

**Department of State Health Services
Council Agenda Memo for State Health Services Council
November 28-29, 2012**

Agenda Item Title: Repeal of rules and new rules concerning Case Management for Children and Pregnant Women

Agenda Number: 5.d

Recommended Council Action:

For Discussion Only

For Discussion and Action by the Council

Background:

Case Management for Children and Pregnant Women services is located in the Health Screening and Case Management Unit of the Specialized Health Services Section, under the Family and Community Health Services Division. The Texas Department of State Health Services (DSHS), by authorization of the Health and Human Services Commission (HHSC), operates and administers the components of this program.

Case Management for Children and Pregnant Women services provides a Medicaid benefit that assists eligible clients in gaining access to the necessary medical, social, educational, and other service needs related to their health condition, health risk or high-risk condition. The services include a face-to-face comprehensive visit with the client and their family to perform a needs assessment and develop a service plan to address the client's and family's unmet needs. Face-to-face follow-up visits and telephone visits with the family and client are authorized to assist the client and family with obtaining the necessary services.

State licensed registered nurses or social workers who have received DSHS approval to be a case manager provide the services, including community referrals and advocacy for the client. Case managers may work as an individual or may be contracted or employed by an agency, which has been approved by DSHS. Case management providers bill Medicaid directly for each service.

In July 2012, there were 245 providers. In fiscal year 2011, there were 3,996 clients served and \$729,841 was paid by Medicaid for Case Management for Children and Pregnant Women claims.

Summary:

The purpose of the repeal and new rules is to restructure the rules, add clarity, remove redundancies, and improve the flow and accuracy of the rule language.

The proposed rules:

- clarify the criteria for client eligibility by using language matching the federal definition of case management;
- define and separate the requirements and responsibilities of provider and case manager;
- increase the provider base by removing the requirement of two years of experience for registered nurses with a bachelor's or advanced degree in nursing and for social workers; and
- align the rule language with licensure rules adopted by the State Board of Social Worker Examiners.

The rules comply with the four-year review of agency rules required by Government Code, Section 2001.039.

Key Health Measures:

By adopting these rules, the expected outcome is an increase in the number of case managers who can provide services. Staff reviewed the education preparation for registered nurses with a bachelor’s or advanced degree and licensed social workers, and determined that the educational curriculum provided adequate training without work experience to provide the service, without compromising the current quality of service delivery. Following rule implementation, DSHS will track the number of case manager enrollments to see if the rule changes have been effective.

Another expected outcome is increased clarity about who is eligible for service. DSHS currently tracks the number of technical assistance calls made to providers regarding eligibility questions following submissions of prior authorization requests. DSHS will continue to track these numbers to assess rule impact. During technical assistance and quality assurance visits, as well as during biannual conference calls between DSHS staff and providers, providers will be queried to determine if their understanding of eligibility has increased.

Summary of Input from Stakeholder Groups:

The program consulted with legal staff at DSHS and HHSC via emails and conference calls during the development phase of the rules. They provided recommendations that were incorporated into the proposed rules.

Input was solicited from the following stakeholders: Jane K. Swanson, plaintiffs’ attorney for *Frew v. Suehs*; Texas Association for Home Care; Texas Association of School-Based Health Centers; Texas State Board of Social Worker Examiners; Texas Board of Nursing; and Case Management for Children and Pregnant Women providers. These entities were informed by letter that the draft proposed rules were posted for comments on the program website. Draft proposed rules were posted July 26, 2012, to August 17, 2012, and DSHS accepted comments and/or suggestions until August 17, 2012.

All comments received were from Jane K. Swanson. Suggestions that were incorporated into the rules include:

- defining “Family” to include biological or adopted children;
- including the phrase “but not limited to” in the sentence describing children’s potential health needs in the definition of “Health and Health-related services;”
- changing the words “better risk” to “greater than average risk” to avoid misinterpretation when defining “High-risk condition;” and
- removing the requirement that a client must request services.

Other suggestions were not included due to definitions and limitations outlined in federal regulations.

The rules were presented and approved by the Medical Care Advisory Committee at the November 8, 2012 meeting.

Proposed Motion:

Motion to recommend HHSC approval for publication of rules contained in agenda item #5.d.

Approved by Assistant Commissioner/Director: Evelyn Delgado		Date: 11/01/12
Presenter: Margaret Bruch, LCSW	Program: Health Screening and Case Management Unit	Phone No.: 512/776-3045
Approved by CCEA: Carolyn Bivens		Date: 10/26/2012

Title 25. Health Services

Part 1. Department of State Health Services

Chapter 27. Case Management for Children and Pregnant Women

Repeal of §§27.1, 27.3, 27.5, 27.7, 27.9, 27.11, 27.13, 27.15

New Subchapter A. General Provisions.

§27.1, §27.3

New Subchapter B. Client Services.

§27.5, §27.7, §27.9, §27.11, §27.13,

New Subchapter C. Provider Qualifications and Responsibilities.

§27.15, §27.17, §27.19, §27.21, §27.23, §27.25, §27.27

Proposed Preamble

The Executive Commissioner of the Health and Human Services Commission, on behalf of the Department of State Health Services (department), proposes the repeal of §§27.1, 27.3, 27.5, 27.7, 27.9, 27.11, 27.13, and 27.15, and new §§27.1, 27.3, 27.5, 27.7, 27.9, 27.11, 27.13, 27.15, 27.17, 27.19, 27.21, 27.23, 27.25, and 27.27 concerning Case Management for Children and Pregnant Women.

BACKGROUND AND PURPOSE

Case Management for Children and Pregnant Women is a Medicaid benefit that assists eligible clients in gaining access to necessary medical, social, educational, and other services related to their health condition or health risk. Case Management for Children and Pregnant Women is administered by the department by authorization of Health and Human Services Commission. The repeal and rewrite of the rules are necessary to restructure the rules, add clarity, remove redundancies, and improve flow and accuracy. Other revisions are to 1) clarify the criteria for client eligibility by providing language which matches the federal definition of case management; 2) define and separate the provider and case manager requirements and responsibilities; and 3) increase the provider base by removing the requirement of two years of experience for registered nurses with a bachelor or advanced degree in nursing; and for social workers.

Government Code, §2001.039, requires that each state agency review and consider for readoption each rule adopted by that agency pursuant to the Government Code, Chapter 2001 (Administrative Procedure Act). Government Code, §2001.039, requires that each state agency review a rule no later than the fourth anniversary of the date on which the rule takes effect and every four years after that date. Sections 27.1, 27.3, 27.5, 27.7, 27.9, 27.11, 27.13, and 27.15 have been reviewed and are being repealed and new rules are proposed and the department has determined that reasons for adopting the sections continue to exist because rules on this subject are needed.

SECTION-BY-SECTION SUMMARY

Subchapter A. General Provisions.

Proposed §27.1 and §27.3 define the purpose and application of the rules and define terms used in this chapter.

Subchapter B. Client Services.

Proposed §27.5 sets forth criteria for client eligibility to receive Case Management for Children and Pregnant Women services. Proposed §27.7 outlines client rights, including freedom of choice of case management providers and the right to a fair hearing. Proposed §27.9 explains how client confidentiality will be protected. Proposed §27.11 describes the essential components of Case Management for Children and Pregnant Women services. The requirement for prior authorization is set forth in §27.13 and requires prior authorization for comprehensive and follow-up contacts.

Subchapter C. Provider Qualifications and Responsibilities

Proposed §27.15 sets forth minimum qualifications to be approved as a provider. Section 27.17 describes the provider approval process. Proposed §27.19 describes the responsibilities of providers. Proposed §27.21 outlines case manager qualifications. Proposed changes to the case manager requirement are that the experience requirement is removed for registered nurses and social workers with a bachelor or advanced degree. Proposed changes indicate that registered nurses with an associate's degree are required to possess two years of cumulative paid full-time work experience or two years of supervised, full-time educational internship/practicum experience in the past ten years with children, up to age 21, and/or pregnant women. Experience must include assessing the psychosocial and health needs of and making community referrals for these populations. The proposed new language also mandates social workers have licensure appropriate for their practice, including the practice of independent social work as governed by 22 TAC Chapter 781.

Proposed §27.23 specifies case manager responsibilities including reporting of suspected abuse and neglect. Utilization and quality assurance review activities and processes are set forth in proposed §27.25, and include provider responsibilities in the event of an overpayment. Proposed §27.27 defines actions the department may take in the event of provider non-compliance with rules, policies, or procedures, including the withdrawal of approval for a provider.

FISCAL NOTE

Ms. Jann Melton-Kissel, Director of the Specialized Health Services Section of the Department of State Health Services, has determined that for each year of the first five years the sections are in effect, there will be no fiscal implications to state or local governments as a result of enforcing and administering the rules as proposed.

SMALL AND MICRO-BUSINESS IMPACT ANALYSIS

Ms. Melton-Kissel has also determined that for each year of the first five years the sections are in effect, there will be no adverse economic impact on micro-businesses or small businesses required to comply with the sections as proposed because this was determined by interpretation

of the rules that small businesses and micro-businesses will not be required to alter their business practices in order to comply with the sections.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

There are no anticipated economic costs to persons who are required to comply with the sections as proposed. There is no impact on local employment.

PUBLIC BENEFIT

Ms. Melton-Kissel has determined that for each year of the first five years the sections are in effect, the public will benefit from adoption of the sections. Public benefit is anticipated as a result of clearer language, better understanding of client eligibility and provider requirements and responsibilities.

REGULATORY ANALYSIS

The department has determined that this proposal is not a "major environmental rule" as defined by Government Code, §2001.0225. "Major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment or reduce risk to human health from environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment or the public health and safety of a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

TAKINGS IMPACT ASSESSMENT

The department has determined that the proposed repeals and new rules do not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, do not constitute a taking under Government Code, §2007.043.

PUBLIC COMMENT

Comments on the proposal may be submitted in writing to Elaine Mittel, Case Management Branch, Health Screening and Case Management Unit, Department of State Health Services, Mail Code 1938, P.O. Box 149347, Austin, Texas 78714-9347, by fax to (512) 776-7574, or by email to elaine.mittel@dshs.state.tx.us. Comments will be accepted for 30 days following publication of this proposal in the *Texas Register*.

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Lisa Hernandez, certifies that the proposed rules have been reviewed by legal counsel and found to be within the state agencies' authority to adopt.

STATUTORY AUTHORITY

The repeals and new sections are authorized by the Government Code, §531.0055, which authorizes the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation of and provision of health and human services by the health and human services agencies; Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001; Health and Safety Code, Chapter 32, provides the authority to establish maternal and infant health improvement services programs in the department to serve eligible recipients; Human Resources Code, §22.0031, which mandates case management for high risk pregnant women and high risk infants; Human Resources Code, Chapter 32, which enables the state to provide medical assistance; and Government Code, §531.021, which provides the Health and Human Services Commission with the authority to propose rules to administer the state's medical assistance program.

The repeals and new sections affect the Government Code, Chapter 531; Health and Safety Code, Chapters 32 and 1001; and Human Resources Code, Chapters 22 and 32.

Repeal of Sections.

§27.1. Definition of Terms.

§27.3. Eligible Recipients.

§27.5. Case Management for Children and Pregnant Women Service Provisions.

§27.7. Service Limitations.

§27.9. Applicant Qualifications.

§27.11. Case Management Provider Requirements.

§27.13. Application Process.

§27.15. Case Management Provider Review and Monitoring Process.

Legend: (Proposed New Rule(s))
Regular Print = Proposed new language

CHAPTER 27. CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN SUBCHAPTER A. GENERAL PROVISIONS.

§27.1. Purpose and Application.

(a) Case Management for Children and Pregnant Women is a Medicaid benefit that assists eligible clients in gaining access to the necessary medical, social, educational, and other service needs related to their health condition/health risk or, for a pregnant women, a high-risk condition. The Department of State Health Services (department), by authorization of the Health and Human Services Commission (HHSC), operates and administers the components of this program.

(b) The rules in this chapter apply to Case Management for Children and Pregnant Women services, client eligibility for these services, provider qualifications to provide these services, and oversight of the administration of Case Management for Children and Pregnant Women services.

§27.3. Definitions.

The following words or terms, when used in this chapter, have the following meanings unless the context clearly indicates otherwise.

(1) Access--The ability of an eligible client to obtain health and health-related services, as determined by factors such as: the availability of Texas Health Steps services; service acceptability to the eligible child, pregnant woman, or both; the location of health care facilities and other resources; transportation; hours of facility operation; and length of time available to see the health care provider.

(2) Active Providers--Providers who have reported that they are currently accepting referrals. Inactive providers are those who have reported that they are not accepting referrals or have been placed on inactive status by the department due the department's inability to make contact with them.

(3) Applicant--An agency, organization, or individual who submits an application to the department for approval as a provider of Case Management for Children and Pregnant Women services.

(4) Application process--Submission of an application to provide Case Management for Children and Pregnant Women services, and the department's ensuing review and disposition of the application.

(5) Case manager--An individual qualified under §27.21 of this title (relating to Case Manager Qualifications) who provides Case Management for Children and Pregnant Women

services, either as an independent provider, or as an employee or contractor of a case management provider.

(6) Case Management for Children and Pregnant Women services--In reference to the federal regulation (42 C.F.R. §440.169) definition of case management, those services that assist eligible clients in gaining access to necessary medical, social, educational, and other services related to their health condition/health risk or high-risk condition.

(7) Children with a health condition/health risk--Children birth through age 20 who have or are at risk for a medical condition, illness, injury, or disability that results in limitation of function, activities, or social roles in comparison with healthy peers of the same age in the general areas of physical, cognitive, emotional, or social growth and development.

(8) Client--An individual who is eligible for Medicaid and receives services described under this chapter, or the client's parent or legal guardian acting on the client's behalf.

(9) Client choice--Clients are given the freedom to choose a provider, to the extent possible, from among three providers.

(10) Family--A basic unit in society having at its nucleus: one or more adults living together and cooperating in the care and rearing of their biological or adopted children; or a person or persons acting as an individual's family, foster family, or identifiable support person(s).

(11) Health and health-related services—Services which are provided to meet the comprehensive (preventive, primary, tertiary, and specialty) health needs of the eligible client, including, but not limited to, medical and dental checkups, immunizations, acute care visits, pediatric specialty consultations, physical therapy, occupational therapy, audiology, speech language services, mental health professional services, pharmaceuticals, medical supplies, prenatal care, family planning, adolescent preventive health, durable medical equipment, nutritional supplements, prosthetics, eyeglasses, and hearing aids.

(12) High-risk condition--Applies to women who are pregnant and have a medical and/or psychosocial condition(s) that places them and their fetuses at a greater than average risk for complications, either during pregnancy, delivery, or following birth.

(13) Medicaid--Medical assistance program implemented by the State of Texas under the provisions of Title XIX of the Social Security Act, as amended, at 42 U.S.C., §1396, *et seq.*

(14) Prior authorization--The department's approval of a provider's request for permission to perform a comprehensive visit and follow-up contacts with a client, based on the department's receipt and review of documentation supporting the client's eligibility for services under this chapter. Prior authorization is a condition of reimbursement, not a guarantee of payment.

(15) Provider--An agency or individual approved by the department to provide Case Management for Children and Pregnant Women services and enrolled as a Medicaid provider.

(16) Quality Assurance Review--A review of a provider's client records, internal quality assurance policy, case manager's licensure, outreach materials, and their compliance with the department's rules and policies.

(17) State--The State of Texas.

(18) TMPPM--Texas Medicaid Provider Procedures Manual.

(19) Utilization Review--A review of claims data in which trends have been identified that could indicate potential concerns with the quality of case management services.

SUBCHAPTER B. CLIENT SERVICES.

§27.5. Client Eligibility.

A client eligible for services under this chapter must be either a child with a health condition/health risk or a pregnant woman with a high-risk condition who:

- (1) is Medicaid-eligible in Texas;
- (2) is in need of Case Management for Children and Pregnant Women services; and
- (3) desires such services.

§27.7. Client Rights.

(a) Use of services is voluntary. Acceptance or refusal of services does not affect eligibility for or receipt of any other Medicaid services, or for future case management services.

(b) All records about clients are considered confidential information, in accordance with the standards and requirements described in §27.9 of this title (relating to Client Confidentiality).

(c) Clients have the right to:

- (1) actively participate in case management decisions, including the right to refuse services from the provider;
- (2) receive prior authorized services when services are requested and informed consent is given;
- (3) receive services free from abuse or harm from the case manager and the case management provider;

(4) have freedom of choice to choose any active provider in their residing county;

(5) have freedom of choice to request a transfer to another case manager in the client's service area at any time; and

(6) request a fair hearing, conducted in accordance with the rules in 1 TAC, Chapter 357, Subchapter A (relating to Uniform Fair Hearing Rules), within 90 days after receiving written notification that services have been denied, reduced, suspended, or terminated.

§27.9. Client Confidentiality.

(a) Federal and state laws and regulations prohibit the disclosure of information about Medicaid clients without effective consent by the client or on behalf of the client, except for purposes directly connected with the administration of the Medicaid program, as described in 42 U.S.C., §1396a(a)(7); 42 C.F.R. §§431.301 - 431.306; Human Resources Code, §12.003 and §21.012; and Government Code, §552.101. Case management providers are not considered directly connected with the administration of the program. Although case management providers are not entitled to confidential information without prior consent, they are able to verify a client's eligibility status.

(b) Entities with which HHSC or the department contracts to perform certain administrative functions, including contractors for outreach, informing, and transportation services, may receive confidential information without the client's consent, but only to the extent necessary to perform and administer the contract. These contracted entities are bound by the same standards of confidentiality applicable to the Medicaid program, and they must provide effective safeguards to ensure confidentiality.

§27.11. Components of Case Management for Children and Pregnant Women Services.

The following are the essential components of Case Management for Children and Pregnant Women services and explanation of billable components.

(a) Intake--A case manager's contact with the client/family/guardian that includes the collection of demographic, health, and other information relevant to the determination of the client's potential eligibility.

(b) Comprehensive visit--A case manager's face-to-face meeting with the client/family/guardian that includes the development of a:

(1) Family Needs Assessment. A comprehensive face-to-face assessment of client needs to determine the need for any medical, educational, social, or other services required to address short- and long-term health and well-being of the client. These assessment activities must be documented on a Family Needs Assessment form and must include:

(A) taking a client's history;

(B) identifying the client's needs, assessing and addressing family issues that impact the client's health condition/risk or high-risk condition and completing related documentation; and

(C) gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the client.

(2) Service Plan. A document developed with the client that determines a planned course of action based upon the information collected through the assessment. The Service Plan must be documented on a Service Plan form and must:

(A) include activities and goals that are developed in consultation with the client, involve the participation of the client, and address the medical, social, educational, and other services needed by the client;

(B) identify a course of action to respond to the assessed needs of the client, including identifying the individual responsible for contacting the appropriate health and human service providers, and designating the time frame within which the client should access services; and

(C) include a Service Plan Addendum if there are revisions or if additional needs have been identified following the initial Service Plan development. The Service Plan Addendum shall be completed and documented during a follow-up visit.

(c) Referral and related activities to help the client obtain needed services, including activities that help link the client with:

(1) medical, social, and educational providers; and

(2) other programs and services that can provide needed services, such as making referrals to providers for needed services and scheduling appointments for the client.

(d) Follow-up contacts by a case manager necessary to ensure the service plan is implemented and adequately addresses the client's needs.

(1) Follow-up contacts shall be conducted as frequently as necessary to determine whether the following conditions are met:

(A) services are being furnished in accordance with the client's service plan;

(B) services in the service plan are adequate; and

(C) the service plan and service arrangement are modified when the client's needs or status change.

(2) Follow-up contacts by case manager for clients who are pregnant women with a high-risk condition shall occur as needed through the 59th day postpartum.

(e) Case management may include collateral contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the client access services and managing the client's care.

(f) The case management components that are eligible for Medicaid reimbursement are the comprehensive visit and each follow-up contact performed in accordance with this section.

(g) Case management services are not reimbursable if they:

(1) are provided to clients who do not meet the definition for client eligibility in §27.5 of this title (relating to Client Eligibility);

(2) are not prior-authorized in accordance with §27.13 of this title (relating to Prior Authorization); or

(3) are provided to a client who has already received another case management service on the same day from the same billing provider.

§27.13. Prior Authorization.

(a) The department may establish policies and procedures that providers must follow in order to obtain prior authorization for services.

(b) Following intake completion, the initial prior authorization request must be supported by required documentation and submitted to the department for review and disposition. If the documentation supports eligibility, a comprehensive visit and follow-up visit(s) will be prior-authorized. The number of follow-up visit(s) that is prior-authorized will be based on the client's level of need, level of medical involvement, and complicating psychosocial factors documented on the request.

(c) Any additional requests for comprehensive or follow-up visit(s) must be prior-authorized. Required documentation must be submitted to the department for review and disposition before any additional services may be prior-authorized.

SUBCHAPTER C. PROVIDER QUALIFICATIONS AND RESPONSIBILITIES

§27.15. Provider Qualifications.

A provider shall not be approved as a provider of Case Management for Children and Pregnant Women unless they meet the following qualifications:

(1) completion of application process and approval by the department;

(2) agreeing to comply with the rules, policies, and procedures of the department relating to Case Management for Children and Pregnant Women;

(3) agreeing to comply with applicable state and federal laws governing participation of providers in the Medicaid program and to enroll as a state Medicaid provider;

(4) be a provider who meets, or employs or contracts with, one or more case managers who each meet, the qualifications specified in §27.21 of this title (relating to Case Manager Qualifications); and

(5) has never been terminated by the department and is not listed on the HHSC Office of Inspector General's Excluded Individual Listing.

§27.17. Provider Approval Process.

(a) To become an approved provider, an applicant must submit a completed application to the department.

(b) The department will review the application and provide a response within timeframes specified in policies and procedures. An application will not be reviewed and considered until all information is provided in a clear and understandable manner.

(c) Providers approved by the department must also enroll with the Medicaid Claims Administrator as a Medicaid provider.

(d) Providers who fail to submit an application to enroll as a state Medicaid provider within twelve months of approval by the department must submit a new application to the department.

§27.19. Provider Responsibilities.

Providers must:

(1) operate in accordance with the laws, rules, regulations, and standards of care relating to the practice of their respective license(s); ensure that their case managers are operating within the laws, rules, regulations, and standards of care relating to the practice of their respective license(s); and ensure that their case managers operate only within the scope of their respective license(s);

(2) provide services according to policies and procedures as published in the TMPPM and Medicaid bulletins, and in accordance with the policies and procedures of the department;

(3) cease providing services and notify the department if the professional license of a provider is suspended or revoked, with such notification to be provided to the department no later than seven calendar days after the date that the suspension or revocation is imposed;

(4) assure that case managers attend required trainings provided by the department;

(5) develop and maintain a quality management system for the provision of services with the primary goal of assisting clients in accessing necessary medical, social, educational, and other services related to their health condition/health risk or high-risk condition;

(6) ensure that outreach activities do not impede freedom of client choice, and that they comply with 1 TAC §371.27 (relating to Prohibition against Solicitation of Medicaid or CHIP Recipients); and

(7) ensure that clients are given choice of providers for case management.

§27.21. Case Manager Qualifications.

An individual shall not be approved to provide Case Management for Children and Pregnant Women unless they meet the following qualifications:

(1) licensed in the State of Texas as a registered nurse (with a bachelor or advanced degree in nursing), whose license is not temporary or provisional in nature; or

(2) licensed in the State of Texas as a registered nurse (with an associate degree in nursing), whose license is not temporary or provisional in nature. The individual must also possess two years of cumulative paid full-time work experience or two years of supervised, full-time educational internship/practicum experience in the past ten years with children, up to age 21, and/or pregnant women. Experience must include assessing the psychosocial and health needs of and making community referrals for these populations; or

(3) licensed in the State of Texas as a social worker with licensure appropriate for his/her practice, including the practice of Independent Social Work, and whose license is not temporary or provisional in nature; and

(4) has completed the department's standardized case management training.

§27.23. Case Manager Responsibilities.

Case managers must:

(1) comply with all licensure requirements of the appropriate state licensure/examining board, including the obligation to report all suspected child abuse/neglect;

(2) cease providing services and notify the department if the case manager's professional license is suspended or revoked, with such notification to be provided to the department no later than seven calendar days after the date that the suspension or revocation is imposed;

(3) provide services convenient to clients, either in their home, an office setting, or other place of client's preference; and

(4) have knowledge of, and coordinate services with, providers of health and health-related services and other active community resources.

§27.25. Utilization and Quality Assurance Reviews and Compliance.

(a) The purpose of a utilization or quality assurance review is to ensure program fiscal integrity, to address the federal mandate requiring program funds be spent only as allowed under federal and state laws and regulations, and to ensure that services are appropriately provided to clients.

(b) During each fiscal year, the department will conduct quality assurance and utilization reviews of all active and inactive providers to monitor claims, quality of case management services and compliance with Case Management for Children and Pregnant Women rule and policy.

(c) Providers must cooperate with the quality assurance and utilization reviews. Providers will be given notification of upcoming reviews in accordance with the department's policies and procedures.

(d) If the results of the utilization or quality assurance review indicate overpayment, the department will notify HHSC of the overpayment and the provider will be given information about how to arrange for repayment.

(e) Providers must voluntarily notify the Medicaid claims administrator to arrange for repayment if they become aware that they received an overpayment.

§27.27. Termination, Suspension, Probation, and Reprimand of Providers.

A provider's violation or non-compliance with federal and or state Medicaid laws, rules and regulations, rules under this chapter, or Case Management and Pregnant Women policies and procedures may result in one or more of the following actions taken by the department.

(1) Notification to the Medicaid claims administrator through HHSC that the department has terminated the case management provider. Providers will receive written notice of termination. Providers who are terminated will not be approved if they reapply.

(2) Suspension of a provider in accordance with the department's policies and procedures. Providers will receive written notice of suspension.

(3) Probation of a provider in accordance with the department's policies and procedures. Providers will receive written notice of probation.

(4) Reprimand of a provider in accordance with the department's policies and procedures. Providers will receive written notice of reprimand.

(5) Report and referral to the appropriate professional licensure entity.

(6) Report and referral to HHSC Office of Inspector General.

(7) Report to a law enforcement agency.

Proposed Repealed Language
~~Strikethrough=repealed text~~

~~§27.1. Definition of Terms.~~

~~The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise.~~

~~(1) Access—The ability of an eligible recipient to obtain health and health related services, as determined by factors such as: the availability of THSteps services; service acceptability to the eligible child, family, and/or pregnant woman; the location of health care facilities and other resources; transportation; hours of facility operation; and length of time available to see the healthcare provider.~~

~~(2) Applicant—An agency, organization, or individual who submits an application to the department to provide Case Management for Children and Pregnant Women under this chapter and who meets the applicant qualifications and requirements as stated in §27.9 and §27.11 of this title (relating to Applicant Qualifications and Case Management Provider Requirements).~~

~~(3) Application process—Submission of an application to provide Case Management for Children and Pregnant Women and the department's ensuing review and disposition of the application.~~

~~(4) Billable contact—A documented Comprehensive Visit or Follow-up contact that continues to support eligibility of a recipient, by an approved case manager who provides an eligible case management service, as defined in §27.5 of this title (relating to Case Management and Pregnant Women).~~

~~(5) Board—The Texas Board of Health.~~

~~(6) Case manager—An individual who provides Case Management for Children and Pregnant Women services either independently or as an employee of a case management provider.~~

~~(7) Case management provider—An agency or individual approved by the department to provide Case Management for Children and Pregnant Women services and enrolled as a Medicaid provider.~~

~~(8) Case Management for Children and Pregnant Women—The federal enhancement service which assists eligible recipients in gaining access to medically necessary medical, social, educational, and other services.~~

~~(9) Children with a health condition/health risk—Children who have or are at risk for a medical condition, illness, injury, or disability that results in limitation of function, activities or social roles in comparison with healthy same age peers in the general areas of physical, cognitive, emotional, or social growth and development.~~

~~(10) Continuity of care—The degree to which: the care of a child is provided by the same medical home or primary care provider; the system of care remains stable and services are consistent, unduplicated and uninterrupted.~~

~~(11) Department—The Texas Department of Health.~~

~~(12) EPSDT—Early and Periodic Screening, Diagnosis, and Treatment program. All states participating in the Medicaid program must offer EPSDT to children under age 21 who qualify for Medicaid. EPSDT provides medical and dental services to Medicaid and Texas Health Steps clients under age 21 years. In Texas, EPSDT is known as Texas Health Steps (THSteps).~~

~~(13) Family—A basic unit in society having at its nucleus: one or more adults living together and cooperating in the care and rearing of their own or adopted children; a person or persons acting as an individual's family, foster family or identifiable support person or persons.~~

~~(14) Health and health-related services—Services which are provided to meet the comprehensive (preventive, primary, tertiary and specialty) health needs of the eligible recipient, including but not limited to, well care and dental check-ups, immunizations, acute care visits, pediatric specialty consultations, physical therapy, occupational therapy, audiology, speech language services, mental health professional services, pharmaceuticals, medical supplies, prenatal care, family planning, adolescent preventive health, durable medical equipment, nutritional supplements, prosthetics, eye glasses, and hearing aids.~~

~~(15) High risk pregnant women—Women who are pregnant and have one or more high risk medical and/or personal/psychosocial condition(s) during pregnancy.~~

~~(16) Preventive services—Services that include health counseling and education, immunizations, wellness care, nutritional supplementation, family planning and screening aimed at avoiding illness and/or disability.~~

~~(17) Primary services—Services that include care for minor illnesses, injuries and abnormalities discovered through screenings.~~

~~(18) Prior authorization—A condition for reimbursement, the prior authorization process requires all providers of Case Management for Children and Pregnant Women services to submit documentation of the requested services for approval before such services may be authorized for payment.~~

~~(19) State—The State of Texas.~~

~~(20) Tertiary services—Services that include care for major illnesses and injuries, and chronic or disabling conditions.~~

~~(21) Texas Health Steps Program (THSteps) — In Texas, the name of the federal program known as EPSDT, which is required of states participating in the Medicaid program.~~

~~§27.3. Eligible Recipients.~~

~~Clients eligible for case management services under this chapter must be either children birth through age 20 with a health condition/health risk or high risk pregnant women who are:~~

~~(1) Medicaid eligible in Texas;~~

~~(2) in need of services to prevent illness(es) or medical condition(s), to maintain function or slow further deterioration; and~~

~~(3) desire case management.~~

~~§27.5. Case Management for Children and Pregnant Women Service Provisions.~~

~~Case Management for Children and Pregnant Women services, as defined in §27.1 of this title (relating to Definitions), are provided to assist eligible recipients in gaining access to medically necessary medical, social, educational and other services for which federal financial participation is available in order to: encourage the use of cost-effective health and health-related care; make referrals to appropriate community resources; discourage over-utilization or duplication of services; and reduce morbidity and mortality. Case Management for Children and Pregnant Women is not a “gatekeeper” function.~~

~~(1) The following contacts are billable:~~

~~(A) Comprehensive Visit — a face-to-face visit that includes the development of:~~

~~(i) Family Needs Assessment — a written evaluation of all issues that impact the short and long term health and well being of the eligible recipient and his/her family. Together, the case manager and family shall assess the medical, social, educational and other medically necessary service needs of the eligible recipient. Documentation of the Family Needs Assessment must include, at a minimum:~~

~~(I) the assessment of the medical, social/family, nutritional, educational, vocational, developmental and health care transportation needs;~~

~~(II) individualized assessment of the client; and~~

~~(III) the case manager’s dated signature.~~

~~(ii) Service Plan – the written summary which:~~

~~(I) documents the services to be accessed;~~

~~(II) identifies the individual responsible for contacting the appropriate health and human service providers;~~

~~(III) designates the time frame within which the eligible recipient should access services;~~

~~(IV) may be sent to the medical provider or others as appropriate in accordance with the limits of confidentiality; and~~

~~(V) must include, at a minimum: the interventions and referrals for addressing needs identified in the Family Needs Assessment; the time frame for the client to access services; the client/parent/guardian's and case manager's dated signatures.~~

~~(B) Follow up contact—a face to face or telephone contact with the eligible recipient and his/her family. The case manager and the client/family review and reassess the client/family's needs, determine what referrals and services specified in the Service Plan have been received by the client/family, and develop appropriate modifications to the Service Plan. The Follow up contact includes the review of the referrals that have occurred or are still needed to complete the Service Plan and meet the client/family's needs. Follow up contacts for children should occur as needed. Follow up contacts for pregnant women should occur as needed through the 59th day post partum. Documentation of the Follow up contacts must include, at a minimum:~~

~~(i) a review of the complete Service Plan;~~

~~(ii) efforts to ascertain on an ongoing basis which needs specified in the Service Plan have been addressed with appropriate referrals provided and services accessed; and~~

~~(iii) evidence of problem solving with client/parent/guardian when needs are not addressed or referrals not accessed.~~

~~(2) Case Management for Children and Pregnant Women services will include a non-billable intake with each client/family. The intake will include the collection of demographic information and determination of the client's eligibility.~~

~~(3) Only one billable contact per client shall be billed per day.~~

~~§27.7. Service Limitations.~~

~~(a) Case Management for Children and Pregnant Women services are not reimbursable if they are duplicative of other billed, comprehensive Medicaid case management services.~~

~~(b) Following intake completion, the initial prior authorization request for a billable contact must be supported by required documentation and submitted to the department for review and disposition. The amount of billable contacts that are prior authorized will be based on the client's level of need, level of medical involvement and complicating psychosocial factors.~~

~~(c) Any additional request for a billable Case Management for Children and Pregnant Women service must also be prior authorized. Required documentation must be submitted to the department for review and disposition before any additional services may be prior authorized.~~

~~§27.9. Applicant Qualifications.~~

~~(a) The minimum qualifications for a Case Management for Children and Pregnant Women applicant are:~~

~~(1) completion and approval of an application for Case Management for Children and Pregnant Women as defined in §27.1 of this title (relating to Definitions);~~

~~(2) agreeing to comply with the department rules, policies and procedures on Case Management for Children and Pregnant Women and the applicable statutory provisions;~~

~~(3) agreeing to comply with applicable state and federal laws governing participation of providers in the Medicaid program;~~

~~(4) employment of case managers with the following qualifications:~~

~~(A) Registered nurse (with a diploma, an associate's, bachelor's or advanced degree) or Social Worker (with bachelor's or advanced degree), currently licensed by the respective Texas licensure board and whose license is not temporary or provisional in nature; and~~

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

~~(5) agreeing to comply with all licensure requirements of the case manager(s) respective state licensure/examining boards including the obligation to report all suspected child abuse/neglect; and~~

~~(6) knowledge of and coordination with providers of health and health-related services and other active community resources.~~

~~(b) A case manager employed in an approved Targeted Case Management for Pregnant Women and Infants or Texas Health Steps Medical Case Management agency at the time of implementation of these rules but who does not meet the educational and/or experience requirements outlined in subsections (a)(4)(A) and (B) of this section, is eligible to continue to provide case management services, provided the case manager presents a certificate issued by the department which attests to the case manager's experience prior to the implementation date of these rules.~~

~~(c) An applicant under investigation or being sanctioned by the department or any other State of Texas or federal governmental agency will not be approved as a case management provider.~~

~~§27.11. Case Management Provider Requirements.~~

~~In order to remain a case management provider, an individual or agency must:~~

~~(1) comply with applicable state and federal laws and regulations governing participation of providers in the Medicaid program;~~

~~(2) maintain provider status with the department;~~

~~(3) develop and maintain a system for Case Management for Children and Pregnant Women services incorporating the following elements:~~

~~(A) Case Management for Children and Pregnant Women services in locations convenient for the eligible recipient to facilitate face-to-face contact;~~

~~(B) Provision of Case Management for Children and Pregnant Women services in order to assist eligible recipients in accessing necessary medical, social, educational, and other services;~~

~~(C) an internal quality assurance plan that includes, but is not limited to, chart reviews and staff observation;~~

~~(D) a current list of opened and closed client records;~~

~~(E) an accounts receivable system through which billed contacts will be tracked and matched with paid claims and client records to assure claims are billed and paid for correct dates of service, were billed with appropriate procedure codes and are not duplicative of other claims for the same client;~~

~~(F) outreach activities that assure individualized referrals. The following activities may impede client choice and therefore are prohibited:~~

~~(i) door-to-door, telephone or other cold-call marketing or solicitation of clients by providers;~~

~~(ii) the distribution of materials to Case Management for Children and Pregnant Women recipients that impede client choice;~~

~~(iii) the distribution of any false or misleading materials to Case Management for Children and Pregnant Women recipients;~~

~~(iv) obtaining lists of Medicaid clients without a specific referral;~~

~~(v) offering incentives for enrollment into case management services;~~
and/or

~~(vi) entering into exclusive referral relationships with referral sources;~~

~~(4) assure Case Management for Children and Pregnant Women services will be provided by approved case managers who meet the qualifications defined in §27.9 and §27.11 of this title;~~

~~(5) assure that approved case managers~~

~~(A) have received department-approved education and training regarding Case Management for Children and Pregnant Women;~~

~~(B) have the opportunity to participate in appropriate Medicaid, case management and THSteps workshops, seminars, and training;~~

~~(C) assume responsibility for all Case Management for Children and Pregnant Women services they provide to eligible recipients, including services by their designated support staff;~~

~~(D) participate in relevant motion or cost studies;~~

~~(E) agree to permit the department or its designee access to the Case Management for Children and Pregnant Women provider's records, and permit direct observation of case management activities for the purpose of determining the provider's suitability to continue participation as a Case Management for Children and Pregnant Women provider; and~~

~~(F) participate in local and/or regional case management systems/coalitions in accordance with program policies to assure cooperation and coordination with local health departments, the department's public health region(s), school districts and other Medicaid-approved case management providers as evidenced by:~~

~~(i) participation in community coalition meetings in accordance with program policy;~~

~~(ii) collaboration in planning case management delivery systems; and~~

~~(iii) involvement in resolving case management problems;~~

~~(6) share information, within the limits of confidentiality, with the department and collaborating agencies to facilitate referral and monitoring of eligible recipients; and~~

~~(7) comply in a timely manner with all department data collection and reporting requirements.~~

~~§27.13. Application Process.~~

~~(a) Applications to become a Case Management for Children and Pregnant Women provider may be obtained by contacting the department or by accessing the department website.~~

~~(b) Applicants must include copies of documentation of all agency licenses, contracts and/or written agreements with their application.~~

~~(c) Applications must be typed and accompanied by all required supporting documentation set out in this chapter. An original must be sent to the appropriate department regional office and one copy of the application must be submitted to the department central office.~~

~~(d) All applications shall be reviewed by the department staff. The review process shall be completed within 20 working days following receipt of an application.~~

~~(e) Incomplete applications shall not be approved and shall be returned to the applicant for completion.~~

~~(f) Applications which do not meet department requirements will be denied.~~

~~(g) Applicants will be notified in writing of approval or non-approval by the department. Applicants must still enroll as Medicaid providers through Medicaid provider enrollment.~~

~~(h) Applicants who have submitted complete applications and who are not approved by the department to provide case management services must wait, at a minimum, 6 months before resubmission of a new application.~~

~~§27.15. Case Management Provider Review and Monitoring Process.~~

~~(a) Approved providers will be monitored on an as-needed basis for compliance with rules and policies.~~

~~(b) Case managers or case management providers who do not comply with program requirements may be terminated, placed on probationary status, referred to appropriate professional licensure entities for review, and/or referred for fraud and abuse investigation as described in department policies and procedures.~~