



HHSC UNIFORM MANAGED CARE MANUAL

CHAPTER	PAGE
12.4	1 of 22
EFFECTIVE DATE	
October 1, 2015	
Version 2.1	

Medicaid Managed Care THSteps Medical Checkups Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)

DOCUMENT HISTORY LOG

STATUS ¹	DOCUMENT REVISION ²	EFFECTIVE DATE	DESCRIPTION ³
Baseline	N/A	September 1, 2007	Initial version Uniform Managed Care Manual Chapter 12.4, "Medicaid MCO THSteps Medical Checkups Annual Report (90-Day STAR and STAR+PLUS Frew Report) Instructions"
Revision	1.1	September 1, 2008	Chapter 12.4 is revised to include clerical corrections that conform to the report template.
Revision	1.2	April 20, 2009	Chapter 12.4 is renamed "Frew 90-Day Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)". Chapter content has been replaced in its entirety to: <ol style="list-style-type: none"> 1. add the STAR Health Program; 2. incorporate the content of former Chapter 12.10, "ICM 90-Day Report Instructions;" and 3. incorporate the instructions for the Refusal Tracking Logs originally found in Chapter 12.6, "Frew 90-Day Refusal Tracking Log" and Chapter 12.12 "ICM 90-Day Refusal Tracking Log."
Revision	1.3	February 5, 2010	Chapter 12.4 is renamed "Medicaid Managed Care THSteps Medical Checkups Quarterly and Annual Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)" for consistency with report titles. Chapter contents have been revised to include clarification of reporting specifications.
Revision	1.4	June 1, 2010	Chapter 12.4 is revised to clarify the instructions and to add timeliness requirements that will be effective September 1, 2010.
Revision	1.5	June 1, 2011	Chapter 12.4 is revised to clarify that the same timeliness requirements apply to STAR, STAR+PLUS, and STAR Health. In addition, language is added regarding the requirements and documentation process for refusals.
Revision	2.0	April 15, 2012	Revision 2.0 applies to contracts issued as a result of HHSC RFP numbers 529-10-0020, 529-06-0293, and 529-12-0002. Chapter 12.4 is renamed "Medicaid Managed Care THSteps Medical Checkups Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)." Chapter 12.4 is revised to add an applicability statement, to clarify the requirements regarding legally emancipated minors and what constitutes a due checkup, and to distinguish



HHSC UNIFORM MANAGED CARE MANUAL

CHAPTER	PAGE
12.4	2 of 22

Medicaid Managed Care THSteps Medical Checkups Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)

EFFECTIVE DATE
October 1, 2015
Version 2.1

DOCUMENT HISTORY LOG

STATUS ¹	DOCUMENT REVISION ²	EFFECTIVE DATE	DESCRIPTION ³
			between the requirements that apply prior to SFY 2012 and on or after SFY 2012.
Revision	2.1	October 1, 2015	<p>Revision 2.1 applies to contracts issued as a result of HHSC RFP numbers 529-10-0020, 529-12-0002, 529-13-0042, 529-13-0071, and 529-15-0001.</p> <p>The applicability statement is modified to include the STAR Kids program.</p> <p>“Part 1: Reporting Requirements for Periods Prior to SFY 2012” is deleted in its entirety and “Part 2: Reporting Requirements for the SFY 2012 Reporting Period and After” is renumbered.</p>

¹ Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions

² Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.

³ Brief description of the changes to the document made in the revision.



HHSC UNIFORM MANAGED CARE MANUAL Medicaid Managed Care THSteps Medical Checkups Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)	CHAPTER	PAGE
	12.4	3 of 22
	EFFECTIVE DATE	
	October 1, 2015	
	Version 2.1	

TABLE OF CONTENTS

Applicability of Chapter 12.4.....	4
PART 1: REPORTING REQUIREMENTS FOR THE SFY 2012 REPORTING PERIOD AND AFTER	4
1 INTRODUCTION	4
2 REPORTING TIMELINES/ REPORT PERIODS	4
3 REPORT SUBMISSION GUIDELINES AND REQUIREMENTS.....	5
4 DEFINITIONS, BUSINESS RULES, and TIMELINESS STANDARDS	7
4.1 New Members.....	7
4.2 Existing Members	8
4.3 THSteps Medical Checkups.....	9
5 MEDICAID MANAGED CARE THSteps MEDICAL CHECKUPS ANNUAL REPORT (STAR and STAR+PLUS ONLY)	9
5.1 General Report Information	9
5.2 Annual Report Template Instructions.....	10
6 MEDICAID MANAGED CARE THSteps MEDICAL CHECKUPS ANNUAL REPORT (STAR Health Only).....	17
6.1 General Report Information	17
6.2 Annual Report Template Instructions.....	18
7 ANNUAL REPORT REFUSAL TRACKING LOG (STAR and STAR+PLUS ONLY).....	20
7.1 General Report Information	20
7.2 MCO Information	20
7.3 Column Heading Specific Instructions	21



HHSC UNIFORM MANAGED CARE MANUAL

CHAPTER	PAGE
12.4	4 of 22
EFFECTIVE DATE	
October 1, 2015	
Version 2.1	

Medicaid Managed Care THSteps Medical Checkups Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)

Applicability of Chapter 12.4

Applicability Added by Version 2.0 and modified by Version 2.1

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR Program, STAR+PLUS Program, STAR Health Program, and STAR Kids Program. The requirements in this chapter apply to all Programs, except where noted.

"Part 1: Reporting Requirements for Periods Prior to SFY 2012" is deleted in its entirety by Version 2.1

"Part 2: Reporting Requirements for the SFY 2012 Reporting Period and After" is added by Version 2.0 and renumbered as Part 1 by Version 2.1

PART 1: REPORTING REQUIREMENTS FOR THE SFY 2012 REPORTING PERIOD AND AFTER

1 INTRODUCTION

This document includes the business rules and instructions for reporting timely Texas Health Steps (THSteps) medical checkups for New and Existing Members using the following THSteps medical checkup reporting templates:

- Medicaid Managed Care THSteps Medical Checkups Annual Report (STAR and STAR+PLUS)
- Medicaid Managed Care THSteps Medical Checkups Annual Report (STAR Health)
- Medicaid Managed Care THSteps Medical Checkups Annual Report Refusal Tracking Log (STAR and STAR+PLUS only)

The templates referenced above are located in Chapter 12 of the Uniform Managed Care Manual (UMCM).

2 REPORTING TIMELINES/ REPORT PERIODS

The Annual Report and Refusal Tracking Log are due as follows:

- Each Annual Report with corresponding Refusal Tracking Log is due on May 12th as follows:

SFY Annual Report/Reported Period	Due Date
SFY 2012	May 12, 2014
SFY 2013	May 12, 2015
SFY 2014 and After	May 12 th of the following year

- The Annual Reporting Period is the State Fiscal Year (September 1 through August 31).



HHSC UNIFORM MANAGED CARE MANUAL Medicaid Managed Care THSteps Medical Checkups Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)	CHAPTER	PAGE
	12.4	5 of 22
	EFFECTIVE DATE	
	October 1, 2015	
	Version 2.1	

- The reporting period includes claims data for Members enrolled with dates of service from September 1 of the SFY through August 31 of the following SFY, with claims adjudicated through the end of March of the year the report is due.

Exceptions for SFY 2012 reporting only:

- The reporting period for MCOs in operation on September 1, 2011, will include claims data for Members enrolled with dates of service from September 1 of the SFY through August 31 of the following SFY, with claims adjudicated through the end of March of the year the report is due.
- The reporting period for new MCOs in operation as of March 1, 2012, will include claims data for Members enrolled with dates of service from March 1 of the SFY through August 31 of the following SFY, with claims adjudicated through the end of March of the year the report is due.
- The reporting period for existing MCOs operating in a new Service Area as of March 1, 2012, will include for the new Service Area claims data for Members enrolled with dates of service from March 1 of the SFY through August 31 of the following SFY, with claims adjudicated through the end of March of the year the report is due.
- The reporting period for existing MCOs no longer operating in a Service Area as of March 1, 2012, will include for that Service Area claims data for Members enrolled with dates of service from September 1 of the SFY through February 28 of the following SFY, with claims adjudicated through the end of March of the year the report is due.

- All 837 encounters submitted to HHSC’s Administrative Services Contractor through March of the year the report is due will be used for validation.
- **ONLY paid claims and encounters, or claims/encounters denied SOLELY for late filing, may be included in the report.**

- If any due dates fall on a national holiday or weekend, the reports will be due on the next Business Day.
- Delinquent (not submitted or submitted late), incomplete, or inaccurate reports may result in HHSC’s assessment of remedies against the MCO.

3 REPORT SUBMISSION GUIDELINES AND REQUIREMENTS

- MCOs must use the Annual Report Templates and Refusal Tracking Log provided in the UCMC. HHSC will not accept reports submitted in other formats nor scanned images of the reports.
- All reports must be typed.
- All fields/ columns for each of the sections of the reports must be completed. (See the general reporting information and instructions for each report for additional details.)
- If the MCO participates in more than one Program, the MCO must submit separate reports for each Program.
- All components of the reports (Report and Refusal Tracking Log) must be submitted together.



HHSC UNIFORM MANAGED CARE MANUAL Medicaid Managed Care THSteps Medical Checkups Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)	CHAPTER	PAGE
	12.4	6 of 22
	EFFECTIVE DATE	
	October 1, 2015	
	Version 2.1	

- STAR, STAR+PLUS, and STAR Health MCOs must submit their reports via TXMedCentral using the following guidelines according to the Program reports being submitted:
 - Each report and corresponding refusal tracking log must be submitted in a zip file together by Program. The refusal tracking log is required for STAR and STAR+PLUS programs only.
 - Each zip file must be saved in the MCO's TXMedCentral folder: **XXXDELIV** (where XXX = the MCO's alpha abbreviation)

Annual Reports Zip File Naming Convention

The MCO must use the following naming convention for each zip file submitted:

- "XXX" = the MCO's alpha abbreviation code
- "frew90" = the Medicaid Managed Care THSteps Medical Checkups Report
- "Program" = The MCO will indicate for "Program" whether the reports in the zip file are STAR, STAR+PLUS (SP), or STAR Health (FC).
- "YY" = the last two digits of the SFY being reported
- "file extension" = saved as .zip

EXAMPLES:

Zip file with STAR Program Annual Report and Refusal Tracking Log for SFY 2012: XXXfrew90STAR12.zip

Zip file with STAR+PLUS Program Annual Report and Refusal Tracking Log for SFY 2013: XXXfrew90SP13.zip

Zip file with STAR Health Annual Report for SFY 2012: XXXfrew90FC12.zip

Annual Reports and Refusal Tracking Logs Naming Conventions

The Annual Reports must use the following naming conventions to identify the report and refusal tracking log contained within each zip file. The refusal tracking log is required for STAR and STAR+PLUS programs only.

- "XXX" = the MCO's alpha abbreviation code
- "frew90" or "frewrtl" = "frew90" will indicate the report and "frewrtl" will indicate the refusal tracking log
- "Program" = The MCO will indicate for "Program" whether the reports in the zip file are STAR, STAR+PLUS (SP), or STAR Health (FC).
- "YY" = the last two digits of the SFY being reported
- "file extension" = saved as the type of file being submitted (such as .doc or .xls)

EXAMPLES:

STAR Annual Report for SFY 2012: XXXfrew90STAR12.doc

STAR+PLUS Annual Refusal Tracking Log for SFY 2014: XXXfrewrtlSP14.xls

STAR Health Annual Report for SFY 2013: XXXfrew90FC13.doc



HHSC UNIFORM MANAGED CARE MANUAL	CHAPTER	PAGE
	12.4	7 of 22
	EFFECTIVE DATE	
Medicaid Managed Care THSteps Medical Checkups Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)	October 1, 2015	
	Version 2.1	

4 DEFINITIONS, BUSINESS RULES, and TIMELINESS STANDARDS

4.1 New Members

Definition

A “New Member” in an MCO is an individual who:

- Is under age 21 at the time of enrollment.
- Enrolls with the MCO (or becomes enrolled in the case of STAR Health) during the period covered by the report (the “reported period.”)
- Has not previously been enrolled for 90 or more continuous days in the MCO at any time in the 730 calendar days prior to the date of enrollment in the MCO.
- Is enrolled for 90 or more continuous days and does not reach age 21 during the 90 or more continuous days. Exception: In Quarter 2 of a non-leap year, a Member enrolled for 89 days, i.e. February 1 to April 30, and does not reach age 21 during this period should be counted as a “New Member.”
- May have multiple periods of enrollment during their first year in the MCO, but has at least one period of enrollment of 90 or more continuous days. Periods of enrollment with a gap of coverage are not to be added together. The period of enrollment must be a continuous 90 days, but may comprise separate eligibility segments. For example, a Member enrolled September 1 through October 31 and again enrolled November 1 through December 31 meets the requirement for 90 days or more of continuous enrollment. A Member enrolled September 1 through October 31 and again enrolled December 1 through January 31 does not meet the requirement for 90 days or more of continuous enrollment.

Business Rules

- For the Annual Reports, Members meeting the definition of New Member will be counted in the SFY in which they were enrolled with the MCO.
 - Example: Member enrolled in managed care during SFY 2012 will be counted in SFY 2012 as having received a checkup or not even if the eligibility window (90 continuous days) crosses into SFY 2013.
- Timely checkup service will be based on the first period of enrollment that qualifies the Member as a New Member.
- A New Member who moves from one plan code to another within the same MCO is considered a New Member when he or she enters the new plan code.
- A New Member who moves from the MCO’s STAR plan to the MCO’s STAR+PLUS plan or vice versa is considered a New Member when he or she enters the new plan code and the new program.
- **STAR and STAR+PLUS ONLY:** The New Member effective date will begin based on the effective date of enrollment indicated on the **first 834 enrollment file** listing the client as a Member of that MCO. If the effective date of the enrollment reflects a retroactive date, the 90-day counter begins with the **receipt** of the 834 enrollment file reflecting the Member being enrolled into the MCO.
- **STAR Health ONLY:** The New Member effective date will begin on the date the MCO **receives** the **Daily Notification File (DNF)** listing the client as a Member of that MCO. If the effective date of the enrollment reflects a retroactive date, the 90-day counter begins



HHSC UNIFORM MANAGED CARE MANUAL Medicaid Managed Care THSteps Medical Checkups Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)	CHAPTER	PAGE
	12.4	8 of 22
	EFFECTIVE DATE	
	October 1, 2015	
	Version 2.1	

with the receipt of the Daily Notification File reflecting the Member being enrolled into the MCO.

Due Medical Checkups

- **STAR and STAR+PLUS:** All New Members are due a checkup within 90 days of enrollment unless the MCO verifies the New Member received a THSteps medical checkup since their last birthday prior to his/her enrollment as a New Member in the MCO.
- **STAR Health:** All New Members are due a checkup within 90 days of enrollment.

Timely Medical Checkups

A New Member Medical Checkup is considered to have been provided timely if:

- It meets the definition of a THSteps Medical Checkup as included in this document, **AND**
- It occurred within 90 days of enrollment or knowledge of enrollment for a New Member, includes newborn checkups.

4.2 Existing Members

Definition

An “Existing Member” in an MCO is an individual who:

- Is not defined as a New Member.
- Was enrolled in the MCO for at least one 90 or more continuous day segment (making them eligible to be counted previously as a New Member at least once) within the 730 calendar days prior to the date of enrollment in the MCO. Exception: For a New Member whose 90 or more continuous days of enrollment cross state fiscal years, the Member will be counted as New in the previous state fiscal year and Existing in the current state fiscal year. For example, a Member is enrolled with the MCO in August, September, October, and November of 2012. The Member is counted as a New Member for SFY 2012 reporting and an Existing Member for SFY 2013 reporting.
- Members who are under age 20 or turning 20 during the reporting period are due a periodic medical checkup. Members who are turning 21 during the reporting period are not due a periodic medical checkup as no periodic medical checkup is due at age 21.
- Has at least one period of enrollment resulting in 90 or more continuous days during the reporting period.

Business Rules

- All Members meeting the definition of Existing Member are counted.
- Timely checkup service is based on checkups due while the Existing Member is enrolled with the MCO.
- Age or ages attained during the reporting period are used to determine which periodic checkups are due within the reporting period.
- An Existing Member who moves from one plan code to another within the same MCO is considered a New Member when he or she enters the new plan code.
- An Existing Member who moves from the MCO’s STAR plan to the MCO’s STAR+PLUS plan or vice versa is considered a New Member when he or she enters the new plan code and the new program.



HHSC UNIFORM MANAGED CARE MANUAL Medicaid Managed Care THSteps Medical Checkups Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)	CHAPTER	PAGE
	12.4	9 of 22
	EFFECTIVE DATE	
	October 1, 2015	
	Version 2.1	

Due Medical Checkups

- All Existing Members are due checkups in accordance with the THSteps periodicity schedule.
- A checkup is due if the periodic due date occurs during the Member’s period(s) of enrollment in the MCO during the reporting period.

Timely Medical Checkups

- Checkups received before the periodic due date are not timely checkups.
- Member is less than 36 months of age: A checkup is considered to have been provided timely if the checkup occurs within 60 days beyond the periodic due date based on an Existing Member’s birthday.
- Member is 36 months of age or older: A checkup is considered to have been provided timely if the checkup occurs within 364 calendar days after the child’s birthday in a non-leap year or 365 calendar days after the child’s birthday in a leap year.

4.3 THSteps Medical Checkups

Criteria for complete Texas Health Steps medical checkups and claims filing are found in the Texas Medicaid Provider Procedures Manual (TMPPM) and its Children’s Services Handbook. Claims must meet requirements as defined within the TMPPM and its Children’s Services Handbook.

5 MEDICAID MANAGED CARE THSteps MEDICAL CHECKUPS ANNUAL REPORT (STAR and STAR+PLUS ONLY)

5.1 General Report Information

- The Medicaid Managed Care THSteps Medical Checkups Annual Report covers ONLY MEDICAID Members under age 21 enrolled in STAR or STAR+PLUS.
- Each Annual Report must include the previous State Fiscal Year (SFY) data (September 1 through August 31). Note: See exceptions for SFY 2012 reporting in Section 2.
- If information is not available for any of the columns within the report, enter a zero. Do not leave cells blank.
- HHSC will calculate and report the percent of New Members who get checkups within 90 days of enrollment as follows:

Number of New Members receiving checkups within 90 days = B.3 divided by the total number of New Members minus the number of New Members receiving a checkup prior to enrollment plus the number of New Members who refused [(B.2)-(B.4+B.5)].



HHSC UNIFORM MANAGED CARE MANUAL Medicaid Managed Care THSteps Medical Checkups Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)	CHAPTER	PAGE
	12.4	10 of 22
	EFFECTIVE DATE	
	October 1, 2015	
	Version 2.1	

Example: Number of New Members (B.2) = 100; number of New Members receiving a checkup (B3) = 60; number of New Members receiving a checkup prior to enrollment (B.4) = 10; number of New Members who refused a checkup (B.5) = 10; Final percent calculation: $60 \div (100 - (10+10)) = 75.00\%$

- HHSC will calculate and report the percent of Existing Members who get all age appropriate checkups in a timely manner as follows:

Number of Existing Members due and receiving checkups = C.3 divided by the total number of Existing Members minus the number of Existing Members not due a checkup plus the number of Existing Members who refused [(C.2) - (C.4+C.5)].

Example: Number of Existing Members (C.2) = 100; number of Existing Members due and receiving a checkup (C.3) = 60; number of Existing Members not due a checkup (C.4) = 10; number of Existing Members who refused a checkup (C.5) = 10; Final percent calculation: $60 \div (100 - (10+10)) = 75.00\%$

- HHSC has the right to inspect and/or request documentation or information that the MCO is required to track and/or retain to support any Annual Reports submitted.

5.2 Annual Report Template Instructions

Section A. Managed Care Organization (MCO) Information

- Report Period: Enter the State Fiscal Year (SFY) in **yyyy** format (i.e. 2012) for the SFY being reported.
- Date Report Compiled: Enter the date the report was prepared in the **mm/dd/yy** format (i.e. 05/12/14).
- MCO Name: Enter the MCO name. Do not use acronyms.
- MCO Plan Code(s): Enter the plan code(s) for the MCO for the Program being reported. Do not include preceding zeros. Do not include Service Area/Rural Service Area Region names or abbreviations. Plan codes may be separated by comma(s) and/or "and."
- Program Served: The MCO must check the appropriate line of business for which the information is being reported (STAR or STAR+PLUS).
- MCO Contact Name and Telephone Number: The MCO must identify a contact person knowledgeable about the preparation and compilation of this report and include that individual's name and telephone contact information.

Section B: New Members (Birth through Age 20) Enrolled in the MCO for 90 or More Continuous Days

Column 1: Service Area/Rural Service Area Region

For the Program Served (STAR or STAR+PLUS) identified in Section A, the MCO will list each Service Area/Rural Service Area Region they serve on a separate line.

- Use the following Service Area names in Column 1 as appropriate: Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant, or Travis.
- Use the following Rural Service Area Region names in Column 1 as appropriate: Central, Northeast, West



HHSC UNIFORM MANAGED CARE MANUAL Medicaid Managed Care THSteps Medical Checkups Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)	CHAPTER	PAGE
	12.4	11 of 22
	EFFECTIVE DATE	
	October 1, 2015	
	Version 2.1	

Column 2: Total Number of New Members

For each Service Area/Rural Service Area Region listed in Column 1, enter the total number of New Members entering that particular MCO for the reporting period.

IMPORTANT: The MCO must identify ALL New Members in the total New Member count in Section B, Column 2. A New Member who does not receive a checkup during or prior to enrollment in the MCO or from whom a refusal was not obtained may only be counted in Column 2.

Column 3: Number of New Members Receiving a THSteps Medical Checkup within the 1st 90 Days of Enrollment

For all New Members, report the total count of New Members that received a THSteps medical checkup within their first 90 days of enrollment.

- New Members who receive multiple THSteps medical checkups within their first 90 days of enrollment are counted once based on the date of the first checkup received.

Example: A baby born during SFY 2012 to a Member covered by the MCO that remains in the MCO has the potential of receiving 4 screens within their first 90 days of enrollment according to the THSteps periodicity schedule: newborn, 3-5 days, 2 weeks, and 2 months. To appropriately count the newborn New Member, the newborn would be **counted once for the first medical checkup completed** during their first 90 days of enrollment. For a newborn New Member that received their newborn, 3-5 days, 2 week, AND 2 month checkups during their enrollment with the MCO, the count will be "1" and appear in Section B, Column 3.

IMPORTANT: The MCO may only count a New Member ONCE in Column 3, Column 4, or Column 5 of the report for whichever column is most appropriate.

Column 4: Number of New Members Receiving a THSteps Medical Checkup Prior to Enrollment

Enter the number of New Members who received a THSteps medical checkup prior to enrollment in the MCO as evidenced by MCO receipt of validation that a THSteps medical checkup was received.

- The MCO or the PCP must retain any documentation used to validate that a complete THSteps checkup due for a New Member was performed prior to enrollment in the MCO that qualifies the Member as a New Member. Section 5.3.1.4, Verification of Medical Checkups, of the 2011 Texas Medicaid Provider Procedures Manual's (TMPPM) Children's Services Handbook provides detail regarding documentation accepted as verification. (Refer to the most recent version of the TMPPM for updates).

HHSC will accept the following documentation as validation:

1. A copy of the Member's medical record or a written statement from the THSteps provider of record that includes the date the full THSteps medical checkup was performed for the Member while the Member was enrolled in Medicaid;
2. A copy of the THSteps paid claim or encounter information for the Member; or
3. Member information HHSC may provide to the MCO that identifies who had a THSteps claim prior to enrollment in the MCO



HHSC UNIFORM MANAGED CARE MANUAL Medicaid Managed Care THSteps Medical Checkups Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)	CHAPTER	PAGE
	12.4	12 of 22
	EFFECTIVE DATE	
	October 1, 2015	
	Version 2.1	

- If the documentation was not received timely, the MCO remains obligated to provide a THSteps medical checkup to the New Member and meet the time period objectives required by contract.
- New Members or Member representatives who voluntarily and knowingly refused a THSteps medical checkup must not be included in this column (see Column 5).

IMPORTANT: The MCO may only count a New Member ONCE in Column 3, Column 4, or Column 5 of the report for whichever column is most appropriate.

Column 5: Number of New Members Refusing a THSteps Medical Checkup

Enter the number of New Members who were **PERSONALLY CONTACTED** and are documented on the Annual Report Refusal Tracking Log as voluntarily and knowingly refusing a THSteps medical checkup during the reporting year.

- Refusal of THSteps medical checkups is only acceptable from a Member, 18 years of age or older or otherwise legally emancipated, or from the minor Member's parent or legal representative. In this context, MCOs may only consider a minor to be emancipated for purposes of refusing THSteps medical checkups if the minor:
 1. Has obtained an order from a Texas court removing his/her disabilities of minority, and provides this to the plan;
 2. Has obtained an out-of-state court emancipation order, has filed an appropriate certified copy in the deed records of any Texas county, and provides this to the plan; or
 3. The minor is unmarried, has a child, has actual custody of the child, and refuses a checkup *for the child*;
 4. The minor is on active duty with the armed services of the United States of America;
 5. The minor is legally married; or
 6. The minor is
 - a. 16 years of age or older and resides separate and apart from the child's parents, managing conservator, or guardian, with or without the consent of the parents, managing conservator, or guardian and regardless of the duration of the residence; and
 - b. managing the child's own financial affairs, regardless of the source of the income.
- New Member refusals must be tracked individually on the "Medicaid Managed Care NEW MEMBER Refusal Tracking Log" of the Annual Report Refusal Tracking Log.
- The Annual Report Refusal Tracking Log will be submitted by the MCO along with the Medicaid Managed Care THSteps Medical Checkups Annual Report even if no Members refused. See the general report information and instructions for the Annual Report Refusal Tracking Log for additional details (Section 7).
- Members who received a checkup prior to enrollment and are counted in Column 4 are not to be included as refusing a checkup.
- The MCO should contact a New Member when enrolled and encourage the Member to obtain a Texas Health Steps checkup.
- A refusal received as a New Member during one SFY cannot be recorded and counted in subsequent SFY reporting unless refusal code 2 ("I am knowingly and voluntarily refusing the THSteps medical checkup(s) permanently") is obtained.
- Refusals obtained prior to the beginning of the SFY being reported may not be counted.
- Refusals should be obtained within 90 days from the start of the Member's 90 continuous days of enrollment segment, or prior to the 90 continuous day segment in the SFY being reported if the Member's refusal was initially obtained during a short enrollment segment of



HHSC UNIFORM MANAGED CARE MANUAL	CHAPTER	PAGE
	12.4	13 of 22
Medicaid Managed Care THSteps Medical Checkups Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)	EFFECTIVE DATE	
	October 1, 2015	
	Version 2.1	

less than 90 continuous days and later in the SFY the Member had 90 continuous days of enrollment.

- See Section 7.3 for information regarding dates of contact, and reporting New Member refusals on the annual report refusal tracking log.
- If the MCO opts to use Refusal Code 6 (“Refused Other”) when a Member or the Member’s caretaker is knowingly dismissive or hangs up the phone before a clear refusal is obtained, the MCO must follow the procedure outlined below. The MCO may count the phone contact as a refusal after completing all of the following:
 1. The MCO representative must confirm that he/she is speaking with the Member or a minor Member’s parent or legal representative.
 2. The MCO must send a letter in English and Spanish as a follow up to the call that educates the Member on the importance of receiving a THSteps medical checkup and offers assistance to the Member. The approved language for the follow-up letter is:

English Letter Language

On (insert date), we called to tell you that it’s time for your child’s Texas Health Steps checkup. We spoke with (enter casehead’s name), but we were unable to finish the call.

Texas Health Steps medical checkups help keep your child healthy. The doctor will look at your child from head to toe, checking for health problems you may not know about. The doctor also will see if your child is growing and developing like other children their age. These checkups can help catch health problems before they get bigger and harder to treat. **As long as your child is on Medicaid, the checkup is free.**

If you need a ride or gas money to get to your child’s checkup, call toll free 1-877-633-8747 (1-877-MED-TRIP), Monday to Friday, 8 a.m. to 5 p.m.

Please call us toll free at xxx-xxx-xxxx to

- Help you find a doctor for your child’s Texas Health Steps medical checkup.
- Set up a checkup.
- Answer your questions about checkups or Texas Health Steps.
- Talk to a case manager to help you find and get other services.

We can take your call Monday to Friday, 8 a.m. to 8 p.m. Please call us back. We have English and Spanish speaking staff here to help you.

Spanish Letter Language

El [insert date in Spanish format], llamamos para avisarle que es hora de programar el examen de Pasos Sanos de Texas de su hijo. Hablamos con [enter casehead’s name], pero no pudimos terminar la llamada.

Los exámenes médicos de Pasos Sanos de Texas ayudan a mantener la buena salud de su hijo. El doctor examinará al niño de pies a cabeza, revisando si hay problemas de salud que usted no haya detectado. El doctor también examinará si el crecimiento y desarrollo del niño son como los de otros niños de su edad. Estos exámenes pueden ayudar a encontrar problemas de salud antes de que sean más graves y difíciles de tratar. **El examen es gratis, siempre que su hijo tenga Medicaid.**



HHSC UNIFORM MANAGED CARE MANUAL Medicaid Managed Care THSteps Medical Checkups Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)	CHAPTER	PAGE
	12.4	14 of 22
	EFFECTIVE DATE	
	October 1, 2015	
	Version 2.1	

Si necesita transporte o dinero para la gasolina para ir al examen de su hijo, llame gratis al 1-877-633-8747 (1-877-MED-TRIP), de lunes a viernes, de 8 a.m. a 5 p.m.

Por favor, llámenos gratis al [xxx-xxx-xxxx] para:

- Recibir ayuda para encontrar a un doctor que haga el examen médico de Pasos Sanos de Texas del niño.
- Programar un examen.
- Contestar sus preguntas sobre los exámenes o sobre Pasos Sanos de Texas.
- Hablar con un administrador de casos para que le ayude a encontrar y obtener otros servicios.

Atendemos llamadas de lunes a viernes, de 8 a.m. a 8 p.m. Por favor, llámenos. Tenemos personal que habla inglés y español dispuesto a ayudarle.

3. If following receipt of the letter, the Member does not respond to or initiate further contact with the MCO related to the contents of the letter and the MCO does not pay a claim for a THSteps medical checkup during the reporting period, the MCO may document the contact as a refusal using refusal code 6 (“Refused Other”).
4. Refusal code 6 (“Refused Other”) obtained for a Member during one SFY cannot be recorded and counted in subsequent SFY reporting. The MCO is required to contact the Member in the subsequent reporting period.

IMPORTANT: The MCO may only count a New Member ONCE in Column 3, Column 4, or Column 5 of the report for whichever column is most appropriate.

Section C: All Existing Members (birth through age 20) Enrolled in the MCO for 90 or More Continuous Days

Column 1: Service Area/Rural Service Area Region

For the Program Served (STAR or STAR+PLUS) identified in Section A, the MCO will list each Service Area/Rural Service Area Region they serve on a separate line.

- Use the following Service Area names in Column 1 as appropriate: Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant, or Travis.
- Use the following Rural Service Area Region names in Column 1 as appropriate: Central, Northeast, West

Column 2: Total Number of Existing Members

For each Service Area/Rural Service Area Region listed in Column 1, enter the total number of Existing Members enrolled during the reporting period.

IMPORTANT: The MCO must identify ALL Existing Members in the total Member count in Section C, Column 2. All Existing Members must be counted in Column 2 even if they do not receive a checkup(s), are not due a checkup(s), or refuse a checkup during enrollment in the MCO.

Column 3: Number of Existing Members Due and Receiving ALL Age-Appropriate THSteps Medical Checkups Timely



HHSC UNIFORM MANAGED CARE MANUAL

CHAPTER	PAGE
12.4	15 of 22
EFFECTIVE DATE	
October 1, 2015	
Version 2.1	

Medicaid Managed Care THSteps Medical Checkups Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)

Enter the number of Existing Members who were due for one or more THSteps medical checkups and received ALL due age-appropriate THSteps medical checkups in a timely manner WHILE THEY WERE ENROLLED IN THE MCO.

IMPORTANT: The MCO may only count an Existing Member ONCE in Column 3, Column 4, or Column 5 of the report for whichever column is most appropriate.

BUSINESS RULES:

- For all Existing Members, report the number of Members who received all due medical checkups in a timely manner based on age(s) attained during the reporting period and in accordance with the following periodicity schedule.

3-5 days	2 weeks	2 months	4 months
6 months	9 months	12 months	15 months
18 months	2 years	30 months	3 years
4 years	5 years	6 years	7 years
8 years	9 years	10 years	11 years
12 years	13 years	14 years	15 years
16 years	17 years	18 years	19 years
20 years			

Column 4: Number of Existing Members Not Due a Checkup

Enter the number of Existing Members who were not due a checkup under the periodicity schedule while enrolled in the MCO. Example: Existing Member enrolled September through December and turned 5 years old in April. The Member was enrolled for greater than 90 days but was not due for his/her checkup during enrollment.

IMPORTANT: The MCO may only count an Existing Member ONCE in Column 3, Column 4, or Column 5 of the report for whichever column is most appropriate.

Column 5: Number of Existing Members Refusing a THSteps Medical Checkup

Enter the number of Existing Members who were **PERSONALLY CONTACTED** and are documented on the Annual Report Refusal Tracking log as voluntarily and knowingly refusing THSteps medical checkups due during the reporting year.

- Refusal of THSteps medical checkups is only acceptable from a Member, 18 years of age or older or otherwise legally emancipated, or from the minor Member's parent or legal representative. In this context, MCOs only may consider a minor to be emancipated for purposes of refusing THSteps medical checkups if the minor:
 - Has obtained an order from a Texas court removing his/her disabilities of minority, and provides this to the plan;
 - Has obtained an out-of-state court emancipation order, has filed an appropriate certified copy in the deed records of any Texas county, and provides this to the plan; or
 - The minor is unmarried, has a child, has actual custody of the child, and refuses a checkup *for the child*;
 - The minor is on active duty with the armed services of the United States of America;
 - The minor is legally married; or
 - The minor is



HHSC UNIFORM MANAGED CARE MANUAL	CHAPTER	PAGE
	12.4	16 of 22
	EFFECTIVE DATE	
Medicaid Managed Care THSteps Medical Checkups Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)	October 1, 2015	
	Version 2.1	

- a. 16 years of age or older and resides separate and apart from the child's parents, managing conservator, or guardian, with or without the consent of the parents, managing conservator, or guardian and regardless of the duration of the residence; and
 - b. managing the child's own financial affairs, regardless of the source of the income.
- Existing Member refusals must be tracked individually on the "Medicaid Managed Care EXISTING MEMBER Refusal Tracking Log" of the Annual Report Refusal Tracking Log.
 - The Annual Report Refusal Tracking Log must be submitted by the MCO along with the Medicaid Managed Care THSteps Medical Checkups Annual Report even if no Members refused. See the general report information and instructions for the Annual Report Refusal Tracking Log for additional details (Section 7).
 - The MCO should contact Existing Members and encourage them to obtain a Texas Health Steps checkup based on their periodic due date.
 - A refusal received as an Existing Member during one SFY cannot be recorded and counted in subsequent SFY reporting unless refusal code 2 ("I am knowingly and voluntarily refusing the THSteps medical checkup(s) permanently") is obtained.
 - Refusals for Existing Members must be within the timely checkup period following the Member's periodic due date in the SFY being reported.
 - If the MCO opts to use Refusal Code 6 ("Refused Other") when a Member or the Member's caretaker is knowingly dismissive or hangs up the phone before a clear refusal is obtained, the MCO must follow the procedure outlined below. The MCO may count the phone contact as a refusal after completing all of the following:
 1. The MCO representative must confirm that he/she is speaking with the Member or a minor Member's parent or legal representative.
 2. The MCO must send a letter in English and Spanish as a follow up to the call that educates the Member on the importance of receiving a THSteps medical checkup and offers assistance to the Member. The approved language for the follow-up letter is:

English Letter Language

On (insert date), we called to tell you that it's time for your child's Texas Health Steps checkup. We spoke with (enter casehead's name), but we were unable to finish the call.

Texas Health Steps medical checkups help keep your child healthy. The doctor will look at your child from head to toe, checking for health problems you may not know about. The doctor also will see if your child is growing and developing like other children their age. These checkups can help catch health problems before they get bigger and harder to treat. **As long as your child is on Medicaid, the checkup is free.**

If you need a ride or gas money to get to your child's checkup, call toll free 1-877-633-8747 (1-877-MED-TRIP), Monday to Friday, 8 a.m. to 5 p.m.

Please call us toll free at xxx-xxx-xxxx to

- Help you find a doctor for your child's Texas Health Steps medical checkup.
- Set up a checkup.
- Answer your questions about checkups or Texas Health Steps.
- Talk to a case manager to help you find and get other services.

We can take your call Monday to Friday, 8 a.m. to 8 p.m. Please call us back. We have English and Spanish speaking staff here to help you.



HHSC UNIFORM MANAGED CARE MANUAL	CHAPTER	PAGE
	12.4	17 of 22
	EFFECTIVE DATE	
Medicaid Managed Care THSteps Medical Checkups Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)	October 1, 2015	
	Version 2.1	

Spanish Letter Language

El [insert date in Spanish format], llamamos para avisarle que es hora de programar el examen de Pasos Sanos de Texas de su hijo. Hablamos con [enter casehead's name], pero no pudimos terminar la llamada.

Los exámenes médicos de Pasos Sanos de Texas ayudan a mantener la buena salud de su hijo. El doctor examinará al niño de pies a cabeza, revisando si hay problemas de salud que usted no haya detectado. El doctor también examinará si el crecimiento y desarrollo del niño son como los de otros niños de su edad. Estos exámenes pueden ayudar a encontrar problemas de salud antes de que sean más graves y difíciles de tratar. **El examen es gratis, siempre que su hijo tenga Medicaid.**

Si necesita transporte o dinero para la gasolina para ir al examen de su hijo, llame gratis al 1-877-633-8747 (1-877-MED-TRIP), de lunes a viernes, de 8 a.m. a 5 p.m.

Por favor, llámenos gratis al [xxx-xxx-xxxx] para:

- Recibir ayuda para encontrar a un doctor que haga el examen médico de Pasos Sanos de Texas del niño.
- Programar un examen.
- Contestar sus preguntas sobre los exámenes o sobre Pasos Sanos de Texas.
- Hablar con un administrador de casos para que le ayude a encontrar y obtener otros servicios.

Atendemos llamadas de lunes a viernes, de 8 a.m. a 8 p.m. Por favor, llámenos. Tenemos personal que habla inglés y español dispuesto a ayudarle.

3. If following receipt of the letter, the Member does not respond to or initiate further contact with the MCO related to the contents of the letter and the MCO does not pay a claim for a THSteps medical checkup during the reporting period, the MCO may document the contact as a refusal using refusal code 6 ("Refused Other").
4. Refusal code "6-Refused Other" obtained for a Member during one SFY cannot be recorded and counted in subsequent SFY reporting. The MCO is required to contact the Member in the subsequent reporting period.

IMPORTANT: The MCO may only count an Existing Member ONCE in Column 3, Column 4, or Column 5 of the report for whichever column is most appropriate.

6 MEDICAID MANAGED CARE THSteps MEDICAL CHECKUPS ANNUAL REPORT (STAR Health Only)

6.1 General Report Information

- The Medicaid Managed Care THSteps Medical Checkups Annual Report covers ONLY MEDICAID Members under age 21 enrolled in the STAR Health managed care program.
- Each Annual Report will include the previous SFY data (September 1 through August 31).



HHSC UNIFORM MANAGED CARE MANUAL Medicaid Managed Care THSteps Medical Checkups Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)	CHAPTER 12.4	PAGE 18 of 22
	EFFECTIVE DATE October 1, 2015	
	Version 2.1	

- If information is not available for any of the columns within the report, enter a zero. Do not leave cells blank.
- HHSC will calculate and report the percent of New Members who get checkups within 90 days of enrollment as follows:

Number of New Members receiving checkups within 90 days = B.3 divided by the total number of New Members (B.2).

Example: Number of New Members (B.2) = 100; number of New Members receiving a checkup (B.3) = 80; Final percent calculation: $80 \div 100 = 80.00\%$

- HHSC will calculate and report the percent of Existing Members who get all age appropriate checkups in a timely manner as follows:

Number of Existing Members due and receiving timely checkups = C.3 divided by the total number of Existing Members minus the number of Existing Members not due a checkup [(C.2)-(C.4)].

Example: Number of Existing Members (C.2) = 100; number of Existing Members due and receiving timely checkups (C.3) = 80; number of Existing Members not due a checkup (C.4) = 10; Final percent calculation: $80 \div (100-10) = 88.88\%$

- HHSC has the right to inspect and/or request documentation or information that the MCO is required to track and/or retain to support any STAR Health Annual Report submitted.

6.2 Annual Report Template Instructions

Section A. Managed Care Organization (MCO) Information

- Report Period: Enter the State Fiscal Year (SFY) in **yyyy** format (i.e. 2012) for the SFY being reported.
- Date Report Compiled: Enter the date the report was prepared in the **mm/dd/yy** format (i.e. 05/12/14).
- MCO Name: Enter the MCO name. Do not use an acronym.
- MCO Plan Code: Enter the MCO plan code.
- Program Served: Enter STAR Health as the program.
- MCO Contact Name and Telephone Number: The MCO must identify a contact person knowledgeable about the preparation and compilation of this report and include that individual's name and telephone contact information.

Section B: New Members (birth through age 20) Enrolled in the MCO for 90 or More Continuous Days

Column 1: Service Area

The STAR Health MCO will list "Statewide" as the Service Area they serve.

Column 2: Total Number of New Members

Enter the total number of New Members entering STAR Health for the reporting period.



HHSC UNIFORM MANAGED CARE MANUAL Medicaid Managed Care THSteps Medical Checkups Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)	CHAPTER	PAGE
	12.4	19 of 22
	EFFECTIVE DATE	
	October 1, 2015	
	Version 2.1	

IMPORTANT: The MCO must identify ALL New Members in the total New Member count in Section B, Column 2. A New Member who does not receive a checkup during enrollment in the MCO may only be counted in Column 2.

Column 3: Number of New Members Receiving a THSteps Medical Checkup within the 1st 90 Days of Enrollment

For all New Members, the MCO will report the total count of New Members that received a THSteps medical checkup within their first 90 days of enrollment.

- New Members who receive multiple THSteps medical checkups within their first 90 days of enrollment are counted once based on the date of the first checkup received.

Example: A baby born during SFY 2012 to a Member covered by the MCO that remains in the MCO has the potential of receiving 4 screens within their first 90 days of enrollment according to the THSteps periodicity schedule: newborn, 3-5 days, 2 weeks, and 2 months. To appropriately count the newborn New Member, the newborn would be **counted once for the first medical checkup completed** during their first 90 days of enrollment. For a newborn New Member that received their newborn, 3-5 days, 2 week, AND 2 month checkups during their enrollment with the MCO, the count will be “1” and appear in Section B, Column 3.

Section C: All Existing Members (birth through age 20) Enrolled in the MCO for 90 or More Continuous Days

Column 1: Service Area

The STAR Health MCO will list “Statewide” as the Service Area they serve.

Column 2: Total Number of Existing Members

Enter the total number of Existing Members for the reporting year.

IMPORTANT: The MCO must identify all Existing Members in the total Member count in Section C, Column 2. All Existing Members must be counted in Column 2 even if they do not receive a checkup(s) or are not due a checkup(s).

Column 3: Number of Existing Members Due and Receiving ALL Age-Appropriate THSteps Medical Checkups Timely

Enter the number of Existing Members who were due for one or more THSteps medical checkups and received ALL due age-appropriate THSteps medical checkups in a timely manner WHILE THEY WERE ENROLLED IN THE MCO.

IMPORTANT: The MCO may only count an Existing Member ONCE in Column 3 or Column 4 of the report for whichever column is most appropriate.

BUSINESS RULES:

- For all Existing Members, report the number of members who received all due medical checkups in a timely manner based on age(s) attained during the reporting period and in accordance with the following periodicity schedule.



HHSC UNIFORM MANAGED CARE MANUAL Medicaid Managed Care THSteps Medical Checkups Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)	CHAPTER 12.4	PAGE 20 of 22
	EFFECTIVE DATE October 1, 2015	
	Version 2.1	

3-5 days	2 weeks	2 months	4 months
6 months	9 months	12 months	15 months
18 months	2 years	30 months	3 years
4 years	5 years	6 years	7 years
8 years	9 years	10 years	11 years
12 years	13 years	14 years	15 years
16 years	17 years	18 years	19 years
20 years			

Column 4: Number of Existing Members Not Due a THSteps Medical Checkup

Enter the number of Existing Members who were not due a checkup under the periodicity schedule while enrolled in the MCO. Example: Existing Member who entered conservatorship in April was enrolled in STAR Health from September through December. The Member was enrolled for 90 or more continuous days but was not due a checkup during his/her enrollment.

IMPORTANT: The MCO may only count an Existing Member ONCE in Column 3 or Column 4 of the report for whichever column is most appropriate.

7 ANNUAL REPORT REFUSAL TRACKING LOG (STAR and STAR+PLUS ONLY)

7.1 General Report Information

- The Annual Report Refusal Tracking Log is a **required attachment** to the Medicaid Managed Care THSteps Medical Checkups Annual Report for STAR and STAR+PLUS programs only.
- The Annual Report Refusal Tracking Log is used to track only MEMBER REFUSALS OBTAINED AFTER PERSONAL CONTACT WITH THE MEMBER OR MEMBER'S LEGAL REPRESENTATIVE.
- The Annual Report Refusal Tracking Log is considered incomplete and inaccurate if any information is missing in any of the columns or does not account for the total number listed in the corresponding sections and columns in the Annual Report (Section B, Column 5 and Section C, Column 5).
- The Annual Report Refusal Tracking Log must be submitted even if no Members refused the medical checkup. If no Members refused, the MCO must complete the MCO Information fields of each refusal tracking worksheet (New Member and Existing Member logs) located at the top of each page. In the first cell, first row, of the first column (Last Name columns) of each worksheet, the MCO must type, "None."

7.2 MCO Information

- The MCO must complete the MCO information located at the top of each Refusal Tracking Log ("Medicaid Managed Care NEW MEMBER Refusal Tracking Log" and "Medicaid Managed Care EXISTING MEMBER Refusal Tracking Log") as appropriate.
 - MCO Name: Enter the MCO name. Do not use acronyms.



HHSC UNIFORM MANAGED CARE MANUAL Medicaid Managed Care THSteps Medical Checkups Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)	CHAPTER	PAGE
	12.4	21 of 22
	EFFECTIVE DATE	
	October 1, 2015	
	Version 2.1	

- Program: Enter STAR or STAR+PLUS for the program being reported.
- MCO Contact Name: The MCO must identify a contact person knowledgeable about the preparation and compilation of this report and enter his/her name.
- MCO Contact Telephone Number: Enter the telephone number of the MCO Contact identified.
- Reporting Period: Enter the SFY of the report in **yyyy** format (i.e. 2012).

7.3 Column Heading Specific Instructions

- Member Last Name: For the line number, enter the last name of the Member. Do not enter the name as Boy/Girl and the mother's name.
- Member First Name: For the line number, enter the first name of the Member. Do not enter the name as Boy/Girl and the mother's name.
- Medicaid ID Number (PCN): For the line number, enter the Medicaid ID Number (PCN) for the Member identified.
- Service Area/ Rural Service Area Region: For the line number, enter the Member's Service Area or Rural Service Area Region. Spell out the name of the Service Area/ Rural Service Area Region.
- Month/ Year of Enrollment: For the line number, enter the month and year the Member became enrolled in the MCO. Spell out the name of the month and enter the year in the format **yyyy** (i.e. July 2012)
 - For the New Member Refusal Log, the months/years of enrollment should be within the SFY being reported. For example, all Members listed on the SFY 2012 refusal log should have a month/year of enrollment within September 1, 2011, through August 31, 2012.
 - For the Existing Member Refusal Log, the months/years of enrollment should be prior to the reporting year reflecting the previous enrollment the MCO identified in the 730 day look back that confirmed the Member's status as an Existing Member. The months/years of enrollment reported should be those within the 730 day look back period prior to the SFY being reported.
- Person Contacted who knowingly and voluntarily refused a THSteps medical checkup: Enter one of the following codes:
 - S = Self (Member)
 - M = Mother
 - F = Father
 - O = Other Legal Representative
- Method of Contact: Identifies the type of contact made with the person contacted when obtaining the refusal. Enter one of the following codes:
 - C = Correspondence
 - T = Telephone
 - P = Personal visit or face-to-face
- Date of Contact: Enter date of contact in which the refusal was obtained in **mm/dd/yy** format (i.e. 09/01/12).
 - For the New Member refusal log:
 - Dates of contact must be within 90 days from the start of the Member's 90 continuous days of enrollment segment, or prior to the 90 day enrollment segment in the SFY being reported if the Member's refusal was initially obtained during a short enrollment segment of less than 90 continuous days and later in the SFY the Member had 90 continuous days of enrollment. Example 1: A New Member enrolled from January



HHSC UNIFORM MANAGED CARE MANUAL Medicaid Managed Care THSteps Medical Checkups Reports and Refusal Tracking Logs Instructions (All Medicaid Programs)	CHAPTER	PAGE
	12.4	22 of 22
	EFFECTIVE DATE	
	October 1, 2015	
	Version 2.1	

2012 through June 2012 should show a date of contact for the refusal within the months of January, February, or March of 2012 (within 90 days from the start of their 90 continuous days of enrollment segment). Example 2: A New Member is enrolled from December 2011 through January 2012 and again from April 2012 through August 2012. The refusal is received in December 2011 (prior to the Member's 90 continuous days of enrollment segment with the MCO in the SFY being reported) and recorded.

- Dates of contact must not be prior to the beginning of the SFY being reported.
- Dates of contact in which refusals are obtained for New Members who enroll in Quarter 4 must be reported in the annual report for which the Member was identified as a New Member. Depending on the date of enrollment, the date of contact may occur up to three months after Quarter 4. Example: A New Member who enrolls on July 1, 2012 (in SFY 2012 Quarter 4) may show a date of contact for the refusal within the months of July, August, or September. The refusal would be counted on the SFY 2012 Quarter 4 report even if the date of contact occurred in September (in SFY 2013). Example 2: A New Member who enrolls on August 31, 2012 (in SFY 2012 Quarter 4), may show a date of contact for the refusal within the months of September, October, and November (in SFY 2013). The refusal would be counted on the SFY 2012 report.
- Dates of contact for New Members identified in Quarters 1, 2, or 3 must be within the SFY being reported.
- For the Existing Member refusal log, dates of contact for refusals must be within the timely checkup period following the Member's periodic due date in the SFY being reported.
- Refusal Code: Enter only one of the following refusal codes per Member entry:
 - 1 = I am knowingly and voluntarily refusing the THSteps medical checkup(s) during the first 90 days of enrollment.
 - 2 = I am knowingly and voluntarily refusing the THSteps medical checkup(s) permanently.
 - 3 = I am knowingly and voluntarily refusing the THSteps medical checkup(s) and will contact the MCO if I change my mind.
 - 4 = I am knowingly and voluntarily refusing the THSteps medical checkup(s) because one was already done before coming to this health plan.
 - 5 = I am knowingly and voluntarily refusing the THSteps medical checkup(s) and give no specific reason for refusing.
 - 6 = Refused Other (See additional requirements to be met prior to the use of this code in Section 5.2: Section B, Column 5 and Section C, Column 5.)