TEXAS
Health and Human Services

Texas Health and Human Services Commission

Charles Smith
Executive Commissioner

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Hurricane Harvey

Medicaid and Children's Health Insurance Program (CHIP)
Frequently Asked Questions

On Aug. 25, Hurricane Harvey hit the Texas coast and caused significant damage and flooding in numerous counties forcing many to evacuate to temporary locations.

Texas Health and Human Services is committed to sharing pertinent Hurricane Harvey information with you with this list of frequently asked questions. This document will provide tools and resources needed to ensure the provision of services and supports to needy residents in Texas in the aftermath of this natural disaster.

New and revised information contained in the FAQ document will be highlighted in yellow and placed under the "New Information" section of the document, in addition to appearing under the appropriate subject heading.

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HHS also has two webpages dedicated to Hurricane Harvey to help our members, providers and stakeholders stay informed.

For providers: https://hhs.texas.gov/services/health/medicaid-chip/provider-information/hurricane-harvey-information-providers

For members: https://hhs.texas.gov/services/financial/disaster-assistance

New Information

Will there be any changes to CHIP co-payments as a result of Hurricane Harvey?

A. HHS is waiving co-payments for CHIP covered services, including pharmacy, for CHIP members with a permanent address in one of the Hurricane Harvey FEMA-declared disaster counties. Co-payments are waived for services provided Aug. 25 through Nov. 30, 2017. Therefore, providers must not require or collect co-payments for CHIP members living in or displaced from a Hurricane Harvey FEMA-declared disaster county.

Providers should contact the Provider Line at 1-800-645-7164 for updated co-payment information.

Managed care organizations will compensate providers for waived CHIP copays. HHSC has directed MCOs to establish a process no later than November 15, 2017, and to collect a form from providers attesting that the co-pay was not collected. Providers should contact MCOs to learn about the process.

Federal Waivers and Modifications

1. **Will the 95-day claims filing deadline be extended?**

A: Yes. For services that require a 95-day claim filing deadline, MCOs and TMHP are required to extend the deadline to 120 days from the date of service. This requirement extends to services delivered by providers located in a FEMA-declared disaster county between August 25, 2017 and the date on which the disaster declaration is rescinded.

2. **Will HHSC allow MCOs and TMHP to extend prior authorizations?**

A. MCO

- Yes, MCOs may extend prior authorizations for authorizations expiring Aug. 25, 2017, through the termination of the emergency period for individuals with a permanent residence in a FEMA-declared disaster county for up to 90 days.

B. TMHP

- HHSC will publish specific information for prior authorizations associated with services paid by TMHP.

3. Will HHSC allow MCOs and TMHP to have flexibility in documentation for any new authorizations?

A. MCO

- Yes, HHSC will allow MCOs to waive currently required provider documentation, MCO and HHSC review criteria, required consultation requirements for authorization, review and documentation requirements of the state plan, contract or limitation of services when the following conditions are met:
    - the individual has a permanent residence in a FEMA-declared disaster county, and
    - the MCO determines that the information required to support the authorization or claim is not immediately available for reasons related to the disaster.
- This flexibility is allowed from Aug. 25, 2017, through the termination of the emergency period for up to 90 days.

B. TMHP

- HHSC will publish specific information regarding flexibilities for new authorizations associated with services paid by TMHP.

2. Does the HHS plan to apply for federal waivers as they have done for past natural disasters?

A. On Friday, Aug. 25, 2017, HHS Executive Commissioner, Charles Smith, sent a letter to Health and Human Services Secretary Tom Price, M.D. requesting a waiver from certain provisions of the Social Security Act. CMS acted quickly, indicating it would waive various federal requirements, employing Title 11, Section 1135 of the Social Security Act.

This authority waives or modifies various federal provisions, including health care provider participation, certification and licensing requirements (permitting those with out of state licenses to render services in Texas), while also providing relief from specific sanctions or penalties. The approved Section 1135 authority can be accessed here: https://www.phe.gov/emergency/news/healthactions/section1135/Pages/harvey-26aug2017.aspx. On Thursday, Aug. 31, 2017, CMS issued further relief to the state under Section 1135, offering flexibility in existing provider

enrollment requirements. This allows Texas to enroll providers by meeting a more limited set of minimum requirements.

On Wednesday, Aug. 30, 2017, HHS also submitted a second request to CMS, requesting flexibility for members served by the state's Children's Health Insurance Program (CHIP). On Thursday, Aug. 31, 2017, CMS approved the state's request, permitting the state the ability to do the following:

- Allow CHIP enrollees to receive services beyond their certification period and provide additional time to submit a renewal or verification.
- Waive certain verification requirements at application and renewal.
- Waive CHIP co-payments through Nov. 30, 2017.
- Waive CHIP enrollment fees for families approved for coverage or renewal in August, September, October and November 2017.

HHS will continue to work with CMS to access needed allowances in order to ensure continuity of care for Medicaid and CHIP enrollees over the course of the disaster event.

3. **Governor Abbott has issued a disaster proclamation certifying that Hurricane Harvey posed a threat of imminent disaster, including severe flooding to 54 counties as of Aug. 28, 2017. Will the federal waivers and modifications apply to the same geographical area?**
   A. Federal waivers and modifications apply to the geographical area identified by FEMA. Those counties are periodically updated. The list can be accessed here: https://www.fema.gov/disaster/4332

4. **Did CMS issue any blanket waivers under Title 11, Section 1135, or Title 18, Section 1812(f) of the Social Security Act or Title 42 of the Code of Federal Regulations so individual facilities do not need to apply?**
   A. Yes, CMS issued the following three blanket waivers:
      - Skilled Nursing Facilities
        - SSA Section 1812(f): This waiver of the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility stay provides temporary emergency coverage of Skilled Nursing Facility services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Harvey in the State of Texas in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)

  - CFR 483.20: This waiver provides relief to Skilled Nursing Facilities on the timeframe requirements for Minimum Data Set assessments and transmission. (Blanket waiver for all impacted facilities)
- Home Health Agencies
  - CFR 484.20(c)(1): This waiver provides relief to Home Health Agencies on the timeframes related to OASIS Transmission. (Blanket waiver for all impacted agencies)
- Critical Access Hospitals
  - This action waives the requirements that Critical Access Hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours. (Blanket waiver for all impacted hospitals)

These temporary emergency policies would apply to the timeframes specified in the waiver(s) issued under section 1135 of the Act in connection with the effect of Hurricane Harvey in the State of Texas. CMS is reviewing additional waivers and will update the following page as decisions are made. https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html

5. What resources are available for Texas residents on dialysis?

A. If a Texas resident is on dialysis and needs assistance finding a dialysis provider, they may call 1.866.407.ESRD for support. If a managed care plan needs assistance in finding a dialysis provider for a member, they can contact a member of Texas' End stage renal disease network directly:
- Javoszia Sterling: JSterling@nw14.esrd.net
- Mary Albin: Mary.Albin@alliantquality.org
- Glenda Harbert: GHarbert@nw14esrd.net

6. Will the eligibility certification period for Medicaid, CHIP and Texas Health Women Program clients be extended for those that have a permanent residence in one of the FEMA-declared disaster counties?

A. Yes. Due to disruptions to mail delivery and to ensure continuity of services, HHS received federal approval to provide a six-month extension of medical benefits for people enrolled in Medicaid, CHIP and Healthy Texas Women whose permanent residence is in one of the FEMA-declared disaster counties.

Anyone whose benefits were up for renewal in August, September, October or November will have their certification periods automatically extended for six months. Clients do not need to take any action for this extension to be effective.

Households with certification periods ending in:

- August 2017 will be automatically extended through February 2018;
- September 2017 will be automatically extended through March 2018;
- October 2017 will be automatically extended through April 2018; and
- November 2017 will be automatically extended through May 2018.

Households will receive a notice when it is time to renew their benefits. Clients are encouraged to use YourTexasBenefits.com or the Your Texas Benefits mobile app to manage their benefits case and to notify HHS of any address changes. Members should update their mailing addresses but keep permanent addresses on file. Clients are also encouraged to sign up for electronic notices to stay informed about their cases.

7. What should members do if they are displaced from Hurricane Harvey and need to update address information?

A. Members should update their mailing addresses but keep permanent addresses on file. This can be done by contacting 211 or through YourTexasBenefits.com. It is important for members to keep their permanent addresses on file if they plan to return home.

8. What are the plans for newly eligible beneficiaries that did not receive their New Enrollment Packet?

A. The Enrollment Broker will contact these members and inform them who their health plan is and provide them an opportunity to change their plan.

Pregnant women and newborns will continue with the current process of being enrolled in managed care. The Enrollment Broker will contact these members and inform them who their health plan is and provide them an opportunity to change their plan.

9. Can members who have been displaced by Hurricane Harvey and are enrolled with an MCO see an out of network provider?

A. MCOs must allow members to see an out of network provider for non-emergency services. This direction pertains specifically to providers who deliver Medicaid or CHIP-covered services to members with a permanent residence in a FEMA-declared disaster county from August 25, 2017 until the emergency declaration has been rescinded. The direction applies to all Medicaid or CHIP-covered services, including nursing facility add-on services.

MCOs shall not require the member's current provider to request authorization for the out of network provider.

As a reminder, MCOs are already required to allow emergency services be provided out of network.

Fair Hearings

10. What happens if a member misses a scheduled Fair Hearing or if the member cannot participate in the scheduled Fair Hearing?

A. HHS will automatically reschedule fair hearings for members that live in an area affected by Hurricane Harvey. This includes those instances where a member may have missed their fair hearing or have one scheduled prior to Sept. 18, 2017, and are unable to participate.

Members getting services pending the appeals process will continue to receive those services. For any member questions related to fair hearings, please call Fair and Fraud Hearings Section at 512-231-5701, or fax 512-231-5743.

CHIP Cost-Sharing

11. Will there be any changes to CHIP co-payments as a result of Hurricane Harvey?

A. HHS is waiving co-payments for CHIP covered services, including pharmacy, for CHIP members with a permanent address in one of the Hurricane Harvey FEMA-declared disaster counties. Co-payments are waived for services provided Aug. 25 through Nov. 30, 2017. Therefore, providers must not require or collect co-payments for CHIP members living in or displaced from a Hurricane Harvey FEMA-declared disaster county.

Providers should contact the Provider Line at 1-800-645-7164 for updated co-payment information.

Managed care organizations will compensate providers for waived CHIP copays. HHSC has directed MCOs to establish a process no later than November 15, 2017, and to collect a form from providers attesting that the co-pay was not collected. Providers should contact MCOs to learn about the process.

Social Security

12. Is there any guidance related to members getting Social Security Payments in areas affected by Hurricane Harvey?

A. The Social Security Administration has issued a press release related to various delivery methods for people getting social security payments in the

wake of hurricane Harvey. Information can be found here: https://www.ssa.gov/news/press/releases/#/print/8-2017-6

Out-of-State Providers and Texas Providers not Enrolled in Medicaid

13. Can out of state pharmacies refill Texas Medicaid prescriptions?

A. MCOs: Yes, must allow payment to these pharmacies.

B. Traditional, Fee-For-Service Providers: Yes, the current override process will allow non-enrolled out-of-state pharmacies to dispense drugs to clients. The claim will be pended in order for HHS to enroll the pharmacy and set-up payment.

14. Will MCOs be able to submit pharmacy encounters for claims paid to out of state pharmacies?

A. MCOs should instruct pharmacies to complete the Temporary Pharmacy Agreement Form at https://www.txvendordrug.com/sites/txvendordrug/files/docs/providers/harvey-phcy-enroll.pdf to enroll. Enrollment will be effective retroactive to 08/25/17 and be valid through 12/31/17. Once enrolled, VDP will notify MCOs via the master provider file that the provider National Provider Identifier (NPI) is enrolled. Once the MCO is notified the NPI is enrolled, encounters can be submitted. This process is valid for instate and out of state providers.

15. How can a non-Texas Medicaid enrolled provider, including out-of-state providers be reimbursed for services rendered to Texas Medicaid eligible clients who were affected by Hurricane Harvey?

A. A simplified provider enrollment application has been created to allow out of state providers and Texas providers not enrolled in Medicaid, to temporarily enroll in Texas Medicaid to deliver acute care services. Providers must be enrolled in Texas Medicaid in order to be reimbursed for rendering services to Texas Medicaid eligible clients whose permanent address is in one of the FEMA-declared disaster counties. The expedited enrollment application can be found here: http://www.tmhp.com/Pages/Topics/Hurricane_Main.aspx

The simplified enrollment process will expedite Texas Medicaid's provider enrollment process and allow providers to temporarily enroll in Texas Medicaid. Providers enrolled through this process will be eligible for

reimbursement for services rendered from Aug. 25 through Dec. 31, 2017. After Dec. 31, 2017, providers enrolled under this process will be automatically dis-enrolled. Future guidance is forthcoming on claims submission and processing.

Providers who wish to continue to provide services to Texas Medicaid clients may pursue traditional provider enrollment with Texas Medicaid. Additional information about this process may be found on www.tmhp.com. Providers may also call the TMHP Contact Center for questions about traditional or expedited enrollment at 1-800-925-9126.

After Texas Medicaid enrollment, providers may reach out to Texas MCOs. Additional provider enrollment information about Texas Medicaid managed care programs can be found here: https://hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-programs (the navigation on the left hand side will include information for several of the managed care programs, including STAR, STAR+PLUS, and STAR Kids).

16. Are there special provisions for out-of-state providers assisting with disaster response?

A. Yes. In accordance with Texas Government Code Title 4, Section 418.016, the Office of the Governor temporarily suspended all necessary statutes and rules to allow health care providers employed by a hospital and licensed in good standing in another state to practice in Texas to assist with the disaster response operations.

Hospitals must submit to the applicable licensing entity each out-of-state provider's name, provider type, state of license and license identification number.

This suspension is in effect until terminated by the Office of the Governor or until the Tropical Depression Harvey disaster declaration is lifted or expires.

E-mail health care provider information (provider's name, provider type, state of license, and license identification number) to: TMBtransition@tmb.state.tx.us

17. A provider has been displaced due to the Hurricane, but is still providing services at an alternate address/shelter, do they need to enroll that location?

A. Providers who have been displaced/evacuated due to the storm, may:
- Update their physical address via the Provider Information Management System (PIMS) located at www.tmhp.com when they have temporarily relocated,
- Enroll as a performing provider within an already enrolled clinic/practice by completing the expedited enrollment process for new emergency enrollees and given a limited term ending 12/31/2017. The application can be found at http://www.tmhp.com/Pages/Topics/Hurricane_Main.aspx; or
- Submit a completed Provider Information Change form (PIC form) to TMHP to permanently change their physical address if they have permanently relocated.
  *** Providers should contact the MCOs they are contracted with to make any updates to their accounts.

20. How will claim submissions and processing be impacted based on response to question directly above?

A. There is no change to standard claims submission and processing procedures. Providers are to follow claim submission and administrative appeal guidelines as outlined in the Texas Medicaid Provider Procedures Manual (TMPPM) also located at www.tmhp.com.

Prescriptions

20. Will MCOs be able to submit pharmacy encounters for claims paid to out of state pharmacies?

A. MCOs should instruct pharmacies to complete the Temporary Pharmacy Agreement Form at https://www.txvendordrug.com/sites/txvendordrug/files/docs/providers/harvey-phcy-enroll.pdf to enroll. Enrollment will be effective retroactive to Aug. 25, 2017, and be valid through Dec. 31, 2017. Once enrolled, VDP will notify MCOs via the master provider file that the provider NPI is enrolled. Once the MCO is notified the NPI is enrolled, encounters can be submitted. This process is valid for instate and out of state providers.

21. Will VDP extend the available drugs beyond the CMS approved list?

A. No, MCOs are only allowed to cover drugs that are included in the Federal Medicaid Drug Rebate Program and not yet on the VDP formulary until approved drugs are available in pharmacies for members with a permanent

residence in a FEMA-declared disaster county. To the extent a pharmacy is unable to stock drugs on the VDP formulary, this approval applies to drugs dispensed from Aug. 25, 2017, until the emergency declaration is rescinded. Once a pharmacy is able to stock approved drugs, this allowance should be lifted. HHS produces a quarterly file that identifies all drug labelers that participate in the Medicaid Drug Rebate Program. The most recent file can be accessed at: https://www.txvendordrug.com/sites/txvendordrug/files/docs/formulary/clinician-administered-drugs/2017-08-labeler.xlsx

22. People often forget their medicines when they evacuate and need an early refill from a pharmacy. In most cases, pharmacists may not dispense more than a 72-hour supply of medication. Is there any way a prescription can be filled sooner?

A. Yes, HHS implemented an emergency procedure for pharmacists to follow if a prescription rejects with an error code "79" ("Refill Too Soon") but only for individuals the pharmacist identifies as affected by Hurricane Harvey. Pharmacy staff should use their professional judgement when filling prescriptions to ensure adherence to state and federal law. HHS guidance on how to fill a prescription earlier may be found here: https://www.txvendordrug.com/hurricane-harvey

Fee-for-service and MCO emergency override procedure is available as of 7 p.m. Central Time on Friday, Aug. 25, and available for claims with service dates of August 24 through October 31 2017.

23. May pharmacists refill Schedule II medications early?

A. Yes, in the event of an emergency, a practitioner may prescribe a controlled substance telephonically and follow up within 7 days with a written prescription. The pertinent citation is as follows:

Texas Controlled Substances Act

Title 6, Section 481.074. Prescriptions.

(b) Except in an emergency as defined by rule of the board or as provided by Subsection (o) or Section 481.075(j) or (m), a person may not dispense or administer a controlled substance listed in Schedule II without a written prescription of a practitioner on an official prescription form or without an electronic prescription that meets the requirements of and is completed by the practitioner in accordance with Section 481.075. In an emergency, a

person may dispense or administer a controlled substance listed in Schedule II on the oral or telephonically communicated prescription of a practitioner. The person who administers or dispenses the substance shall:

(1) if the person is a prescribing practitioner or a pharmacist, promptly comply with Subsection (c); or

(2) if the person is not a prescribing practitioner or a pharmacist, promptly write the oral or telephonically communicated prescription and include in the written record of the prescription the name, address, and Federal Drug Enforcement Administration number issued for prescribing a controlled substance in this state of the prescribing practitioner, all information required to be provided by a practitioner under Section 481.075(e)(1), and all information required to be provided by a dispensing pharmacist under Section 481.075(e)(2).

(c) Not later than the seventh day after the date a prescribing practitioner authorizes an emergency oral or telephonically communicated prescription, the prescribing practitioner shall cause a written or electronic prescription, completed in the manner required by Section 481.075, to be delivered to the dispensing pharmacist at the pharmacy where the prescription was dispensed. A written prescription may be delivered in person or by mail. The envelope of a prescription delivered by mail must be postmarked no later than the seventh day after the date the prescription was authorized. On receipt of a written prescription, the dispensing pharmacy shall file the transcription of the telephonically communicated prescription and the pharmacy copy and shall send information to the board as required by Section 481.075. On receipt of an electronic prescription, the pharmacist shall annotate the electronic prescription record with the original authorization and date of the emergency oral or telephonically communicated prescription.

24. How are Medicaid and CHIP members' refill requirements affected by the Governor's Disaster Declaration?

A. MCOs: Effective Aug. 26, 2017, the Texas Department of Insurance released a Commissioner's Bulletin (# B-0014-17) requires MCOs to provide coverage for up to 90-day supplies of prescription drugs that would be denied or rejected due to an early refill limitation. This bulletin and other TDI guidance related to the Harvey Disaster Response may be found at this link.

B. Pharmacists: Currently, the Board and Texas Medicaid/CHIP are allowing pharmacies to dispense up to 30 days of a prescription drug, other than a

Schedule II drug if an emergency refill is needed. Emergency refills are refills made without the authorization of the prescribing physician (e.g. no refills remaining on prescription). State law does not allow for more than 30 days to be dispensed without a physician's authorization. This notice and additional guidance from the Texas State Board of Pharmacy may be found at this link.

Pharmacists and MCOs are advised to monitor as much as possible guidance from the Texas State Board of Pharmacy, VDP and the Texas Department of Insurance for changes or additions to this guidance.

25. What may a pharmacist do if a prescribed drug is out of stock?

A. Pharmacists must adhere to the Texas State Board of Pharmacy substitution rules. Generally, they may dispense a generically equivalent drug or interchangeable biological product if:

- the generic drug or interchangeable biological product costs the patient less than the prescribed drug product;
- the patient does not refuse the substitution; and
- the practitioner does not certify on the prescription form that a specific prescribed brand is medically necessary as specified in a dispensing directive described in subsection (c) of the Texas State Board of Pharmacy substitution rules.

Nursing Facility Guidance

26. Numerous Medicaid beneficiaries have been evacuated and relocated to new nursing facility.

What are the evacuating facility responsibilities?

A. During an evacuation, the evacuating facility retains responsibility for the care of their evacuated residents. As with past disasters, the evacuating facility will be responsible for payment to the accepting facility [or facilities] for the care of their residents. HHS recommends evacuating facilities establish an agreement with the accepting facilities as soon as feasible regarding housing and care of evacuees, and for reimbursement of services.

B. Monitor the care of their residents for the duration of the event, including the potential re-evacuation of a resident.

C. After residents have returned to the evacuating facility or have been discharged, the evacuating facility must complete all assessments in accordance with federal guidance.

D. Bill the appropriate Medicaid managed care plan.

E. After payment by the managed care plan, the evacuating facility must pay the accepting facility for their resident's care for the duration of his or her residency at the accepting facility, per the payment agreement.

F. Be responsive to the member's managed care plan.

27. What are the accepting facility responsibilities?

A. Communicate regularly with the evacuating facility on the status of their residents.

B. Maintain records, as required, about each resident to be sent when the resident returns to the evacuating facility.

C. Work with the evacuating facility on an informal payment agreement.

D. Support service delivery to residents as though they are your own and in accordance with their indicated care plans that were provided by the evacuating facility.

E. Be responsive to the member's MCO.

28. What are the managed care plan's responsibilities?

A. Track and monitor members that have been evacuated.

B. Provide support to evacuating and accepting facilities, proactively and as needed.

C. The managed care plan service coordinator must work with the evacuating and receiving facility to continue to meet all responsibilities outlined in contract including: addressing identified needs, assisting the member in locating providers of add-on services and referring for any necessary services.

D. Pay the evacuating facility for the services rendered by the accepting facility, even if the accepting facility is out-of-network or a non-Medicaid provider. Be flexible and cooperative with providers so they receive prompt and proper payment for the care delivered by both facilities.

E. Promptly reply to inquiries and complaints from facilities and members or their representatives. Offer dedicated contact information or an e-mail box, if necessary, to facilitate disaster-related communications, even outside of normal business hours.

29. If a nursing facility, assisted living facility, or adult foster care home evacuates its residents to a facility that is not in the network of its contracted Medicaid MCO, will the evacuating facility/home be paid the full rate?

A. Yes. At minimum, the MCO should pay the evacuating facility/home its full, contracted rate for the services rendered by the accepting facility/home; even if the accepting facility/home is out-of-network or a non-Medicaid provider.

30. Will the state reduce the number of forms required during the duration of the disaster?

A. Yes, the following forms are not required from either facility for the duration of this disaster:

- Form 3618 Resident Transaction Notice;
- Form 3619 Medicare/Skilled Nursing Facility Patient Transaction Notice; or
- CFR Section 483.20: The SSA Section 1135 waiver provides relief to Skilled Nursing Facilities on the timeframe requirements for Minimum Data Set assessments and transmission. (Blanket waiver for all impacted facilities)

Visit the following CMS site for additional information and to download their "All Hazards" document: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html

31. What are the Minimum Data Set assessment requirements for NFs in FEMA-declared disaster counties that evacuated their residents and those who received residents?

A. The 1135 waiver does not eliminate the need for assessments, it just gives each facility some relief from penalties for late completion and submission. It is vitally important that each facility conduct MDS assessments as soon as feasible in order to receive payment per the assessed RUG level.

B. If your NF received evacuees from FEMA-declared disaster counties and they were not discharged from the evacuating facility you will not need to complete any assessments. Exception: if it is determined that they will reside in your NF on an extended basis, beyond 30 days or permanently, you should admit the resident(s) and complete the required assessments.

32. Will nursing facilities continue to get paid for their Medicaid residents whose eligibility ends during the disaster?

A. Yes. Nursing facility eligibility at the current Resource Utilization Groups (RUG) level will be extended for 90 days for those residents who would otherwise have an eligibility lapse, or until the MDS is completed as outlined in question #31 under Nursing Facility Guidance. See this FAQ document for additional information.

33. For facilities in FEMA-declared disaster counties, at what RUG rate will they be paid for residents whose MDS assessments and Long-Term Care Medicaid Information (LTCMI) is overdue?

A. During the time period between the MDS expiration date and the submission of a new MDS and LTCMI, evacuating facilities will be paid at the resident's current RUG rate. Overdue MDS assessments must be completed as soon as feasible.

B. If a facility admits new residents, whether from an evacuating facility or other location, the facility must complete admission forms and MDS assessments/LTCMI within required time frames. The RUG rate will be based on the completed assessment.

34. Is there an established process to expedite billing and payments? Are there concerns with payment delays from the MCOs? How will providers receive payments if they are not able to send in documentation for billing?

A. The current requirement for the MCOs to process claims payments is 10 days. Currently, the MCOs are making payments in 6 to 8 business days. At the present time, there are no issues with the SAS files that are being used to determine payments to the NFs.

B. All MCOs provide a web-based portal for claim submission so even if the staff of the NF are not in the actual facility to submit data, claims data can be submitted on any computer. TexMedConnect, provided by TMHP, is also available for all NF claim submissions

35. What are the requirements for submission of forms 3618/3619?

A. A temporary waiver of forms (3618/19) submission was provided to NFs located in FEMA Disaster Declared counties who had to evacuate due to the recent storm.

B. If you are in a facility that has received evacuees in which there was an agreement with the evacuating facility, then you will not be required to complete the forms. Exception: if it is determined that the evacuees will reside in your NF on an extended basis, beyond 30 days or permanently, you should admit the resident(s) and complete the required assessments.

C. According to the CMS All Hazards Health Standards FAQs, (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html) question K-5, evacuating facilities should make a decision by day 15 of the evacuation if they will be able to readmit residents to the home facility within 30 days from the date of the evacuation. If this is not possible then the evacuating facility must complete form 3618/3619, as appropriate, and the discharge assessments for each resident. If the evacuating NF has received an extension past the 30 days from CMS then the extension date applies.

D. For residents who will not be able to return to their evacuating NF, the receiving facility may admit the resident if this is the resident's choice or must work with the resident to offer alternative choices. Once admitted, the receiving facility will need to complete all OBRA Admission assessments along with the necessary 3618/3619 forms, within required time frames. The discharge/admission date should occur within 30-days from the evacuation date.

36. Would Texas be willing to explore the option of an administrative payment (or other solution) to reduce the risk to facilities related to decreased or delayed payments? [Note: the administrative payment would be "repaid" to the state by withholding future payments after facilities submit all their claims for the disaster period].

A. As long as the evacuating NF is able to submit claims, the standard claims process will pay more quickly than the manual administrative payment process for FFS.

B. The Uniform Managed Care Contract 8.1.4.8.4 Advanced Payments reads: MCOs are required to develop a process by which providers may request advanced payments for authorized services that have been delivered. The

MCO will develop an agreement with the provider to determine what portion of funds for claims payments will apply towards the balance of the advanced payments until that balance is reduced to zero. The MCO may not charge the provider interest on the balance of the advanced payments.

- Although the UMCC allows for the NF to request administrative payments from the MCO for their members, HHSC, at this time, feels that this is inadvisable due to it being a manual process which likely would require more time than actual claims payments, thus delaying payments to the NF. Additionally, there is a risk that the NF may receive an overpayment that ultimately must be recouped.

Benefits

37. What is the STAR+PLUS MCO's process for transitioning individuals receiving PDN to STAR+PLUS at age 21 who have not been assessed for STAR+PLUS HCBS or inclusion of nursing in their IDD waiver?

A. The STAR+PLUS MCOs must honor existing PDN authorizations for 90 days or until an assessment and service plan can be finalized. HHSC will reimburse the health plan for PDN services, including for IDD waiver individuals who lost PDN at age 21, through the administrative payment process defined in Section 5400 of the STAR+PLUS handbook. This exception will apply to individuals who meet the following criteria:

1. qualify for Medicaid;

2. turn 21 September 2017 through February 2017; and

3. whose assessment and service planning cannot be completed timely and whose assessment delay is approved by sending an email to the HHSC Transition/High Needs Coordinator at: HHSC_UR_High_Needs_CCR@hhsc.state.tx.us

38. Once the devastating floodwaters recede, there will be a substantial increase of mosquitoes in the affected areas of the state. Do Medicaid, CHIP and other state programs cover mosquito repellant products for the prevention of Zika virus?

A. Yes. Medicaid, CHIP, CHIP-Perinatal, Healthy Texas Women, CSHCN and the Family Planning Program cover mosquito repellent products for pregnant women of any age, women and girls ages 10-55, and men and boys 14 and older.

39. What is the benefit?

A. The benefit began May 1 and ends on Dec. 31, 2017. One can or bottle of mosquito repellent is permitted per pharmacy fill, with 1 refill allowed per month. Mosquito repellent won't count against the monthly 3-prescription limit for those clients with a monthly limit.

40. Is there a website providers can direct members to for information about their MCO, including provider directories and member handbooks?

A. Yes, the "Questions about your Benefits" webpage on the HHS website has information for members, including a link to each of the MCOs serving the different managed care programs (including CHIP, STAR, STAR+PLUS, STAR Kids, STAR Health, and Children's Medicaid Dental Services). These links to MCO webpages will direct members to member handbooks and provider directories. The webpage is located here: https://hhs.texas.gov/services/questions-about-your-benefits

41. How do clients get the repellent?

A. Many pharmacies can provide clients mosquito repellent without a prescription from their doctor. Clients should contact their pharmacy to make sure they are participating in this benefit.

If a pharmacy recommends getting a prescription or if the client is enrolled in CSHCN, they may contact their healthcare provider and ask them to send a prescription to the pharmacy.

Providers can send a prescription to their pharmacy via phone, fax or e-prescription.

If the client receives services from the Family Planning Program, and their healthcare provider offers this benefit, they can pick up mosquito repellent at a participating Family Planning Program clinic.

42. How are the Medicaid/CHIP health plans helping members who have evacuated to shelters?

A. The Texas Health and Human Services Commission (HHSC) has been working closely with the Medicaid and CHIP health plans to help members who have been evacuated because of Hurricane/Tropical Storm Harvey. The health plans are reaching out to members with high needs, members evacuated from nursing facilities and other residential settings, and responding to members' requests for help.

43. How can members find PCPs in new cities?

A. If the member knows their health plan, and has the number available (on the back of the insurance card), call the member services number for assistance.

If the member does not know the name of the health plan, or doesn't have the health plan's number available, contact HHSC to get the member's health plan information at 1-800-964-2777.

Members may also navigate to the MCO's provider directory using this link: https://hhs.texas.gov/services/questions-about-your-benefits

If the member still has questions, please contact the HHSC Office of the Ombudsman at 1-866-566-8989 or 2-1-1, select a language, and then press option 2.

44. How can providers help Medicaid and CHIP health plan members?

A. Providers can follow the instructions listed below on how to coordinate with Medicaid and CHIP members:

- Ask evacuees if they have Medicaid or CHIP.
- If yes, ask if they know the name of their Medicaid or CHIP health plan.
- If they know their health plan, and have the number available (on the back of the insurance card), call the member services number for assistance.
    - To maintain confidentiality, volunteers should contact the health plan together with the evacuee.
- If the evacuee doesn't know the name of the health plan, or doesn't have the health plan's number available, contact HHSC to get the evacuee's health plan information at 1-800-964-2777.
    - To maintain confidentiality, volunteers should contact the managed care helpline together with the evacuee.
- If you still have questions, contact the HHSC Office of the Ombudsman at 1-866-566-8989 or 2-1-1, select a language, and then press option 2.

45. Can an attendant provide services to a member in a Hurricane Harvey Shelter?

A. Yes. Attendants may provide services in a shelter.

Texas Health Steps

46. How should Texas Health Steps providers handle laboratory specimens that must be sent to the Department of State Health Services Laboratory for testing?

A. On Aug. 25, 2017, the DSHS Laboratory issued the following guidance regarding specimen collection and handling in response to Hurricane Harvey.

- Collect all specimens as usual.
- Expect delays from courier and postal services for areas that will be impacted by the hurricane. Hold specimens until shipping and mailing services become available next week.
- Store specimens to ensure they remain at the appropriate temperature until shipping/mailing.
- Freeze serum specimens after collection for glucose, cholesterol/HDL/lipid panel, and HIV/syphilis.
- Refrigerate whole blood specimens for lead and hemoglobin.
- Anticipate loss of power and possible flooding. Prepare a backup storage method, especially for those specimens that require refrigeration and freezing.
- Maintain specimens in a dry location, especially for newborn screening specimens.
- Expect a possible backlog for courier and postal services when they resume.

B. Newborn screenings in response to Hurricane Harvey.

- Collect and dry newborn screens within the appropriate time frames.
- Ensure the parent/guardian contact information will be valid throughout any potential family/baby relocation.

- Ship as soon as possible, preferably within 24 hours after collection.
- Contact courier directly for service information for your area.
- If courier services are interrupted, store the specimens at room temperature in a dry location.
- Do not put specimens in air-tight sealed containers.
- Ensure that newborn screening results are known, documented and discussed with the family/caregiver.
- Facilitate repeat or confirmatory testing, appropriate subspecialty referral and timely intervention if necessary.

Additional information is available on the DSHS Laboratory website: http://www.dshs.texas.gov/lab/default.shtm. Contact the DSHS Laboratory at 512-776-7318 or toll free at 888-963-7111, ext. 7318.

Provider Enrollment

47. Will there be any changes related to HHS's plan to require providers that ordered, referred or prescribed services for Medicaid, CSHCN, and Healthy Texas Women be enrolled in Texas Medicaid?

A. Due to the impact of Hurricane Harvey and pending decisions that may impact the implementation of the Federal Regulation, HHS is delaying the start of this requirement. All medical and pharmacy claims will continue to pay through calendar year 2017 regardless of the ordering, referring, or prescribing provider's Texas Medicaid enrollment status.

HHS will begin enforcing the enrollment requirement in January 2018 for Medicaid, CHIP, CSHCN Services Program and Healthy Texas Women. HHS will provide specific dates and details in the coming weeks.

If possible, ordering, referring, and prescribing providers should begin the enrollment process before January by completing the application online at http://www.tmhp.com/Pages/ProviderEnrollment/PE_TX_Medicaid_New.aspx

Electronic Visit Verification

The following temporary electronic visit verification polices are for provider agencies who were impacted by Hurricane/Tropical Storm Harvey. The provider agency office or individual/member home must be located in a FEMA-declared county.

Visits may be subject to recoupment if it is determined the provider agency or individual/member is not located in a FEMA-declared county.

If a provider agency or individual/member is located in a county that has not be declared a disaster, but was impacted by Hurricane/Tropical Storm Harvey; you must reach out to your payor for approval.

48. Can I complete visit maintenance if it is past the 60-day visit maintenance timeframe?

A. Yes

- Providers affected by Hurricane Harvey will have 90 calendar days from the date of the visit to complete visit maintenance for visits from Aug. 21 through Sept. 30, 2017.
- Providers may allow their attendants to manually document service delivery time for visits from Aug. 21 through Sept. 30, 2017.
- The Provider agency must keep all documentation of service delivery from Aug. 21 through Sept. 30, 2017. If documentation is not provided when requested by payor(s), the visits may be subject to recoupment.
- Service delivery documentation must include the following:
    - Provider Agency Name;
    - HHSC Contract Number or MCO NPI;
    - Individual/Member first and last name;
    - Individual/Member Medicaid ID;
    - Date of the visit;
    - Actual time in and actual time out;
    - Attendant first and last name; and
    - Location of the visit; in the home or in the community.

49. Can I bill a claim before completing visit maintenance?

A. Yes

- Providers may bill visits prior to completing visit maintenance for visits from Aug. 21 through Sept. 30, 2017.
- Providers must still enter visits that occurred from Aug. 21 through Sept. 30, 2017 into the EVV system within 90 days. Providers may use Reason Code 130, Disaster or Emergency, to complete visit maintenance. Providers must enter the time in and time out and add Hurricane Harvey in the free text.

50. If the landline or the small alternative device is not working, can my attendants use their personal cell phone if they are providing services?

A. Yes

- Providers may allow attendants to use personal cell phones for visits from Aug. 21 through Sept. 30, 2017.
- The member's cell phone cannot be used.
- Providers must complete visit maintenance using a new temporary reason code, Reason Code 131: Hurricane -Attendant allowed to use personal cell phone.
- HHSC, EVV vendors, provider agency and payors are not liable for:
  - any cost occurred for using personal cell phones
  - any virus(es) on the attendant's personal cell phone
  - hacked, damaged, lost or stolen cell phones
  - non-working cell phones

51. What reason code do I use if I am affected by Hurricane/Tropical Storm Harvey?

A. Reason Code 130: Disaster or Emergency or Reason Code 131: Hurricane - Attendant allowed to use personal cell phone.

- Reason Code 130: Disaster or Emergency

- is a preferred reason code;
- is selected when an attendant or assigned staff is unable to provide all or part of the scheduled services to an individual/member due to a disaster.
- Free text is required in the comment field; the provider must document the:
  - nature of the disaster; and
  - actual time service delivery begins and ends.

- Reason Code 131: Hurricane - Attendant allowed to use personal cell phone.
  - is a preferred reason code;
  - is selected when an attendant uses a personal cell to call in and call out because of a hurricane.
  - Free text is not required.

52. Are there alternate ways for a consumer directed services (CDS) employer to submit payroll information if he or she does not have access to a fax machine?

A: If a CDS employer does not have access to a fax machine, he or she may submit payroll information using another method compliant with the Health Insurance Portability and Accountability Act (HIPAA). CDS employers also may have 90 days to submit corresponding timesheet records in accordance with program rules.