboratory cannot.

* Another example involves family planning agencies. Since family planning agencies are the only place where some teenaged girls go for health care, they could be an important link to provide EPSDT services to this group of recipients. But, some family planning agencies have not enrolled to provide EPSDT medical check ups. Apparently, their concern is that they cannot provide referrals to the various specialists whose services might be required after an EPSDT medical check up finds a problem.

* Further, Medicaid uses a special payment method to reimburse several categories of public providers, such as migrant and community health centers and "look alike" clinics. The Medicaid program pays them on a cost basis. The result is that their regular reimbursement exceeds EPSDT's $40 reimbursement for EPSDT medical check ups. So, the clinics sometimes do not bill for EPSDT medical check ups. This billing problem prevents Defendants from properly counting the number of check ups performed. It will also wreak havoc with the

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[1] Currently, providers must send all EPSDT medical check up specimens to the TDH laboratory in Austin and await results. The wait is generally 7-10 days.

outreach program, since the trigger for outreach services is the absence of a bill for a check up.

135. Defendants do not agree with the facts described by Plaintiffs.

136. Defendants will assist public providers to fully serve EPSDT recipients. The TDH regional provider relations staff will be responsible for this effort. They will resolve the problems that prevent recipients from receiving full EPSDT services from public providers. For example, together with Bexar County Hospital District, Defendants will determine if the local laboratory can provide adequate laboratory services. If feasible, Defendants will develop a system to allow Bexar County Hospital District to perform EPSDT laboratory tests locally. Similarly, Defendants will work with family planning agencies to develop networks of providers who are willing to accept referrals of EPSDT recipients for specialty care. Defendants will develop strong links between TDH's provider relations staff and family planning clinics to facilitate referrals. Further, Defendants will resolve issues concerning the provision of EPSDT check ups by providers who receive cost based reimbursement.

137. If possible, TDH regional provider staff will assess each public providers' need for training in areas relevant to the provision of services to EPSDT recipients. Regional staff will facilitate the receipt of training when appropriate. Training may be provided by TDH staff, NHIC staff and/or continuing education programs. Clinical training for professionals will emphasize the comprehensive nature of EPSDT services, the provision of services to teenagers and mental health issues (mental health assessments, referrals and EPSDT's expanded coverage of mental health services). Further, as new clinical issues relevant to the provision of EPSDT services arise, Defendants will emphasize them.

138. In addition, regional provider staff will facilitate training about EPSDT and how it works for all relevant public provider staff. Relevant staff may include anyone from the executive director through to the receptionist.

139. Recruitment of Public Health Care Agencies By May, 1995, Defendants will determine which Medicaid family planning agencies are not enrolled to provide EPSDT medical check ups. By January, 1996, Defendants will conduct an initiative to encourage all family planning agencies that serve Medicaid recipients to enroll as EPSDT medical check up providers. The effort to recruit family planning clinics to provide EPSDT medical check ups will be coordinated with TDH's family planning staff.

140. Defendants will further continue to make efforts to enroll all non-participating public providers.

141. Further, TDH will recruit independent school districts to provide EPSDT medical and dental check ups and coordinate other needed services. TDH will emphasize the development of centers to address the needs of pregnant teenagers in school districts that are interested in developing this resource for their students.

142. TDH will cooperate with Head Start programs to ensure that Head Start students who are EPSDT recipients have access to EPSDT services.

DENTAL

143. Defendants must provide periodic dental check ups and needed dental services to relieve pain, restore teeth and maintain dental health for EPSDT recipients. 42 U.S.C.

§ 1396d(r)(3). The Texas EPSDT periodicity schedule provides that dental checks ups begin at age 1 and continue every 6 months thereafter.

144. Advances in modern dentistry mean that children can now reach adulthood with no dental decay. Research shows that many children who have adequate access to ongoing dental care actually grow up free of cavities. But, research also shows that the benefits of modern dentistry are not available to many indigent children. As a result, indigent children, including EPSDT recipients in Texas, frequently suffer from dental disease that proper care could prevent.

145. Indigent children and youth frequently report that dental problems are among their most pressing health care concerns.

146. The parties agree to and the Court orders the following improvements to the EPSDT dental program:

147. Improvements in outreach for dental check ups are described on pages 9-10 and 16.

148. BABY BOTTLE TOOTH DECAY To help to prevent Baby Bottle Tooth Decay (BBTD), Defendants will conduct outreach to families with EPSDT recipient infants, beginning in January, 1996. BBTD is a preventable dental disease of young children. It causes rampant decay of the teeth, sometimes to the extent that the young child's upper front teeth are completely gone. Exhibit 5. BBTD is associated with increased decay in the baby and adult teeth. It is also associated with fever, infection, eating problems and in some instances failure to thrive.

149. BBTD is partially caused by the transfer of bacteria from the mouths of adults (frequently mothers) to the mouths of infants or toddlers. For example, bacteria transfer

can occur when an adult tastes a spoonful of formula to determine its temperature and returns the spoon to the warming saucepan.

150. The fairly common practice of letting young children sleep with a bottle that contains sugar (milk, juice, etc.) facilitates the development of BBTD. Sugary fluids nourish the bacteria that cause BBTD.

151. Since many young children cannot sit still for drilling and other procedures in the dental office, BBTD frequently requires outpatient hospital treatment under general anesthesia. This treatment is expensive and subjects young recipients to health risks that could be avoided.

152. Since they are EPSDT recipients, Medicaid recipients who are teenage mothers are themselves eligible for dental services.[2] One purpose of this phase of outreach will be to encourage teenaged mothers to get dental check ups and treatment, if needed, for themselves promptly after the birth of their infants. Mothers' treatment should be finished, if possible, before infants' teeth begin to erupt at about 6-8 months. This dental care will benefit the mother. It was also benefit her infant. If the mother's decay is treated, she may avoid passing on bacteria to her infant and so avoid BBTD.

153, Age appropriate outreach will also address the prevention of BBTD. See pages 10-11, 13, 19.

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[2] The Texas Medicaid program does not cover most dental services for recipients who are not eligible for EPSDT, i.e., adults.

SEALANTS

154. Dental Scans TDH may at its option perform dental scans for recipients who are in 2d or 3rd and 6th or 7th grades. Dental scans are brief examinations of the mouth by a dentist. They will be performed by TDH public health dentists or by dentists who contract with TDH. Dental scans will

* inform recipients about their apparent dental health and need for dental care;
* help to arrange dental care for recipients;
* encourage the placement of sealants by informing recipients about them in a timely manner; and
* place sealants when recipients do not have access to another dentist who makes sealants available.

155. Sealants are a modern development in dentistry. They are plastic protective coverings that prevent decay on the chewing surfaces of molars. Sealants are appropriate when teeth are prone to decay but decay has not yet started or is in its very early stages.

156. After proper preparation of the tooth, a sealant is painted onto the tooth surface and allowed to dry; much like clear nail polish. The sealant thus prevents the tooth from contacting substances that cause decay. To be effective, sealants must be placed within 12 months of the eruption of molars in children's mouths. Generally, sealants should be placed on the first permanent molars when children are about 7 years old (2d grade) and on the second permanent molars when children are about 13 years old (7th grade).

157. Many Texas EPSDT recipients do not receive sealants in a timely manner. Accordingly, TDH's scan program is aimed at children during the ages when sealants should be placed, to encourage use of this protective treatment.

158. Dental scans are not a substitute for full dental check ups. The scan program will be carefully designed and implemented to encourage recipients to receive full dental exams every 6 months. Recipients will be informed if they need dental care immediately, soon or within 6 months. The program will further assist recipients to schedule dental check ups after scans are completed.

159. It is preferable for recipients to receive sealants in the context of dental check ups as part of comprehensive dental care. But, when arrangements for sealants cannot be made with local dentists, TDH public health dentists should provide sealants for recipients who want them, if dentally appropriate.

160. Elimination of Age Limit Current EPSDT regulations allow the placement of sealants for recipients younger than 14 years. Although most recipients who require sealants are in this age group, some recipients require sealants at other ages. The limitation based on age is therefore inconsistent with the EPSDT requirement that services be available whenever necessary. 42 U.S.C. § 1396d(r)(5). By September 30, 1995, Defendants will cover all necessary sealants regardless of the recipient's age.

161. Training for Providers By April 30, 1995, Defendants will identify all dentists who provide services to EPSDT recipients but provide no or few sealants. By May 31, 1995, the TDH Dental Director will write to dentists whose practices could reasonably include sealants about sealants. The Dental Director will provide current information about a) the benefits

of sealants, b) how to use sealants and c) EPSDT reimbursement for sealants. Letters will be sent to dentists who regularly provide sealants and dentists who do not. By May 31, 1996, Defendants will review billing records to determine if the number of dentists who regularly provide sealants has increased. Dentists who do not provide sealants will receive further targeted outreach information about sealants unless their specialty indicates that they would not provide this service.

PROVIDERS

162. This settlement agreement discusses many issues pertaining to the recruitment, retention and training of providers of dental care. See page 30 et seq. The following provisions also pertain to dental providers:

163. Provider Participation Reports Accurate reports about provider participation are important to the administration of the EPSDT program. They allow assessment of provider trends and strategies for increasing provider participation.

164. Defendants maintain records of the number of dentists who have provided services to at least 1 EPSDT recipient in the past 12 months.

165. Beginning no later than October 31, 1995, Defendants will maintain reports of the number and percent of participating dentists who see 0-29, 30-99 and 100+ EPSDT recipients every 3 months. The format of these reports will be similar to those already prepared for medical doctors.

166. Audits of Dental Practices Defendants audit a small number of dental practices to determine if recipients receive proper services. Audits can result in sanctions such as a request for repayment of funds paid by Defendants for services to recipients.

167. The professional conduct of audits is important to EPSDT recipients. Plaintiffs contend that unprofessional conduct of audits may cause dentists to stop serving EPSDT recipients. Accordingly, Defendants will finalize policies or rules for the audits by September 30, 1995. Further, they began a 3 month moratorium on audits on April 1, 1995.

168. Use of Current Professional Standards Plaintiffs contend that Defendants use outdated standards for approval of some dental care for EPSDT recipients. The use of outdated standards poses problems for recipients because a) they cannot get services that meet current professional standards and b) dentists become frustrated with NHIC and may stop providing services to recipients.

169. Defendants are committed to the use of appropriate professional standards in the EPSDT program. They will develop standards that comport with professional judgment, based upon consultation with appropriate experts, including the chairs of the Departments of Pediatric Dentistry in Texas.

ACCOUNTABILITY/MEASUREMENT

170. Check Ups Each recipient is supposed to receive a dental check up every 6 months, starting at 1 year.

171. Defendants do not maintain records of the number of recipients who receive 1 or 2 dental check ups each year. The parties agree that by September 30, 1996, Defendants will prepare a report of the number and percent of recipients who receive 1 dental check up/year and 2 dental check ups/year. They will prepare similar reports every year.

172. By December 1, 1996, the parties will agree on expected increases in the number and percent of recipients who receive 1 and 2 dental check ups/year.

173. Recipients' Health A reporting system to determine whether recipients receive all needed follow up diagnosis and treatment would be so cumbersome that it would collapse under its own weight. Accordingly, Defendants will report on dental health outcomes in the EPSDT population. If the EPSDT dental program works, the incidence of dental disease in the EPSDT population should decrease over time, because most dental disease can be prevented. But, in the interim, dental disease may appear to increase because many recipients who previously had no care will begin to receive care as a result of increased outreach. It is likely that they will have significant dental disease because they have not received treatment in the past.

174. By March 1, 1996, Defendants will arrange for a study to assess the dental health of the EPSDT population. The study will assess changes over time. At a minimum, the study will evaluate improvements in the number and percent of recipients who 1) have no cavities, 2) have no untreated cavities and 3) require hospital treatment for dental problems. The method will be subject to Plaintiffs' approval. Plaintiffs' approval will be limited to whether the method for the study is professional and valid. Plaintiffs will not unreasonably withhold approval. If they approve of the method, Plaintiffs may still offer suggestions about the proposed method. Defendants may accept or reject Plaintiffs' suggestions.

SPECIAL GROUPS

175. Several groups require special attention so that they can receive the full benefits of the Texas EPSDT program. This list is not exhaustive. The parties may agree at a later date that other groups should be included.

FARMWORKERS

176. Texas is home base to about 500,000 migrant farmworkers. The number who receive Medicaid or EPSDT benefits is unknown but the parties agree that many EPSDT recipients are children of migrant farmworkers.

177. Plaintiffs contend that

* although migrant farmworkers share many characteristics, there is also considerable variation within this population. Generally, migrant farmworkers leave their home base for the north in the spring after the school year ends and return before the school year begins in the fall. But, within these parameters, there is considerable variation in travel schedules.

* There is also significant variation in living arrangements. Some farmworkers live in communities that are composed primarily of other farmworkers but others do not.

* The children of migrant farmworkers are more likely than many others to be in ill health. Unhealthy working and living conditions, dire poverty, poor nutrition, lack of education and illiteracy contribute to their poor health.

* Despite their increased need for health care, farmworkers often do not receive services that they require. First, they often live in areas where health care providers are few and far between.

* In addition, migrant farmworker families leave Texas during the summers to work in other states. This migration adds to their

health care difficulties. First, recipients may lose Texas Medicaid eligibility when they leave the state. As a result, some recipients face delays in receipt of care upon return to Texas in the fall, because they are not eligible for benefits. Further, given their hectic travel schedules when out of Texas, some cannot schedule health care appointments during the summer. When farmworkers move from place to place, they sometimes have trouble locating new health care providers who are willing to serve them. Also, it is sometimes virtually impossible to determine what services recipients receive because medical records do not follow recipients from state to state. Finally, the physical and emotional stress of long distance travel exacerbates some migrants' health care problems.

178. The purpose of outreach to recipients who are children of migrant farmworkers will be to help them to receive as many needed EPSDT services as possible while they are in Texas. To accomplish this goal, the parties agree and the Court orders:

179. Defendants will identify a) the counties where recipients who are the children of migrant farmworkers live during part of the year and b) approximately when farmworker families return to those counties.

180. In 1995, Defendants will begin this program in the Lower Rio Grande Valley. Later, they will expand appropriate outreach efforts for farmworker families to other areas of the state as needed.

181. Defendants will make efforts to help farmworker families to utilize EPSDT benefits promptly upon return to Texas. These efforts will include door to door outreach in communities where migrant farmworkers live.

182. When migrant farmworkers apply for Medicaid benefits on behalf of EPSDT eligible children, the TDHS eligibility worker will determine if the applicant would like further information about EPSDT or help to schedule appointments.

183. When outreach units receive information about the identity of migrant farmworker recipients who request outreach services, outreach units will give priority status to those recipients. They will provide outreach as quickly as possible. Outreach information will encourage this group of recipients to receive as many needed services as possible before they move on again.

RECIPIENTS IN MANAGED CARE

184. Managed care is a health care system where managed care organizations are paid to manage patients' care appropriately. The Texas Medicaid program currently uses 2 managed care models.

185. In capitated fee models, managed care organizations are paid flat fees to provide all or a range of services for their patients. Since organizations are paid a flat fee to serve their patients, the theory is that they provide cost effective care to avoid expensive care for illnesses that could be prevented. A criticism of this theory is that managed care organizations may not provide needed treatment to save money.

186. In primary care case management models, individual health care providers are paid a small monthly fee to arrange referrals and other services that their patients need. In

this model, providers are still paid a fee for services that they provide, such as check ups, diagnosis and treatment.

187. The Texas Medicaid program began managed care pilot projects in 1993. The pilot projects are in Travis County and the tri-county area of Galveston, Chambers and Jefferson Counties. One Travis County pilot project uses a full capitation fee structure. The second uses a partial capitation fee structure, so the managed care organization is at risk for the costs of all care except hospital care. The tri-county project uses a primary care case management model.

188. The Texas legislature considered the expansion of managed care for the Medicaid population in the 1995 session. Ultimately, the legislature passed and the Governor signed SB 10, SB 600, SB 601 and SB 602. Exhibit 6. The legislation requires the Texas Medicaid program to increase the number of recipients who are served by managed care organizations. Most Texas Medicaid recipients will receive services from managed care organizations within a few years.

189. Regardless of their disagreements about the merits of managed care, the parties agree that managed care must be implemented in a manner that benefits EPSDT recipients and does not harm them. For this reason, the parties agree and the Court orders that:

190. EPSDT recipients served by managed care organizations are entitled to timely receipt of the full range of EPSDT services, including but not limited to medical and dental check ups.

191. TDH will assure by various means that the number and percent of EPSDT patients in each managed care organization who receive all medical and dental check ups when due and information for outcomes research as needed is accurately collected.

192. TDH will assure by various means that managed care organizations provide medical and dental check ups to newly enrolled recipients no later than 90 days after enrollment except when recipients knowingly and voluntarily decline or refuse services. Managed care organizations will also have the capacity to accelerate services to the children of migrant farmworkers to accommodate their special circumstances. TDH will also assure medical and dental check ups in a timely manner to all recipients.

193. TDH will assure by various means that managed care organizations cooperate with outreach units so that recipients who miss medical and/or dental check ups receive prompt services.

194. TDH will assure by various means that managed care organizations arrange appropriate training for all health care providers and their staff who serve EPSDT recipients as authorized by SB 601. All will be trained about program requirements relevant to their responsibilities, including the relevant terms of this settlement.

195. Recipients who receive services from managed care organizations are entitled to challenge decisions made by managed care programs by fair hearings and otherwise as authorized by SB 601.

196. The financial soundness of managed care organizations is important to recipients to assure that their source of care does not disappear because of financial problems.

Defendants will contract only with managed care organizations that are financially sound, as required by SB 10.

197. TDH will assure by various means that managed care organizations have an adequate supply of appropriate providers who can serve EPSDT recipients (including specialists) located conveniently so that recipients do not face unreasonable 1) delay scheduling appointments, 2) delay waiting for appointments once at the office or 3) travel times to get to the office as authorized by SB10 and SB 600.

198. Defendants will assure a system that allows recipients to enroll promptly with a new managed care organization, if it exists, when recipients move from one geographic area to another within Texas.

199. Managed care organizations will be subject to independent evaluation of their patients' health outcomes, patients' satisfaction and process measures, including but not limited to the number and percent of EPSDT recipients who receive all medical and dental check ups when due.

TEENS

200. Plaintiffs contend that teens face many complex health problems, which frequently go unresolved. Common problems include, eating problems (overweight, underweight, anorexia, bulimia, etc.), substance abuse (alcohol, illegal drugs, steroids), mental health problems, sexually transmitted diseases and unwanted pregnancy. Many of teens' health problems are embedded in psycho-social problems, which make the problems worse and treatment more difficult.

201. Federal law requires Medicaid programs to expand eligibility categories to cover an increasing number of young people to age 19. States must provide Medicaid to applicants born after September 30, 1983 whose incomes do not exceed 100% of the federal poverty guidelines. In essence, eligibility at the 100% of poverty level is inching upward in age as the years go by.

202. The eligibility expansion has had a significant impact in Texas, where many older applicants only receive Medicaid benefits if they also qualify for Aid to Families with Dependent Children. The income cut off for AFDC is about 20% of the federal poverty guidelines.

203. As a result of the expansion, the number of teenagers who are eligible for Medicaid and EPSDT is about to balloon in Texas. But, to date, the participant ratio (receipt of medical check ups) for 15-20 year olds[3] are as follows:

FY91	3%
FY92	4.34%
FY93	5.65%

204. To better serve the teenaged population, the parties agree and the Court orders:

205. Defendants will use innovative means to provide EPSDT services to teenagers. For example, Defendants will provide or arrange for services in locations where

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[3] These data are taken from Defendants' Annual EPSDT Participation Report (HCFA Form 416) submitted to the federal government. Data for 13 and 14 year olds are combined with data for younger children.

teenagers go, when possible. TDH regional staff will determine locations where teens can be found (schools, recreation centers, homeless shelters). They will further determine if the locations are suitable for provision of EPSDT services, i.e., sufficient privacy, room, host organization support, etc. When possible, Defendants will provide services at those locations, either by use of properly trained TDH nurses or by contract with other EPSDT providers who can serve teens well.

206. Plaintiffs contend that some teenaged girls get health care only at family planning agencies. There are 130 family planning agencies in Texas that accept Medicaid. Some of them do not provide EPSDT medical check ups, even though they are able to do so. As a result, teenaged recipients do not get EPSDT check ups and referrals. Efforts to recruit family planning agencies are described in pages 38, 40.

207. Efforts to inform teens and their parents about EPSDT will address the complex privacy and consent issues involved. Parents have the legal right and responsibility to consent to medical treatment for their teens. The problem arises when teens face sensitive health care problems. The mere need to inform parents to get consent prevents some teens from receiving care because they do not want their parents to know about touchy problems.

208. Each family strikes the balance between parental knowledge/consent and teen privacy differently. Defendants' role is only to bring the issue to recipients' attention so they can resolve it together with teens' health care providers.

209. Written outreach information for teens is described in pages 9-11. Efforts to provide dental care to teenaged mothers are described in page 42. Efforts to train providers about teenagers' unique needs are described in page 33. In addition, the reevaluation of the

mental health assessment tool and provider training about mental health issues is described in page 33. Although mental health is relevant to EPSDT recipients of all ages, it is particularly relevant to teens.

RECIPIENTS UNDER THE SUPERVISION OF THE TEXAS DEPARTMENT OF PROTECTIVE AND REGULATORY SERVICES

210. The Texas Department of Protective and Regulatory Services is the agency that supervises children who have been abused or neglected. In some instances, TDPRS removes children from their families. Many of the removed children are eventually reunited with their families. Research shows that this population of children and youth are more likely than others to have health problems.

211. Many children under TDPRS supervision are EPSDT recipients. To provide needed services for them, the parties agree and the Court orders:

212. TDH and TDPRS will present a Memorandum of Understanding for Plaintiffs' approval by August 31, 1995 and to the Court by October 1, 1995. The Memorandum of Understanding will

* provide for appropriate training about EPSDT to parent(s) or adult caretakers before recipients are reunited with their families, including explanation of EPSDT in parenting classes for the families, and
* establish a method to report the number and percent of EPSDT recipients under the supervision of TDPRS who receive all of their medical and dental check ups when due, and

* assure that all EPSDT recipients under the supervision of TDPRS receive all medical and dental check ups when due, and

* establish procedures to refer EPSDT recipients, in a coordinated manner, to appropriate case managers when needed upon recipients' release from TDPRS supervision. The case management portion of the TDH/TDPRS agreement may be delayed until the parties reach agreement about case management. See page 65 et seq.

TRANSPORTATION/SCHEDULING

213. TRANSPORTATION Plaintiffs contend that many EPSDT recipients do not receive needed services simply because they have no way to get there. They further contend that transportation problems are a significant barrier that impede the Texas EPSDT population's access to health care services.

214. Current Program Defendants must provide transportation assistance when recipients need it. 42 C.F.R. §§ 431.53; 440.170. Defendants provide several forms of transportation assistance, including:

* 15 cents/mile reimbursement for rides provided by volunteers including family members;

* fixed route transportation such as vans that run circuits in rural areas or tokens to use public transportation in urban areas;

* demand responsive transportation for recipients who cannot use fixed route transportation or when fixed route transportation is not available;

* intercity buses;

* airplanes and trains.

215. Contracting organizations provide many transportation services, such as van service and pre-payment of mileage fees in some parts of the state.

216. The transportation program also pays for hotels and meals when recipients must travel overnight to needed treatment. The current reimbursement for meals is $15/day for adults and $10/day for recipients under the age of 12. The transportation program covers the cost of hotels and meals for the recipient and an attendant when needed. The attendant may be a family member.

217. NHIC reimburses for ambulance transportation.

218. In FY94, the transportation budget increased from $8 million to $12 million. The legislature appropriated $18,069,431 for the transportation program in FY96 and $20,341,204 in FY97.

219. Plaintiffs contend that in the past, the Texas Medicaid Transportation program has not served all recipients well. They further contend that

* according to Defendant Friedholm, there is "universal dissatisfaction" with the program. The system creates problems for recipients because sometimes rides arrive at the wrong time or even on the wrong day. Recipients sometimes have to wait for very long times to be picked up. Trips can take several times as long as they would by other means. These problems frustrate some recipients to the point that they no longer want to try to use Medicaid transportation services.

* As a result of problems caused by transportation difficulties, some health care providers do not serve Medicaid patients, including EPSDT recipients. Some limit the number of recipients who they serve. Some perceive that Medicaid recipients, including EPSDT recipients, are often late for appointments or do not show up at all. This wastes providers' time and creates scheduling problems in their offices.

* Further, to minimize scheduling problems, some providers schedule all of their Medicaid patients at one time, for example, the third Thursday of the month. Then, they double or triple book appointments to have a full schedule in spite of "no shows." This means that recipients have to wait a long time in overcrowded waiting rooms to get in to see the doctor.

* Also, because of transportation problems, some recipients arrive early for appointments or wait in providers' offices for long times after the appointment is over. This crowds providers' offices and poses problems for office staff and other patients.

* Transportation services are essential to 1) get recipients to needed services and 2) alleviate scheduling and overcrowding problems to increase providers' willingness to serve EPSDT recipients.

220. Effective transportation assistance is an essential component of the EPSDT health care delivery system. Therefore, the parties agree to and the Court orders the following improvements to the Medicaid transportation program:

221. Recipients may request transportation assistance by 1) calling the transportation office 2) visiting TDH offices or 3) with help from outreach workers or case managers when they meet with recipients.

222. TDHS Informing TDHS eligibility workers will briefly describe the transportation program, including the mileage reimbursement option, during each initial eligibility interview. Oral outreach staff will describe the transportation program in detail in each outreach session.

223. Annual Assessments and Corrective Action Plans Defendants will conduct annual assessments of the effectiveness of the transportation program. The first assessment will be completed by March, 1996.

224. The assessments will be specific and comprehensive enough to validly evaluate the transportation program in each Standard Metropolitan Statistical Area and the rural area in each of the 8 TDH regions. The assessments will determine where services are needed, the amount of services that are needed and if existing services meet the need for transportation assistance.

225. Each assessment will evaluate:

* unmet need for transportation assistance;
* recipient and provider satisfaction with the transportation program;
* the reasons for recipient and provider dissatisfaction with the transportation program;
* whether transportation times are reasonable; and

* whether recipients missed or did not schedule EPSDT services because of transportation problems, including those attributable to medical transportation program deficiencies.

226. Over time, the results of the evaluations will improve.

227. Defendants' method for evaluating the transportation system will be subject to Plaintiffs' approval. Plaintiffs' approval will be limited to whether the method is professionally acceptable and valid. Plaintiffs will not unreasonably withhold approval. They will submit their decision to Defendants within 45 days of receipt of the proposed method. If Plaintiffs approve the method, they may still offer suggestions. Defendants may accept or reject the suggestions.

228. Defendants will take corrective action wherever the assessment indicates that transportation services are inadequate. "Inadequate" means problem(s) exist that Defendants can reasonably be expected to correct.

229. Upon completion of each annual transportation assessment, the parties will determine a method to decide where corrective action is needed, how quickly it is needed and what actions will be taken.

230. Urgent Requests Plaintiffs contend that transportation staff sometimes do not meet - or even attempt to meet - urgent requests for services or requests to reschedule transportation services. Defendants will train transportation staff to respond appropriately in these circumstances by July, 1995.

231. Mileage Reimbursement Plaintiffs also contend that the mileage reimbursement option is little understood and underutilized. Plaintiffs contend that the advantages of the mileage reimbursement option are:

* it preserves EPSDT recipients' dignity by allowing them to travel to health care by the same means that most others use; and

* EPSDT recipients can arrive and leave on time, to the benefit of recipients and health care providers.

232. Defendants agree to increase the mileage reimbursement rate (currently 15 cents/mile). Beginning September 1, 1995, the rate will be the same as the reimbursement rate for state employees (currently 28 cents/mile). The Medicaid reimbursement rate will change whenever the state employee reimbursement rate changes in the future.

233. Plaintiffs contend that another problem with the mileage reimbursement option is delays in receipt of reimbursement. Since many volunteer drivers are themselves indigent, they cannot afford to wait several weeks or more to be paid back.

234. To improve the mileage reimbursement process, by September 1, 1995, Defendants will determine:

* in which TDH regions advance payments are not available, if any, and why;

* whether advance payment can be made available throughout the state;

* what methods can be used to speed up the reimbursement process for mileage reimbursement requested after trips occur.

235. By October 31, 1995, the parties will attempt to agree on a method to implement improvements to the administration of the mileage reimbursement program.

236. In addition, Defendants will effectively inform health care providers about the mileage reimbursement option so that they can refer patients when appropriate.

237. Revision of Regulations Current regulations only provide transportation services to the closest health care provider. Plaintiffs contend that this limitation is inconsistent with allowing recipients to develop good working relationships with providers because it limits recipients' choice of providers.

238. Defendants will establish new transportation regulations that cover reasonable transportation to establish or maintain an ongoing relationship with a health care provider. The regulations will be finalized by September 30, 1995 absent unusual controversy in the rulemaking process.

239. SCHEDULING ASSISTANCE Plaintiffs contend that many recipients do not receive EPSDT services because they cannot locate a health care provider who is willing to serve them. Many cannot schedule appointments because they do not speak English or have a telephone.

240. Defendants must help recipients to schedule appointments. 42 U.S.C. § 1396a(a)(43(B);(C). This duty is deceptively simple. It includes the often difficult task of finding a health care provider who will serve the recipient. It also includes assisting recipients who have communication problems such as lack of a telephone or language barriers.

241. Toll Free Help Lines TDH has toll free telephone numbers for recipients to call for help with scheduling appointments. But, Plaintiffs contend that in the past, some recipients have been ill served by these numbers. For example, some recipients have called a toll free number only to be told that the staff can help with transportation but cannot help to schedule an appointment. This does not help recipients who do not already have appointments or who cannot schedule appointments because they do not know providers who will see them.

242. By September 1, 1995, TDH will reevaluate the use and operation of its toll free numbers to improve scheduling assistance for recipients. Toll free number staff will be familiar with local resources and needs.

243. The toll free numbers to request transportation and scheduling assistance will either be combined or linked. When recipients call to ask for help with transportation, they will also be able to get help with scheduling (or vice versa). This system will be more hospitable and helpful to recipients than the past system.

244. When recipients ask for help to find a provider, staff will provide the name, address and telephone number of at least 1 provider of the appropriate specialty in a convenient location. Defendants recognize that recipients have freedom to choose among providers. Staff will determine if recipients wish the names of more than 1 provider. If so, staff will provide additional names if providers exist. Providers of the appropriate specialty in a convenient location will be identified, if possible, on a rotating basis. When recipients receive services through managed care arrangements, they will be notified of their freedom to choose a primary care physician of their choice at enrollment.

245. When recipients ask for help in scheduling appointments, TDH staff will provide information about providers as described in the above paragraph. Staff will determine if recipients wish assistance with scheduling appointments and/or transportation. If so, staff will provide assistance.

246. Self Correction/Provider Shortages TDH regional staff are to notify central office provider relations staff about inadequate supplies of providers. For this purpose, "inadequate supply of providers" means that staff cannot satisfy a recipient's request for a needed

provider or providers. Central office staff will make extra efforts to recruit providers in shortage areas.

247. Standards for Toll Free Help Lines (Transportation, Scheduling Assistance and Other) Toll free numbers for EPSDT recipients will be staffed sufficiently by well trained personnel. Each recipient will receive prompt service by a person who is knowledgeable, helpful and polite. All calls will be answered promptly absent equipment failure. Equipment will be adequate so failure results only from circumstances beyond Defendants' control, such as bad weather. TDH will make reasonable arrangements to meet the needs of recipients who do not speak English. No calls may be "answered" by a tape recording during working hours except in unusual circumstances.

CASE MANAGEMENT

248. EPSDT programs must provide case management to each recipient if needed. Since case management is a service that Medicaid programs may cover, 42 U.S.C. §§ 1396d(a)(19); 1396n(g), Medicaid programs must cover it for EPSDT recipients if medically necessary. 42 U.S.C. § 1396d(r). Texas currently provides case management to several groups of recipients but not all recipients when needed.

249. Case management is divided into two categories - administrative case management and medical case management.

250. ADMINISTRATIVE CASE MANAGEMENT Administrative case management includes a broad range of functions needed for the efficient administration of the Medicaid program. Some aspects of administrative case management directly assist recipients,

such as a) accepting and processing applications for benefits, b) EPSDT outreach and c) scheduling transportation or appointments. Other aspects of administrative case management do not directly benefit recipients, such as utilization review activities to determine if health care providers have properly submitted claims for payment.

251. The federal government generally reimburses state Medicaid programs for 50% of the costs of administrative case management. The federal reimbursement rate is 75% for administrative case management services that must be performed by health care professionals.

252. Administrative case management functions are generally performed by state agency staff or by other agencies that contract with the state.

253. MEDICAL CASE MANAGEMENT Medical case management directly benefits recipients. When medically necessary, this service assists recipients to gain access to needed medical, social, educational and other services. It helps to coordinate services and provide continuity of care.

254. Medical case management is an integral part of the health care of children when needed. Generally, either nurses or social workers provide these services at the direction of an appropriate health care provider or when need is properly documented. Case management is provided in consultation with the child's medical home, if it exists, and other relevant providers.

255. Medical case management involves two levels of sophistication. Some recipients have serious and complex health care problems, such as those who need solid organ transplants or very low birth weight infants. They require services from tertiary care facilities, where specialists and special equipment are available. Medical case managers provide services

at tertiary care facilities to meet recipients' needs when they are under care there. These sophisticated case managers may also help to coordinate care when recipients leave the tertiary care facility.

256. Medical case management also is provided in the community where recipients live. In this instance, medical case management serves recipients with serious and complex health care problems when they are at home. This aspect of community based medical case management involves coordination with the tertiary care facility and specialists. It also involves the local coordination of needed services.

257. Community based medical case management also serves recipients who need help to coordinate health care and other services even though their health problems are treated locally.

258. The federal government reimburses the Texas Medicaid program for medical case management at the federal financial participation rate of about 64%.

259. Medical case management may be financed through contractual agreements with appropriate local agencies. This method reimburses agencies for the percent of staff time devoted to reimbursable services to recipients.

260. The EPSDT program may also pay for medical case management on a fee for service basis. This is the same method used to pay for many other medical services. This reimbursement method is important because it allows doctors to provide case management in their own offices.

261. Many agencies offer different forms of case management to their clients. Some of those agencies' clients are also EPSDT recipients.

262. The potential for duplication of services poses a significant challenge to the effectiveness of case management. From the recipient's perspective, conflicting instructions and assistance from several well meaning case managers can defeat the purpose of case management - to coordinate services and assure that the recipient's needs are met. "Help" from a bevy of case managers can easily cross the line into confusion and aggravation. From the state's perspective, paying for several case managers when one - or two at most - would do is wasteful.

263. The parties agree and the Court orders as follows:

264. Case Management Plan and Implementation Schedule By January 31, 1996, the parties will complete a case management plan for the EPSDT program. Case management includes arrangments for the child and the family which are needed to meet the child's health care needs. The plan will make sufficient case management available in every county or cluster of counties where few recipients reside. It may provide case management by contract with local agencies or on a fee for service basis, whichever is more effective in each county.

265. Among other issues, the plan will address methods to encourage the acceptance of case management by recipients and providers. For example, some providers resent case management because they confuse it with "utilization review." "Utilization review" determines if services are provided appropriately. Some providers view utilization review as an interference with their practice methods.

266. The plan will also address the relationship between case management and managed care organizations. All EPSDT recipients, including those in managed care, are entitled to the full range of case management assistance when medically needed.

267. In addition, the plan will address the proper role of case managers. The role is to help recipients to make and effectuate their own choices about their health care and related issues. The role is not to restrict recipients' choices in this realm.

268. The plan will also address case management for the children of migrant and seasonal farmworkers and how best to provide case management to that population.

269. Finally, the plan will address the coordination of case management services provided by the various agencies that serve EPSDT recipients. Coordination will be achieved in a manner that permits recipients to choose their case managers.

270. By September 1, 1996, Defendants will finalize medical case management regulations and implement the program.

STATEWIDENESS

271. Medicaid services, including EPSDT services, must be available "in every political subdivision of the state." 42 U.S.C. § 1396a (a)(1).

272. Currently, the percent of EPSDT recipients who receive services varies from county to county throughout Texas.

273. The parties agree to implement a process to meet the statewideness requirement. This process will

* annually monitor the percent of recipients who receive EPSDT check ups throughout Texas and locally, and

* increase the percent of recipients who receive check ups in areas where that percent is low.

274. The process is intended to prevent areas of the state from lagging behind even if the percent of recipients who receive services in the state as a whole increases.

275. The parties agree to and the Court orders the following statewideness process:

276. The unit of measurement generally is the county. When necessary, counties where few recipients live may be clustered so that statistically valid results can be achieved.

277. Beginning in 1996, Defendants will measure the percent of EPSDT recipients who receive medical check ups. Beginning in 1997, Defendants will conduct 2 analyses. They will measure the percent of EPSDT recipients who receive medical check ups and 2 dental check ups/year in each county or county cluster.

278. By September 30, 1995, Defendants will develop a statistically valid method to determine which counties or county clusters lag behind in the percent of recipients who receive medical or dental check ups. The method is subject to Plaintiffs' approval. Plaintiffs' approval is limited to whether the proposed method is professionally acceptable and valid. The deadline for Plaintiffs' decision is November 15, 1995. Plaintiffs will not unreasonably withhold approval. If Plaintiffs agree that the method is acceptable, they may nonetheless offer suggestions. Defendants may accept or reject Plaintiffs' suggestions.

279. Defendants may improve the method for the statewideness analysis. Defendants will submit proposed changes to Plaintiffs for approval, as specified above. Plaintiffs will have 45 days to submit their decision about the new method to Defendants. Again, they may submit suggestions, which Defendants may accept or reject.

280. Defendants will complete a statewideness analysis every year by March 30. Defendants will identify the counties or county clusters that lag behind the state average for medical check ups beginning in 1996 and for medical and/or dental check ups beginning in 1997 and continuing annually thereafter for the duration of this agreement.

281. Each year, Defendants will develop a corrective action plan for those counties that lag behind so that participation in those counties improves. Defendants have discretion to use one or more appropriate means to improve participation in each county because local problems and needs vary from county to county. Appropriate means include:

* increase and/or improve informing and outreach;
* increase and/or improve transportation assistance;
* assign appropriate TDH public health professionals to provide medical and/or dental check ups;
* arrange for local or nearby private practitioners to provide medical and/or dental check ups;
* establish local providers of medical and/or dental check ups;
* increase and/or improve scheduling assistance; and/or
* any other means that can be reasonably expected to increase participation.

MEASUREMENT/ACCOUNTABILITY

282. The parties have reached agreement and the Court orders the following measurements and reports.

283. METHOD TO REPORT CHECK UPS First, Defendants report EPSDT participation statistics to the federal government every year on the HCFA Form 416. The HCFA Form 416 uses calculations to approximate the number of recipients who receive EPSDT medical check ups.

284. Every year from 1996 through 1999, Defendants will also report to Plaintiffs the number and percent of recipients who receive all of their scheduled medical check ups. They will further report the number and percent of recipients who receive all of their scheduled dental check ups. Defendants will provide these reports to Plaintiffs no later than December 31 of each year.

285. For these reports, Defendants will develop a method that records all recipients who receive the full number of scheduled check ups within a year. Since the reports will be based upon billing information, Defendants may extend the reporting period a reasonable length of time not to exceed 3 months to account for billing delays or other data collection problems. This short extension of the reporting period also accounts for recipients who receive check ups slightly behind schedule. The complexities associated with collecting utilization data require the parties' continued collaboration in the design and implementation of this system.

286. HEALTH OUTCOMES STUDIES AS A PROXY MEASURE OF FOLLOW UP CARE Second, the other reports mentioned in this agreement do not measure an important aspect of the EPSDT program. They do not measure whether recipients receive "[s]uch other necessary health care, diagnostic services, treatment, and other measures ... to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services...." 42 U.S.C. § 1396d(r)(5).

287. A system to measure whether all of the approximately 1.5 million Texas EPSDT recipients receive all needed services would be so complex that it would collapse under its own weight. Further, accuracy might be impossible.

288. So, the EPSDT program will measure several indicators of the health of the EPSDT population. These health outcome indicators will serve as a proxy to measure whether recipients receive the full range of services that they need and are entitled to receive.

289. The parties will together choose health outcomes indicators. To the extent possible, the indicators will gauge the EPSDT population's health in ways that can be measured. Further, the indicators will be chosen wisely, so that they measure important aspects of the population's health. In addition, the indicators will be diverse enough to gauge the health of the entire EPSDT population, not merely factions of the population.

290. In concept, the parties already agree about several indicators. For example, they agree that the prevalence of timely completed immunizations must increase. They further agree that immunization status is an important indicator of the EPSDT population's health and whether recipients actually receive needed health services. Further, it is possible to measure the prevalence of completed immunizations in the EPSDT population because of TDH's new immunization billing forms.

291. The parties also agree that another important health outcome indicator is the decreasing average age of detection of significant congenital hearing problems. Although the average age of detection in other countries is less than 1 year, in the United States the average age is about 24 months. Delayed detection of hearing problems can prevent treatment and interfere with language development.

292. The parties further agree that an appropriate health outcome measure is the increasing percent of pregnant teens who receive prenatal care in the second and third trimesters of pregnancy. This indicator measures teens' health and receipt of care. It also is a proxy measure of the health of the new infants, who should automatically be eligible for Medicaid and EPSDT benefits. 42 U.S.C. § 1396a(e)(4). Receipt of prenatal care can be measured because birth certificates record maternal prenatal care.

293. But, wise decisions about other important health outcome indicators require research and thought. The parties will develop a list of health outcome indicators by September 1, 1995. The list will include about 12 indicators. The parties may agree to change, add or delete indicators.

294. The parties will further agree on a target goal for each health outcome indicator. The health outcome goals are not enforceable, in and of themselves.

295. Defendants will report the best available information on each health indicator annually, beginning on September 1, 1996 and continuing through 1999. The EPSDT program will arrange for studies to evaluate the health of the EPSDT population, including each health outcome indicator. Defendants will present their proposed methodology for Plaintiffs' approval by April 1, 1996. Plaintiffs will not unreasonably withhold approval. If they approve, Plaintiffs may make suggestions. Defendants may accept or reject the suggestions.

296. If reported results do not achieve the goal for each indicator, Defendants will develop corrective action plans to address all matters within Defendants' control to improve results for each indicator. Defendants will present their corrective action plans for Plaintiffs'

review and comment by January 30 each year. Defendants will not unreasonably reject Plaintiffs' suggestions.

297. Some health outcome indicators may initially appear to get worse before they get better. In some circumstances, this may perversely suggest that the Texas EPSDT program is working, because recipients who never before received services are finally getting attention.

298. MANAGEMENT INFORMATION SYSTEM Defendants will revise their Management Information System (MIS) in the future. MIS is a computer system that can aggregate data about Medicaid recipients and other public benefits recipients. It can also provide information about individual Medicaid recipients. One of its strengths is that the MIS system can provide information about all recipients, not just a sample.

299. The parties may agree to revise the health outcomes evaluation system to use MIS data. They may decide to substitute MIS data if the MIS improves so that it can provide information that is comparable to or better than the information described above.

MISCELLANEOUS

300. Defendants may contract with individuals and entities to provide EPSDT services. But, Defendants remain ultimately responsible for the administration of the EPSDT program in Texas and compliance with federal EPSDT law.

301. This Consent Decree represents the parties' attempt the resolve many of the issues in this litigation amicably, in the best interests of the class and without the need for the

Court's intervention. Plaintiffs do not concede the validity of Defendants' defenses or that their claims lack merit. Defendants do not concede liability.

302. The term "Defendants" is used broadly in this Decree. From time to time it refers to state agencies. The term "will" creates a mandatory, enforceable obligation.

303. This Decree contemplates that the parties will reach agreement in the future about several issues. It further contemplates that Defendants' future activities will comport with the terms and intent of this Decree. If this proves to be incorrect, the parties may request relief from this Court. Absent emergency, no party may request relief from the Court without first providing the opposing party with one month's written notice.

304. Further, the parties may agree to revise deadlines contained in this Decree for all years after 1995. They may also agree to revise the substance of this decree when new issues arise that were not foreseen when this Decree was entered. All revisions of deadlines and substance will be reasonable, consistent with the spirit of this Decree and consistent with relevant law.

305. Absent emergency, the parties will meet twice a year to consider proposed revisions of deadlines and substance. They will meet in the spring (February - April) and in the summer/fall (July - September). The parties will report any agreed changes to the Court no later than May 15 and October 15 of each year. Absent emergency, unless written proposals for revision are received 15 days in advance, the parties are not required to consider them.

306. For the duration of this Decree, Defendants will make monitoring reports every January, April, July and October. The monitoring reports will include a chart and supporting documentation. Defendants will file the chart with the Court by the end of each month

mentioned above. They will also serve the charts and supporting documentation on Plaintiffs' counsel at the same time.

307. The chart will identify each paragraph in this Decree that obliges Defendants to act and each required action. The chart will further state the status of each activity. The parties will agree on the chart's content and may revise it from time to time.

308. The Court notes that the agreements negotiated by the parties which led to this Order were reached within the framework of federal law related to the EPSDT and Medicaid programs as it existed prior to the execution of the Court's Order. The Court and the parties are aware that Medicaid reform is stated to be high priority for Congress. Ultimately changes could occur in federal law which would alter, amend, or eliminate obligations placed upon the states related to the EPSDT or Medicaid programs. This Order is not intended to preclude the Defendants from making changes to the EPSDT or Medicaid programs when such changes are based upon changes in federal law. More specifically, this Order is not intended to bind the Defendants to any terms of this Order which may subsequently not be a requirement of federal law including changes which may be optional to states. Defendants will provide Plaintiffs with advance and adequate notice of changes, as contemplated in this paragraph, to the EPSDT or the Medicaid program as it affects EPSDT. Plaintiffs reserve the right to challenge these changes by litigation or otherwise. Moreover, Defendants may seek waivers permitted by law. Prior to seeking a waiver, Defendants will provide advance notice, including a copy of the waiver application packet, to Plaintiffs as early as possible. Plaintiffs agree to keep the waiver packet confidential until it is released to the public. Defendants will promptly present Plaintiffs' written comments to the appropriate decision maker. Defendants will not reject unreasonably any

comments made by Plaintiffs. Plaintiffs may challenge any waivers as allowed by law by litigation or otherwise.

Done February 16th, 1995 at Tyler, Texas.

UNITED STATES DISTRICT JUDGE

ORD 3-11-96

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF TEXAS

PARIS DIVISION

LINDA FREW, et al.,	§	
Plaintiffs,	§	
v.	§	CIVIL ACTION NO. 3:93cv65
MICHAEL McKINNEY, et al.,	§	
Defendants.	§	

ORDER TO CORRECT CONSENT DECREE

Upon consideration of all matters of record, the Court has determined that Plaintiffs' Unopposed Motion to Correct Consent Decree has merit and should be **GRANTED.** Accordingly, it is

ORDERED that the date originally set forth in the Consent Decree shall be, and is hereby, AMENDED, so as hereafter to read "February 16, 1996."

SIGNED this 11th day of March, 1996.

William Wayne Justice
United States District Judge