Section 4: Client Eligibility

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SECTION 4: CLIENT ELIGIBILITY

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4.1 General Medicaid Eligibility

A person may be eligible for medical assistance through Medicaid if the following conditions are met:

- The applicant must be eligible for medical assistance at the time the service is provided. It is not mandatory that the process of determining eligibility be completed at the time service is provided; the client can receive retroactive eligibility. Services or supplies *cannot* be paid under Texas Medicaid if they are provided to a client before the effective date of eligibility for Medicaid or after the effective date of denial of eligibility. Having an application in process for Medicaid eligibility does *not* guarantee the applicant will be eligible.
- The service must be a benefit and determined medically necessary (except for preventive family planning, annual physical exams, and Texas Health Steps [THSteps] medical or dental checkup services) by Texas Medicaid and must be performed by an approved provider of the service.
- Applicants for medical assistance potentially are eligible for Medicaid coverage up to three calendar months before their application for assistance, if they have unpaid or reimbursable Medicaid-covered medical bills and have met all other eligibility criteria during the time the service was provided. The provision also includes deceased individuals when a bona fide agent requests application for services. An application for retroactive eligibility must be filed with the Health and Human Services Commission (HHSC); it is not granted automatically. The applicant must request the prior coverage from an HHSC representative and complete the section of the application about medical bills.

Clients who are not eligible for Medicaid but meet certain income guidelines may receive family planning services through other family planning funding sources. Clients not eligible for Medicaid are referred to a family planning provider. Clients seeking other services may be eligible for state health-care programs, some of which are described in this section.

Refer to: HHSC website at www.healthytexaswomen.org for information about family planning and the locations of family planning clinics that receive HHSC Family Planning Program funding.

4.1.1 Your Texas Benefits Medicaid Card

Clients receive a Your Texas Benefits Medicaid card that can be used to verify the client eligibility for various state-funded programs, including Medicaid.

The front of the card includes the client's name, member ID, the ID of the agency that issued the card, and the date on which the card was sent.

The back of the card provides:

- An eligibility verification contact number. The number can be used to determine:
  - Program eligibility dates.
  - Retroactive eligibility (when applicable).
  - Eligible services (when applicable).
  - Medicaid managed care eligibility.
- An eligibility website address for clients and non-pharmacy providers.
- A non-managed care pharmacy claims assistance contact number.
- The Medicaid Client Hotline contact number.

Client TPR and other insurance information can also be verified using the benefit card.

Refer to: Subsection 4.2, "Eligibility Verification" in this section for additional ways to verify client eligibility.

Your Texas Benefits Medicaid card (English and Spanish) on the TMHP website at www.tmhp.com.

4.1.2 Retroactive Eligibility

Medicaid coverage may be assigned retroactively for a client. For claims for an individual who has been approved for Medicaid coverage but has not been assigned a Medicaid client number, the 95-day filing deadline does not begin until the date the notification of eligibility is received from HHSC and added to the TMHP eligibility file.

The date on which the client's eligibility is added to the TMHP eligibility file is the add date. To ensure the 95-day filing deadline is met, providers must verify eligibility and add date information by calling the Automated Inquiry System (AIS) or using the TMHP Electronic Data Interchange (EDI) electronic eligibility verification.

If a person is not eligible for medical services under Texas Medicaid on the date of service, reimbursement for all care and services provided must be resolved between the provider and the client receiving the services. Providers are not required to accept Medicaid for services provided during the client's retroactive eligibility period and may continue to bill the client for those services. This guideline does not apply to nursing facilities certified by the Department of Aging and Disability Services (DADS).

If it is the provider's practice not to accept Medicaid for services provided during the client's retroactive eligibility period, the provider must apply the policy consistently for all clients who receive retroactive eligibility. Providers must inform the client about their policy before rendering services. If providers accept Medicaid assignment for the services provided during the client's retroactive eligibility period and want to submit a claim for Medicaid-covered services, providers must refund payments received from the client before billing Medicaid for the services.

The provider should also check the eligibility dates electronically through TexMedConnect or the Your Texas Benefits Medicaid website at www.yourtexasbenefitscard.com to see whether the client has retroactive eligibility for previous bills. Retroactive eligibility and the retroactive eligibility period may be verified by visiting www.yourtexasbenefitscard.com. Texas Medicaid considers all services between the Eligibility Date and the Good Through date for reimbursement. Providers can determine whether a client has retroactive eligibility for previous bills by verifying eligibility on www.tmhp.com, transmitting an electronic eligibility request, or calling AIS or the TMHP Contact Center.

Examples of Medicaid identification forms are found at the end of this section. Actual Medicaid forms can be identified by a watermark.

Refer to: Your Texas Benefits Medicaid card (English and Spanish) on the TMHP website at www.tmhp.com.

4.1.3 Expedited Eligibility (Applies to Medicaid-eligible Pregnant Women Throughout the State)

HHSC processes Medicaid applications for pregnant women within 15 business days of receipt. Once eligibility has been certified, a Your Texas Benefits Medicaid card will be issued to verify eligibility and to facilitate provider reimbursement.

4.1.4 Medicaid Buy-In Program for Employed Individuals with Disabilities

The Medicaid Buy-In (MBI) Program allows employed individuals with disabilities to receive Medicaid services by paying a monthly premium. Some MBI participants, based on income requirements, may be determined to have a $0 premium amount and therefore are not required to make a premium payment. Individuals with earnings of less than 250 percent of the federal poverty income limits (FPIL) may be eligible to participate in the program. Applications for the program are accepted through HHSC's regular Medicaid application process.

Participants will receive the Your Texas Benefits Medicaid card. MBI participants in urban service areas will be served through Texas Medicaid fee-for-service.

4.1.5 Newborn Eligibility

A newborn child may be eligible for Medicaid for up to 1 year if:

- The child's mother received Medicaid at the time of the child's birth.
- The child's mother is eligible for Medicaid or would be eligible if pregnant.
- The child resides in Texas.

If the newborn is eligible for Medicaid coverage, providers must not require a deposit for newborn care from the guardian. The hospital or birthing center must report the birth to HHSC Eligibility Services at the time of the child's birth.

If the hospital or birthing center notifies HHSC Eligibility Services that a newborn child was born to a Medicaid-eligible mother, then the hospital caseworker, mother, and attending physician (if identified) should receive a Medicaid Eligibility Verification (Form H1027) from HHSC a few weeks after the child's birth. Form H1027 includes the child's Medicaid identification number and effective date of coverage. After the child has been added to the HHSC eligibility file, a Your Texas Benefits Medicaid card is issued. Newborn clients will receive the Your Texas Benefits Medicaid card approximately two weeks after birth.

Providers can verify eligibility though the Medicaid eligibility verification website at www.yourtexasbenefitscard.com. After the newborn becomes a Medicaid client, the card website shows that client as eligible, even if the card has not been produced yet.

Note: *Claims submitted for services provided to a newborn eligible for Medicaid must be filed using the newborn client's Medicaid number. Claims filed with the mother's Medicaid number cause a delay in reimbursement.*

The Medicaid number on the Medicaid Eligibility Verification (Form H1027) may be used to identify newborns eligible for Medicaid.

Refer to: Your Texas Benefits Medicaid card (English and Spanish) on the TMHP website at www.tmhp.com.

4.1.6 Potential Supplemental Security Income (SSI)/Medicaid Eligibility for Premature Infants

The Supplemental Security Income (SSI) program includes financial and Medicaid benefits for people who are disabled. When determining eligibility for SSI, the Social Security Administration (SSA) must establish that the person meets financial and disability criteria. When determining financial eligibility for a newborn child, SSA does not consider the income and resources of the child's parents until the month following the month the child leaves the hospital and begins living with the parents. Determinations of disability are made by the state's Disability Determination Services and may take several months. Federal regulations state that infants with birth weights less than 1,200 grams are considered to meet the SSI disability criteria.

The SSA issued a policy to local SSA offices to make presumptive SSI disability decisions and payments for these children, making it possible for a child to receive SSI and Medicaid benefits while waiting for a final disability determination to be made by Disability Determination Services. The child's parent or legal guardian must file an SSI application with the SSA. It is in the child's best interest that the application with the SSA be filed as soon as possible after birth. The SSA accepts a birth certificate with the child's birth weight or a hospital medical summary as evidence for the presumptive disability decision.

Providers should not change their current newborn referral procedures to HHSC for children who are born to mothers who are eligible for Medicaid as described in this section. However, providers are encouraged to refer parents and guardians of low birth weight newborns to the local SSA office for an SSI application.

4.1.7 Foster Care

Most children in the state of Texas foster care program are automatically eligible for Medicaid.

Extended health-care coverage is also available for some former foster care youth clients enrolled in an institution of higher education through the Former Foster Children in Higher Education (FFCHE) program.

To ensure that these children have access to the necessary health-care services for which they are eligible, providers can accept the Medicaid Eligibility Verification (Form H1027) as evidence of Medicaid eligibility. Although this form may not list the client's Medicaid identification number, it is an official state document that establishes Medicaid eligibility.

Providers should honor the Medicaid Eligibility Verification (Form H1027) as proof of Medicaid eligibility and must bill Texas Medicaid as soon as a Medicaid ID number is assigned. Medicaid ID numbers will be assigned approximately one month from the issue date of the Medicaid Eligibility Verification (Form H1027). The form includes a Department of Family and Protective Services (DFPS) client number that provides an additional means of identification and tracking for children in foster care.

Note: *The DFPS client number is accepted by Medicaid Vendor Drug Program (VDP)-enrolled pharmacies to obtain outpatient prescribed drug benefits. VDP pharmacies must submit subsequent pharmacy claims with the Medicaid ID number after it has been assigned.*

Reminder: *Adoption agencies/foster parents are not considered third party resources (TPRs). Medicaid is primary in these circumstances.*

4.1.8 Former Foster Care

Texas Health and Human Services Commission (HHSC) provides Medicaid health-care coverage to former foster care youth who:

- Are 18 through 25 years of age.
- Were in Texas foster care on their 18th birthday or older and were receiving Medicaid when they aged out of Texas foster care.
- Are U.S. citizens or have a qualified alien status (i.e., green card).

4.1.9 Medicaid Managed Care Eligibility

All clients who are determined to be eligible for Texas Medicaid are first enrolled as fee-for-service clients. Specific client groups within the Texas Medicaid population are eligible for managed care based on criteria such as age, location, and need. A client who is determined to be eligible for Medicaid managed care is enrolled in the appropriate managed care organization (MCO) or dental plan with a separate eligibility date. In most cases, Medicaid managed care enrollment is not retroactive.

Refer to: The *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for more information about managed care eligibility and enrollment.

4.2 Eligibility Verification

To verify a client's Texas Medicaid eligibility, use the following options:

- Verify electronically through TMHP EDI. Providers may inquire about a client's eligibility by electronically submitting one of the following for each client:

  - Medicaid or Children with Special Health Care Needs (CSHCN) Services Program identification number.
  - One of the following combinations: Social Security number and last name; Social Security number and date of birth; or last name, first name, and date of birth. Providers can narrow the search by entering the client's county code or sex.
- Submit electronic verifications in batches limited to 5,000 inquiries per transmission.
- Verify the client's Medicaid eligibility using the Medicaid Eligibility Verification (Form H1027) or by accessing the Your Texas Benefits Medicaid website at www.yourtexasbenefitscard.com.
- Contact the TMHP Contact Center or AIS at 1-800-925-9126 or 1-512-335-5986.
- Submit a hard-copy list of clients to TMHP. This service is only used for clients with eligibility that is *difficult* to verify. A charge of $15 per hour plus $0.20 per page, payable to TMHP, applies to this eligibility verification. The list includes names, gender, and dates of birth if the Social Security and Medicaid ID numbers are unavailable. TMHP can check the client's eligibility manually, verify eligibility, and provide the Medicaid ID numbers. Mail the lists to the following address:

  Texas Medicaid & Healthcare Partnership Contact Center
  12357-A Riata Trace Parkway
  Suite 100
  Austin, TX 78727

  Note: *Providers can obtain client eligibility information for a client who is enrolled in a Medicaid managed care organization (MCO) from the MCO's web page. Providers can also check the MCO's web page for submission of electronic claims, prior authorization requests, claim appeals and reconsiderations, exchange of clinical data, and other documentation necessary for prior authorization and claim processing.*

4.2.1 Advantages of Electronic Eligibility Transactions

Eligibility transactions through TexMedConnect or EDI have the following advantages:

- Submissions are available 24-hours a day 7 days a week.
- Submission of EDI batches of 5000 per transmission.
- Submission of client group lists through TexMedConnect. Providers can create lists of clients to verify eligibility. Each client group can contain up to 250 clients, providers can create up to 100 groups for each National Provider Identifier (NPI).

Electronic eligibility responses contain:

- Restrictions applicable to the client's eligibility such as lock-in, emergency, or womens health.
- Medicare eligibility and effective dates, including Part A, B, and C.
- Complete other insurance information, including name and address, and effective dates. EDI transactions also indicate the patient relationship to policy holder.

4.2.2 Contract with Outside Parties

The *State Medicaid Manual*, Chapter 2, "State Organization," (Section 2080.18) allows states to contract with outside agents to confirm for providers the eligibility of a Medicaid client. Medicaid providers may contract with these agents for eligibility verification with a cost to the provider. The provider remains responsible for adhering to the claims filing instructions in this manual. The provider, not the agent, is responsible for meeting the 95-day filing deadline and other claims submission criteria.

4.3 Medicaid Identification and Verification

Providers are responsible for requesting and verifying current eligibility information from clients by using the methods listed in subsection 4.2, "Eligibility Verification" in this section or by asking clients to produce their Your Texas Benefits Medicaid card or Medicaid Identification form (H1027).

Providers may verify client eligibility electronically through TexMedConnect or through the Medicaid eligibility verification website at www.yourtexasbenefitscard.com from which website providers can print a copy of a client's proof of eligibility.

Providers must accept either of these forms as valid proof of eligibility. Providers should retain a copy for their records to ensure the client is eligible for Medicaid when the services are provided. Clients should share eligibility information with their providers.

Providers should request additional identification if they are unsure whether the person presenting the form is the person identified on the form.

Providers should check the Eligibility Date to see whether the client has possible retroactive eligibility for previous bills.

Only those clients listed on the Medicaid Eligibility form or the Your Texas Benefits Medicaid card are eligible for Medicaid. If a person insists he or she is eligible for Medicaid but cannot produce a current Your Texas Benefits Medicaid card or Medicaid Eligibility Verification (Form H1027), has lost it, or has forgotten to bring it to the appointment, providers can verify eligibility through the methods listed in subsection 4.2, "Eligibility Verification" in this section. Providers must document this verification in their records and treat these clients as if they had presented a Your Texas Benefits Medicaid card or Medicaid Eligibility Verification (Form H1027).

When a client's Your Texas Benefits Medicaid card has been lost or stolen, HHSC issues a temporary Medicaid verification Form H1027. The following is a sample of forms:

- *Form H1027-A*. Medicaid eligibility verification is used to indicate eligibility for clients who receive regular Medicaid coverage.
- *Form H1027-B*. Medicaid Qualified Medicare Beneficiary (MQMB) is issued to clients eligible for MQMB coverage.
- *Form H1027-C*. Qualified Medicare Beneficiary (QMB) is issued to clients who are eligible for QMB coverage only.
- *Form H1027-F*. Temporary Medicaid identification for clients receiving Former Foster Care in Higher Education (FFCHE) health care.

Refer to: Subsection 4.10.1, "QMB/MQMB Identification" in this section.

The Medicaid Eligibility Verification (Form H1027) is acceptable as evidence of eligibility during the eligibility period specified unless the form contains limitations that affect the eligibility for the intended service. Providers must accept any of the documents listed above as valid proof of eligibility. If the client is not eligible for medical assistance or certain benefits, the client is treated as a private-pay patient.

Refer to: Subsection 4.2, "Eligibility Verification" in this section.

Providers must review limitations identified on the Medicaid electronic eligibility file, AIS, the Your Texas Benefits Medicaid website at www.yourtexasbenefitscard.com, or the Medicaid Eligibility Verification (Form H1027). Clients may be required to use a designated primary provider or pharmacy. QMB clients will be limited to Medicaid coverage of the Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare coinsurance or deductible according to current payment guidelines.

If the client is identified as eligible and no other limitations of eligibility affect the intended service, proceed with the service. Eligibility during a previous month does not guarantee eligibility for the current month. The Medicaid Eligibility Verification (Form H1027) and the Your Texas Benefits Medicaid card are the only documents that are honored as verification of Medicaid eligibility.

Refer to: "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*) for TPL information.

In accordance with current federal policy, Texas Medicaid and Texas Medicaid clients cannot be charged for the client's failure to keep an appointment. Only claims for services provided are considered for payment. Clients may not be billed for the completion of a claim form, even if it is a provider's office policy.

4.4 Restricted Medicaid Coverage

The following sections are about limitations that may appear on the Your Texas Benefits Medicaid card, indicating that the client's eligibility is restricted to specific services. Unless "LIMITED" appears on the form, the client is not locked into a single provider.

4.4.1 Emergency Only

The word "EMERGENCY" on the form indicates the client is restricted to coverage for an emergency medical condition. "Emergency medical condition" is defined in subsection 4.4.2.2, "Exceptions to Lock-in Status" in this section.

Certification for emergency Medicaid occurs after the services have been provided. The coverage is retroactive and limited to the specific dates that the client was treated for the emergency medical condition.

Clients limited to emergency medical care are not eligible for family planning, THSteps, or Comprehensive Care Program (CCP) benefits. Only services directly related to the emergency or life-threatening situations are covered.

Undocumented aliens and aliens with a nonqualifying entry status are identified for emergency Medicaid eligibility by the classification of type programs (TPs) 30, 31, 32, 33, 34, 35, and 36. Under Texas Medicaid, undocumented aliens are only eligible for emergency medical services, including emergency labor and delivery.

Any service provided after the emergency medical condition is stabilized is not a benefit.

If a client is not eligible for Medicaid and is seeking family planning services, providers may refer the client to one of the clinics listed on the HHSC website at www.healthytexaswomen.org.

4.4.2 Client Lock-in Program

Texas Medicaid fee-for-service clients can be required to use a designated primary care provider and/or a primary care pharmacy.

The client is assigned to a designated provider for access to medical benefits and services when one of the following conditions exists:

- The client received duplicative, excessive, contraindicated, or conflicting health-care services, including drugs.
- A review indicates abuse, misuse, or fraudulent actions related to Medicaid benefits and services.

After analysis through the neural network component of the Medicaid Fraud and Abuse Detection System (MFADS), qualified medical personnel validate the initial identification and determine candidates for lock-in status. The validation process includes consideration of medical necessity. For the lock-in status designation, medical necessity is defined as the need for medical services to the amount and frequency established by accepted standards of medical practice for the preservation of health, life, and the prevention of more impairments.

Except for specialist consultations, services rendered to a client by more than one provider for the same or similar condition during the same time frame may not be considered medically necessary.

4.4.2.1 Lock-in Medicaid Identification

Clients with lock-in status receive the Your Texas Benefits Medicaid card with "Lock-in" printed on the card. The designated provider and pharmacy names are printed on the card under the word "Lock-in."

When a Texas Medicaid fee-for-service client in the Lock-in Program attempts to obtain nonemergency services from someone other than their designated lock-in primary care provider, the provider must do one of the following:

- Verify the lock-in status online on the TMHP website or by calling AIS or the TMHP Contact Center at 1-800-925-9126.
- Attempt to contact the client's designated lock-in primary care provider for a referral. If the provider is unable to obtain a referral, the provider must inform clients that they are financially responsible for the services.

4.4.2.2 Exceptions to Lock-in Status

Lock-in clients may go to any provider for the following services or items:

- Ambulance services
- Anesthesia
- Annual well-woman checkup
- Assistant surgery
- Case management services
- Chiropractic services
- Counseling services provided by a chemical dependency treatment facility
- Eye exams for refractive errors
- Eyeglasses
- Family planning services (regardless of place of service [POS])
- Genetic services
- Hearing aids
- Home health services
- Laboratory services (including interpretations)
- Licensed clinical social worker (LCSW) services
- Licensed professional counselor (LPC) services
- Mental health rehabilitation services
- Intellectual disability/related condition assessment performed by an intellectual or developmental disability (IDD) provider
- Nursing facility services
- Primary home care
- Psychiatric services
- Radiology services (including interpretations)
- School Health and Related Services (SHARS)

- Comprehensive Care Program (CCP)
- THSteps medical and dental services

For referrals or questions, contact:

HHSC
Office of Inspector General
Lock-in Program - MC 1323
PO Box 85200
Austin, TX 78708
1-800-436-6184

If an emergency medical condition occurs, the lock-in restriction does not apply. The term emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the client's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Important: *A provider who sends in an appeal because a claim was denied with explanation of benefits (EOB) 00066 must include the performing provider identifier, not just a name or group provider identifier. Appeals without a performing provider identifier are denied. The NPI of the designated provider must be entered in the appropriate paper or equivalent electronic field for nonemergency inpatient and outpatient claims to be considered for reimbursement.*

Note: *Only when the designated provider or designated provider representative has given permission for the client to receive nonemergency inpatient and/or outpatient services, including those provided in an emergency room, can the facility use the designated provider's NPI for billing.*

4.4.2.3 Selection of Designated Provider and Pharmacy

Texas Medicaid fee-for-service clients identified for lock-in status can participate in the selection of one primary care provider, primary care pharmacy, or both from a list of participating Medicaid providers. Eligible providers cannot be under administrative action, sanction, or investigation. In general, the designated primary care provider's specialty is general practice, family practice, or internal medicine. Other specialty providers may be selected on a case-by-case basis. Primary care providers can include, but are not limited to the following:

- A physician
- Physician assistant
- Physician group
- Advanced practice nurse
- Outpatient clinic
- Rural health clinic (RHC)
- Federally qualified health center (FQHC)

If the client does not select a primary care provider or primary care pharmacy, HHSC selects one for the client.

When a candidate for the designated provider is determined, HHSC contacts the provider by letter. The designated provider receives a confirmation letter from HHSC that verifies the name of the client confirming the name of the client, primary care provider or primary care pharmacy, and the effective date of the lock-in arrangement.

4.4.2.4 Pharmacy services

The primary care pharmacy helps the Lock-in Program ensure that prescriptions that are filled for clients with lock-in status are written either by the primary care provider or other health-care providers to whom the primary care provider has referred the client. HHSC has identified by therapeutic class those medications that require additional monitoring. When a medication that requires additional monitoring is prescribed by an emergency room provider, the primary care pharmacy may be reimbursed for dispensing up to 72 hours or three business days of the prescribed dosage, which allows for holidays and weekends. The primary care pharmacy may dispense the remainder of the medication after receiving approval by the primary care provider or the other providers that HHSC deems to be appropriate.

Some circumstances allow a client to be approved to receive medications from a pharmacy other than the primary care pharmacy. A pharmacy override occurs when the Lock-in Program approves an individual client's request to obtain medication at an alternate pharmacy other than the lock-in pharmacy. The Lock-in Program is notified when the client or pharmacist calls the HHSC-OIG Hotline telephone number at 1-800-436-6184 to request a pharmacy override.

The Lock-in Program staff refers the client to the notification letter titled "What You Need to Know About the Lock-in Program," which was sent at initial lock-in. This letter explains the pharmacy override process. The client is instructed to have the alternate pharmacy call the Lock-in Program to request the override.

The following are allowable circumstances for pharmacy override approval:

- The recipient moved out of the geographical area (more than 15 miles from the lock-in pharmacy).
- The lock-in pharmacy does not have the prescribed medication, and the medication will remain unavailable for more than two to three days.
- The lock-in pharmacy is closed for the day, and the recipient needs the medication urgently.
- The lock-in pharmacy does not carry the medication and is either unable to order it or unwilling to stock it.
- The lock-in pharmacy no longer wants to be the designated pharmacy for a particular lock-in client.
- The client has valid complaints against the lock-in pharmacy or its staff.

For questions about pharmacy services for clients that are locked into a primary care pharmacy, contact the Lock-in Program by calling the HHSC OIG Hotline at 1-800-436-6184.

4.4.2.5 Duration of Lock-in Status

The Lock-in Program duration of lock-in status is the following:

- Initial lock-in status period–minimum of 36 months.
- Second lock-in status period–additional 60 months.
- Third lock-in status period–will be for the duration of eligibility and all subsequent periods of eligibility.
- Clients who have been arrested for, indicted for, convicted of, or admitted to a crime that is related to Medicaid fraud will be assigned lock-in status for the duration of eligibility and subsequent periods of eligibility.

HHSC uses the same time frames for clients with a lock-in status as noted by the word "LIMITED" on the Your Texas Benefits Medicaid card.

Clients are removed from lock-in status at the end of the specified limitation period if their use of medical services no longer meets the criteria for lock-in status. A medical review also may be initiated at the client's or provider's request. Clients or providers can reach the Lock-in Program by calling the HHSC OIG Hotline at 1-800-436-6184 to request this review.

Providers may request to no longer serve as a client's designated provider at any time during the lock-in period by contacting the Lock-in Program by calling the HHSC OIG Hotline at 1-800-436-6184. Providers are asked to serve or refer the client until another arrangement is made. New arrangements are made as quickly as possible.

4.4.2.6 Referral to Other Providers

Texas Medicaid fee-for-service clients with a lock-in status may be referred by their designated provider to other providers. For the referred provider to be paid, the provider identifier of the referring designated provider must be in the referring provider field of the claim form. Claims submitted electronically must have the NPI of the referring designated provider in the Referring Provider Field. Providers must consult with their vendor for the location of this field in the electronic claims format.

Refer to: Subsection 6.2, "TMHP Electronic Claims Submission" in "Section 6: Claims Filing" (*Vol. 1, General Information*)

4.4.2.7 Hospital Services

An inpatient hospital claim for a lock-in Medicaid fee-for-service client is considered for reimbursement if the client meets Medicaid eligibility and admission criteria. Hospital admitting personnel are asked to check the name of the designated provider for the client that is noted on the Your Texas Benefits Medicaid website at www.yourtexasbenefitscard.com and inform the admitting physician of the designated provider's name if the two are different.

Provider claims for nonemergency inpatient services for lock-in Texas Medicaid fee-for-service clients are considered for payment *only* when the designated provider identifier appears on the claim form as the billing, performing, or referring physician.

Providers can get information about claim reimbursement for lock-in clients by calling the TMHP Contact Center at 1-800-925-9126.

4.4.2.8 Lock-in Status Claims Payment

Payment for services to a lock-in Medicaid client is made to the designated provider only, unless the services result from a designated provider referral or emergency. An automated review process determines if the claim includes the lock-in primary care provider's provider identifier as the billing, performing, or referring provider. If the lock-in primary care provider's provider identifier is not indicated on the claim, the claim is not paid. Exceptions to this rule include emergency care and services that are included in subsection 4.4.2.2, "Exceptions to Lock-in Status" in this section. Appeals for denied claims are submitted to TMHP and must include the designated Medicaid provider identifier for reimbursement consideration.

Claims for provider services for Texas Medicaid fee-for-service clients must include the provider identifier for the designated primary care provider as the billing or performing provider or a referral number in the prior authorization number (PAN) field.

4.4.3 Hospice Program

DADS manages the Hospice Program through provider enrollment contracts with hospice agencies. These agencies must be licensed by the state and Medicare-certified as hospice agencies. Coverage of services follows the amount, duration, and scope of services specified in the Medicare Hospice Program. Hospice pays for services related to the treatment of the client's terminal illness and for certain physician services (not the treatments).

Medicaid Hospice provides palliative care to all Medicaid-eligible clients (no age restriction) who sign statements electing hospice services and are certified by physicians to have six months or less to live if their terminal illnesses run their normal courses. Hospice care includes medical and support services designed to keep clients comfortable and without pain during the last weeks and months before death.

Texas Medicaid clients who are 21 years of age and older and who elect hospice coverage waive their rights to all other Medicaid services related to their terminal illness. They do not waive their rights to Medicaid services that are unrelated to their terminal illness.

Texas Medicaid clients who are 20 years of age and younger and who elect hospice care are not required to waive their rights to concurrent hospice care and treatment of the terminal illness. They do not waive their rights to Medicaid services that are unrelated to their terminal illness.

Medicare and Medicaid clients must elect both the Medicare and Medicaid Hospice programs.

Concurrent hospice care and treatment services include:

- Services related or unrelated to the client's terminal illness
- Hospice care (palliative care and medical and support services related to the terminal illness.

Direct policy questions about the hospice program to DADS at 1-512-438-3519. Direct all other general questions related to the hospice program, such as billing, claims, rate key issues, and authorizations to DADS at 1-512-438-2200.

DADS pays the provider for a variety of services under a per diem rate for any particular hospice day in one of the following categories:

- Routine home care
- Continuous home care
- Respite care
- Inpatient care

4.4.3.1 Hospice Medicaid Identification

Individuals who elect hospice care are issued a Your Texas Benefits Medicaid card. Hospice status may be verified by visiting the Your Texas Benefits Medicaid website at www.yourtexasbenefitscard.com. Clients may cancel their election at any time.

4.4.3.2 Physician Oversight Services

Physician oversight is defined as "physician supervision of clients under the care of home health agencies or hospices that require complex or multidisciplinary care modalities." These modalities involve regular physician client status review of related laboratory and other studies, communication with other health professionals involved in patient care, integration of new information into medical treatment plans, and adjustment of medical therapy. Medicaid hospice does not reimburse for physician oversight services.

4.4.3.3 Medicaid Services Unrelated to the Terminal Illness

When services are unrelated to the Medicaid Hospice client's terminal illness, Medicaid (TMHP) pays its providers directly. Providers of services that are unrelated to the terminal illness are required to follow Medicaid prior authorization and claims filing deadlines.

Refer to: "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for more information about prior authorizations for Medicaid hospice clients.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for more information about filing claims for Medicaid Hospice Clients.

4.4.4 Presumptive Eligibility

Presumptive eligibility allows qualified hospitals and entities to determine whether an individual can get short-term Medicaid. Clients who have PE receive immediate, short-term Medicaid eligibility while their regular Medicaid application is processed. PE eligibility categories receive full coverage with the exception of pregnant women who receive ambulatory care services only.

4.4.4.1 PE Medicaid Identification

"PE" on a Your Texas Benefits Medicaid card indicates that a client has presumptive eligibility. PE clients may be identified by visiting the Your Texas Benefits Medicaid website at www.yourtexasbenefitscard.com. An individual who is certified for Presumptive Eligibility receives the regular Your Texas Benefits Medicaid card.

4.4.4.2 Services

Presumptive eligibility provides full coverage for all PE types of assistance with the exception of pregnant women. Pregnant women only receive ambulatory care services. Labor, delivery, inpatient services, and THSteps medical are not covered during the PE period for pregnant women. If the woman is determined to be eligible for regular Medicaid for the same period of time, regular Medicaid coverage overlays the PE period and provides a full range of services. Client eligibility for PE coverage must be determined by a qualified hospital or qualified entity. Once eligibility has been determined, services may be obtained from any enrolled Medicaid provider. The claims filing procedures for clients who have PE are the same as those for all other Medicaid clients.

There are five client type programs that provide full Medicaid coverage through presumptive eligibility. Services reimbursed under the presumptive eligibility process are fee-for-service only.

The following client type programs are eligible for presumptive eligibility:

- 74—Children under 1 year of age presumptive
- 75—Children 1–5 years of age presumptive
- 76—Children 6–18 years of age presumptive
- 83—Former Foster Care Children presumptive
- 86—Parents and caretaker relatives presumptive
- 42—Pregnant women presumptive

The length of coverage depends on several factors:

- If the individual submits an application for regular Medicaid, the PE Medicaid coverage ends the date the state makes a determination for regular Medicaid.
- If the individual does not submit an application for regular Medicaid, the PE coverage ends the last day of the month following the PE determination.

4.4.4.3 Qualified Provider Enrollment

To make PE determinations, the provider must be a qualified hospital or qualified entity. A qualified hospital:

- Is a Medicaid provider.
- Notifies HHSC of its intent to make presumptive eligibility determinations.

- Agrees to make presumptive eligibility determinations according to HHSC policies and procedures.
- Can make presumptive eligibility determinations for pregnant women, children, former foster care children, and parents and other caretakers.
- Helps individuals complete and submit online applications for regular Medicaid.
- Helps individuals understand which documents to send to the state to determine whether they qualify for regular Medicaid.
- Has not been disqualified.

A qualified entity meets the same criteria as a qualified hospital, except that a qualified entity:

- Can be a hospital, clinic, school, or other entity.
- May only make presumptive eligibility determinations for pregnant women.

For more information on how to become a qualified hospital or entity, visit www.TexasPresumptiveEligibility.com.

4.4.4.4 * Process

Qualified hospital or entity staff determine eligibility for PE coverage based on the client's statement of residency, income, household composition, citizenship or immigration status, and pregnancy (for Pregnant Women Presumptive). The client is certified for PE if their statement indicates that they meet Medicaid eligibility criteria.

If the client chooses to apply for regular Medicaid, qualified hospital or entity staff assist the client in completing the application. The application is then forwarded to HHSC to determine the client's eligibility for regular Medicaid.

The period of PE begins on the date the qualified hospital or entity makes the determination and ends when HHSC makes the final Medicaid determination.

4.5 CHIP Perinatal Program

The Children's Health Insurance Program (CHIP) Perinatal Program provides CHIP perinatal benefits for 12 months to the unborn children of non-Medicaid-eligible women. This program allows pregnant women who are ineligible for Medicaid because of income or immigration status to receive prenatal care and provides CHIP benefits to the child upon delivery for the duration of the coverage period. Continuous Medicaid coverage for 12 months is provided from birth to CHIP Perinatal newborns whose mothers received Emergency Medicaid for the labor and delivery. The 12 months of continuous Medicaid coverage for the newborn is available only if the mother received Medicaid for labor and delivery.

4.5.1 Program Benefits

CHIP Perinatal benefits are provided by select CHIP health plans throughout the state. Benefits for the unborn child include:

- Up to 20 prenatal visits:
  - First 28 weeks of pregnancy—one visit every four weeks.
  - From 28 to 36 weeks of pregnancy—one visit every two to three weeks.
  - From 36 weeks to delivery—one visit per week.
  - Additional prenatal visits are allowed if they are medically necessary.
- Pharmacy services, limited laboratory testing, assessments, planning services, education, and counseling.

- Prescription drug coverage based on the current CHIP formulary.
- Hospital facility charges and professional services charges related to the delivery. Preterm labor that does not result in a birth and false labor are not covered benefits.

Program benefits after the child is born include:

- Two postpartum visits for the mother.
- Medicaid benefits for the newborn.

4.5.2 Claims

Providers who serve CHIP Perinatal clients must follow the claims filing guidelines in subsection 6.19.1, "CHIP Perinatal Newborn Transfer Hospital Claims" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

4.5.3 Client Eligibility Verification

The *State Medicaid Manual*, Chapter 2, "State Organization," (Section 2080.18) allows states to contract with outside agents to confirm for providers the eligibility of a Medicaid client. Medicaid providers may contract with these agents for eligibility verification with a cost to the provider. The provider remains responsible for adhering to the claims filing instructions in this manual. The provider, not the agent, is responsible for meeting the 95-day filing deadline and other claims submission criteria.

A number is issued for the baby based on the submission of the Emergency Medical Services Certification Form H3038 or CHIP Perinatal - Emergency Medical Services Certification, Form H3038P for the mother's labor with delivery.

Establishing Medicaid for the newborn requires the submission of the Emergency Medical Services Certification Form H3038 or CHIP Perinatal - Emergency Medical Services Certification, Form H3038P for the mother's labor with delivery. If Form H3038 or H3038P is not submitted, Medicaid cannot be established for the newborn from the date of birth for 12 continuous months of Medicaid coverage. Once enrolled, clients are identified as type program (TP) 36 for the mother and TP 45 for the newborn.

Establishing Medicaid (and issuance of a Medicaid number) can take up to 45 days after Form H3038 or H3038P is submitted. Medicaid eligibility for the mother and infant can be verified using the online lookup on the TMHP website at www.tmhp.com or by calling AIS at 1-800-925-9126.

For clients enrolled in the CHIP Program, the CHIP health plan assigns a client ID to be used for billing. Providers should contact the CHIP health plan for billing information.

Newborns whose mother received Medicaid including emergency Medicaid are eligible to receive Medicaid benefits beginning at the date of birth and will not be assigned a client ID from the CHIP health plan.

HHSC requires the expectant mother's provider to fill out the Emergency Medical Services Certification (Form H3038 or H3038P).

The expectant mother will receive this form from HHSC before her due date, along with a letter reminding her to send information about the birth of her child after delivery. The letter will instruct the expectant mother to take the form to her provider, have the provider fill out the form, then mail the form back to HHSC in a preaddressed, postage-paid envelope. In many cases this activity will occur after delivery when the mother is being discharged from the hospital.

Once HHSC receives the completed Emergency Medical Services Certification (Form H3038 or H3038P), Emergency Medicaid coverage will be added for the mother for the period of time identified by the health care provider. The Emergency Medical Services Certification (Form H3038 or H3038P) is the same form currently required to complete Emergency Medicaid certification.

The CHIP perinatal mother whose income is at or below pregnant women's Medicaid FPIL will not be required to fill out a new application or provide new supporting documentation to apply for Emergency Medicaid. HHSC will determine the woman's eligibility for Emergency Medicaid by using income and other information the mother to-be provided when she was determined to be eligible for CHIP perinatal coverage, as well as information included on the Emergency Medical Services Certification (Form H3038 or H3038P).

If a woman fails to return the completed Emergency Medical Services Certification (Form H3038 or H3038P) within a month after her due date, HHSC will send her another Emergency Medical Services Certification Form H3038 or H3038P with a postage-paid envelope. If the woman fails to submit Emergency Medical Services Certification (Form H3038 or H3038P), and the hospital cannot locate a Type Program 36 for her in the TMHP online provider lookup tool, then the hospital can bill her for facility fees incurred during her stay.

4.5.3.1 Confirming Receipt of Form H3038 or H3038P

Providers who would like to confirm receipt of form H3038 or H3038P can contact MAXIMUS at 1-877-KIDS-NOW (1-877-543-7669), prompt #6 (for reporting changes) after 48 hours from fax submission. If the submission is by regular mail, providers should allow five business days before contacting MAXIMUS. When calling this number, providers should be prepared to provide the following information:

- National Provider Identifier (NPI)
- Provider name
- Name of person calling
- CHIP perinatal case number (Without the case number, MAXIMUS cannot provide confirmation of receipt. Confirmation of receipt cannot be provided based on client name or address.)

Each form H3038 or H3038P should be faxed one at a time, rather than in a batch. It is important that the form be filled out completely and accurately. If the form is not filled out accurately, it will delay processing and MAXIMUS may not be able to confirm receipt after 48 hours from fax submission.

4.5.3.2 Eligibility Verification for Clients Without a Medicaid ID

Providers should first attempt to verify if a Medicaid number has been issued by calling TMHP at 1-800-925-9126 and using the prompt for AIS or speaking to a representative. Providers can also use TexMedConnect to check client eligibility. If a provider is unable to locate a Medicaid number for the mother or infant 45 days after form H3038 or H3038P was faxed, the provider can contact the HHSC Central Processing Center (CPC) in one of the following ways:

- By email at CPC@hhsc.state.tx.us
- By telephone at 1-866-291-1258

CPC needs the following information to respond to requests or inquiries. Providers should submit the information only once. All submissions must be sent in a secure manner. If there are multiple inquiries that are over 45 days, providers can submit them together.

Required information includes the following:

- CHIP perinatal case number
- Mother's name as it appears on her CHIP Perinatal card
- Dates of service
- Date Form H3038 or H3038P was faxed to MAXIMUS
- Baby's first and last name

- Baby's date of birth
- Name and telephone number of the person completing the request

CPC will research inquiries and respond to the provider within 10 business days. This time frame is an approximation and may only apply if all information, including complete contact information, is provided and fewer than 25 names were submitted.

4.5.3.3 Mother's eligibility

For mothers who currently receive CHIP perinatal and have an income at or below the pregnant women's Medicaid FPIL, and who receive Emergency Medicaid coverage, providers can check eligibility by performing an eligibility verification on the TMHP website at www.tmhp.com or by calling the TMHP AIS at 1-800-925-9126.

4.5.3.4 Newborn's eligibility

For CHIP Perinatal newborns with a family income at or below pregnant women's Medicaid limits FPIL, providers can obtain eligibility information and the newborn's PCN by performing an eligibility verification on the TMHP website or by calling the TMHP Contact Center at 1-800-925-9126.

TMHP cannot provide CHIP Perinatal Program eligibility information for the newborn or mother, regardless of the client's income level. For CHIP Perinatal Program eligibility information, contact the CHIP health plan.

A report of birth remains an important step to ensure timely Medicaid eligibility for the newborn. A birth must be reported to the state through the typical birth registry process (e.g., use of Texas Electronic Registration system [TER]). In TER, the screen containing the Medicaid/CHIP number should continue to be populated with the mother's alpha-numeric CHIP Perinatal Program number (e.g., J12345678). In addition, a mother can report the birth by calling 1-877-KIDS-NOW (1-877-543-7669).

4.5.4 Submission of Birth Information to Texas Vital Statistics Unit

Hospital providers must submit birth registry information to the DSHS Vital Statistics Unit in a timely manner. Once received by the Vital Statistics Unit, birth information is transmitted to the state's eligibility systems, so a PCN (Medicaid number) can be issued for newborns whose mothers were at or below the pregnant women's FPIL. Hospitals should use the CHIP Perinatal health plan ID to enter the mother's CHIP perinatal coverage ID number in the Medicaid/CHIP number field on the Texas Electronic Registration (TER) screen. This number will appear as an alpha-numeric combination, starting with a letter followed by eight digits. For example, G12345678.

For more information, go to the HHSC website at www.hhsc.state.tx.us/chip/perinatal/VitalStatisticsInstructions_062807.pdf, or call Texas Vital Statistics at 1-800-452-9115.

4.6 Medically Needy Program (MNP)

The MNP with spend down is limited to children 18 years of age and younger and pregnant women.

The MNP provides Medicaid benefits to children (18 years of age and younger) and pregnant women whose income exceeds the eligibility limits under Temporary Assistance for Needy Families (TANF) or one of the Medical Assistance Only (MAO) programs for children but is not enough to meet their medical expenses. Coverage is available for services within the amount, duration, and scope of Texas Medicaid. Individuals are considered adults beginning the month following their 19th birthday.

Medicaid benefits, including family planning and THSteps preventive services through the MNP, are available to:

- Pregnant women.
- Children 18 years of age and younger.

MNP provides access to Medicaid benefits. Applications are made through HHSC. HHSC determines eligibility for the appropriate Medicaid program.

If spend down is applicable, HHSC issues a Medical Bills Transmittal (Form H1120) to the MNP applicant that indicates the spend down amount, months of potential coverage (limited to the month of application and any of the three months before the application month that the applicant has unpaid medical bills), and HHSC contact information.

The applicant is responsible for paying the spend down portion of the medical bills. The TMHP Medically Needy Clearinghouse (MNC) determines which bills may be applied to the applicant's spend down according to state and federal guidelines. No Medicaid coverage may be granted until the spend down is met.

Newborns of mothers who must meet a spend down before becoming eligible for Medicaid are *not* automatically eligible for the full year of newborn coverage. The newborn and mother are eligible for the birth month and the two following months. Hospitals and other providers that complete newborn reporting forms should continue to follow the procedures in subsection 3.2.4, "Newborn Care" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for these newborns.

4.6.1 Spend Down Processing

Applicants are instructed to submit their medical bills or completed claim forms for application toward their spend down to TMHP MNC along with the Medical Bills Transmittal/Insurance Information Form H1120. Charges from the bills or completed claim forms are applied in date of service order to the spend down amount, which is met when the accumulated charges equal the spend down amount.

Providers can assist medically needy clients with their applications by giving them current, itemized statements or completed claim forms to submit to MNC. MNC holds manually completed claim forms used to meet spend down for ten calendar days preceding the completion of the spend down case, then forwards them to claims processing. The prohibition against billing clients does not apply until Medicaid coverage is provided.

Current itemized statements or completed claim forms must include the following:

- Statement date
- Provider name
- Client name
- Date of service
- All services provided and charges
- Current amount due
- Any insurance or client payments with date of payment (the date and amount of any insurance or payments)

Important: *Amounts used for spend down are deducted from the total billed amount by the provider. Using older bills may provide earlier eligibility for the client.*

Bills for past accounts must be current, itemized statements (dated within the last 60 days) that are from the provider and that verify the outstanding status of the account and the current balance due. Accounts that have had payments made by an insurance carrier, including Medicare, must be accompanied by the carrier's EOB or Remittance Advice and show the specific services covered and amounts paid.

Unpaid bills incurred before the month of potential eligibility (the month with spend down) may be used to meet spend down. Itemized statements must be dated within 60 days of the date they are received at TMHP MNC.

The unpaid balance on currently due accounts may be applied toward the spend down regardless of the date of service. All bills or completed claim forms must be itemized showing the provider's name, client's name, dates of service, statement date, services provided, charge for each service, total charges, amounts and dates of payments, and total due.

Clients have 30 days to submit their bills or completed claim forms. Thirty-day extensions are available to the client as necessary to gather all needed information. The provider can assist by furnishing the additional information to the applicant.

All communication about submission of billing information is carried out between MNC and the applicant; however, providers can assist clients by:

- Providing clients with current itemized statements or completed claim forms.
- Encouraging clients to submit *all* of their medical bills or completed claim forms incurred from *all* providers at the same time.
- Submitting manual claim forms directly to MNC or to applicants for the MNP, that can be used to meet spend down.

Bills or claim forms submitted to MNC are for application toward the spend down only. Submitting a bill or claim forms for spend down is *not* a claim for reimbursement. *No* claims reimbursement is made from such submittals unless the claim form is complete. The provider must file a Medicaid claim after eligibility has been established to have reimbursement considered by Texas Medicaid. If the provider assisted the client with submission of a claim form, the MNC retains all claim forms for ten calendar days preceding the completion of the spend down case. The MNC then forwards all claim forms directly to claims processing to have reimbursement considered by Texas Medicaid.

MNC informs the applicant and HHSC when the spend down is met. HHSC certifies the applicant for Medicaid and sends the Medicaid Identification form to the applicant when Medicaid eligibility is established. The TMHP MNC mails notification letters to providers when clients have met spend down and TMHP has not yet received any claim for the client's bills. The notification letter states that an invoice was submitted for the spend down and that the provider should submit claims for any bills that fall within the indicated spend down month. Clients are encouraged to inform medical providers of their Medicaid eligibility and make arrangements to pay the charges used to meet the spend down amount. When notified of Medicaid eligibility, the provider asks if the client has retroactive eligibility for previous periods. All bills submitted to MNC are returned to the client, except for claim forms. An automated letter specific to the client's spend down case is attached, indicating which:

- Bills and charges were used to meet the spend down.
- Bills and charges the client is responsible for paying in part or totally.
- Bills the provider may submit to Medicaid for reimbursement consideration.
- Claims have been received and forwarded to TMHP claims processing.

Providers may inquire about status, months of potential eligibility, Medicaid or case number, and general case information by calling the TMHP Contact Center at 1-800-925-9126.

Medically needy applicants who have a case pending or have not met their spend down are considered private-pay clients and may receive bills and billing information from providers. No claims are filed to Medicaid. A claim that is inadvertently filed is denied because of client ineligibility.

4.6.2 Closing an MNP Case

Medically needy cases are closed by MNC for the following reasons:

- Bills were not received within the designated time frame (usually 30 days from the date on which the case is established by the HHSC worker).

- The client failed to provide requested additional case/billing information within 30 days of the MNC request date.
- Insufficient charges were submitted to meet spend down, and the client did not respond to a request for additional charges to be submitted within 30 days of the notification letter.

Charges submitted after the spend down has been met will not reopen the case automatically. The client must call the Client Hotline at 1-800-335-8957.

Note: *For information regarding the Medically Needy Program for CSHCN Services Program clients refer to the CSHCN Services Program Provider Manual.*

4.7 Medicaid Buy-in for Children (MBIC) Program

The MBIC program is mandated by S.B. 187, 81st Legislature, Regular Session, 2009, to provide acute care Medicaid coverage for children who are 18 years of age and younger and have disabilities. This program creates a state option for children who are ineligible for Supplemental Security Income (SSI) for reasons other than disability.

Children with disabilities must meet the following requirements to be eligible for MBIC:

- Be 18 years of age or younger.
- Have a family income that is no more than 300 percent of FPL before allowable deductions.
- Meet citizenship, immigration, and residency requirements.
- Be unmarried.
- Not reside in a public institution.

Exception: *Clients who are enrolled in the MBIC program before they enter a nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) will continue to receive MBIC benefits until eligibility for the appropriate institutional Medicaid program is determined.*

MBIC clients will be enrolled as Medicaid fee-for-service. MBIC clients have access to the same benefits as Medicaid clients who have disabilities. Claims and prior authorization requests for MBIC clients may be submitted according to current guidelines for Medicaid fee-for-service as indicated in this manual.

MBIC benefits are available to enrolled clients through the end of the month that contains their nineteenth birthday. Clients whose birthday falls on the last day of February of a leap year (e.g., February 29, 2004) will be eligible for benefits through the end of March following their nineteenth year.

4.8 Healthy Texas Women (HTW) Program

The goal of the HTW program is to expand access to women's health and family planning services to reduce unintended pregnancies, positively affect the outcome of future pregnancies, and positively impact the health and wellbeing of women and their families in the eligible population.

HTW provides family planning services, related preventive health services that are beneficial to reproductive health and other preventive health services that positively affect maternal health and future pregnancies for women who meet the following qualifications:

- Must be 15 through 44 years of age

  Note: *Women who are 15 through 17 years of age must have a parent or legal guardian apply on their behalf.*

- Must be a United States citizen or eligible immigrant
- Must be a resident of Texas

- Does not currently receive benefits through a Medicaid program (including Medicaid for Pregnant Women), Children's Health Insurance Program (CHIP), or Medicare Part A or B.
- Has a household income at or below 200 percent of the federal poverty level
- Is not pregnant
- Does not have other insurance that covers the services HTW provides

Exception: *A client with other private health insurance may be eligible to receive HTW services if she believes that a third party may retaliate against her or cause physical or emotional harm if she assists HHSC or its designee with pursuing claims against that third party.*

Refer to: Subsection 2.1, "Guidelines for HTW Providers" in the *Women's Health Services Handbook* (*Vol. 2, Provider Handbooks*).

4.9 Medicaid for Breast and Cervical Cancer (MBCC)

The MBCC program provides full Medicaid benefits to women who meet the program's eligibility requirements. The goal of the program is to improve timely access to breast and cervical cancer treatment for uninsured women who are screened and identified by the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) of the Centers for Disease Control and Prevention (CDC). Additionally, the Texas State Legislature provided funding in 2007 to expand the pool of providers who provide screening and diagnostic services to women so that any provider can diagnose a woman for breast or cervical cancer and she may become eligible for Medicaid through MBCC.

DSHS receives funds from the CDC and awards the funds to providers across the state to perform breast and cervical cancer screenings and diagnostic services under the Breast and Cervical Cancer Services (BCCS) program.

4.9.1 * Initial MBCC Program Enrollment

The woman must be diagnosed and in need of treatment for one of the following biopsy-confirmed breast or cervical cancer diagnoses:

- Grade 3 cervical intraepithelial neoplasia (CIN III)
- Severe cervical dysplasia
- Cervical carcinoma in situ
- Primary cervical cancer
- Ductal carcinoma in situ
- Primary breast cancer

A woman may also be eligible for MBCC if she has a diagnosis of metastatic or recurrent breast or cervical cancer and a need for treatment.

Eligibility is determined by a BCCS contractor, DSHS, and HHSC as follows:

- The BCCS contractor screens the client for eligibility if she has a qualifying diagnosis and, if applicable, helps the woman to complete Form H1034, Medicaid for Breast and Cervical Cancer application. The BCCS contractor reviews and collects all of the required eligibility documentation. The woman cannot apply for MBCC at a local HHSC eligibility office.
- DSHS verifies the client's qualifying diagnosis and submits Form 1034 to HHSC eligibility staff.
- HHSC Centralized Benefits Services staff makes the final Medicaid eligibility determination.

Refer to: The Breast and Cervical Cancer Treatment Information page of the DSHS website for more information about the enrollment process.

4.9.2 MBCC Program Eligibility

To be eligible for MBCC, a woman must be:

- 64 years of age or younger and have been screened for breast or cervical cancer and found to need treatment for either breast or cervical cancer.
- A U.S. citizen or eligible immigrant.
- Uninsured or otherwise not eligible for Medicaid.
- A resident of Texas.

A woman who is eligible to receive Texas Medicaid under MBCC receives full Medicaid benefits beginning the day after she received a qualifying diagnosis and for the duration of her cancer treatment. Services are not limited to the treatment of breast and cervical cancer.

4.9.3 Continued MBCC Program Eligibility

After a woman is enrolled in the MBCC program, eligibility may continue if she meets one of the following criteria:

- She is being treated for active disease as defined above,
- She has completed active treatment while in MBCC and is currently receiving hormonal treatment,
- She has completed active treatment while in MBCC and is currently receiving active disease surveillance for TNRBC.

A woman may continue to receive Medicaid benefits as long as she meets the eligibility criteria and provides proof that she is receiving active treatment for breast or cervical cancer. Women who are no longer in MBCC may reapply if they are diagnosed with a new breast or cervical cancer or a metastatic or recurrent breast or cervical cancer.

> ***Note:*** *Active disease surveillance (for the purposes of determining eligibility for MBCC) is periodically monitoring disease progression in order to quickly treat cancerous and precancerous conditions that arise from the presence of a previously diagnosed TNRBC.*

If the client's cancer is in remission and the physician determines that the client requires only routine health screening for a breast or cervical condition (e.g. annual breast examinations, mammograms, and Pap tests as recommended by the American Cancer Society and the U.S. Preventative Services Task Force), the client is not considered to be receiving treatment; and MBCC coverage will not be renewed. A client who is subsequently diagnosed with a new, metastatic, or recurrent breast or cervical cancer may reapply for MBCC benefits.

4.10 Medicare and Medicaid Dual Eligibility

Medicaid clients who are also eligible for Medicare Part A (inpatient coverage), Part B (medical coverage), or Part C (noncontracted Medicare Advantage Plans [MAPs]), may be covered by Texas Medicaid as follows:

- QMB clients are eligible for coinsurance and deductible payments according to the current payment guidelines.
- MQMB clients are eligible for coinsurance and deductible payments according to the current payment guidelines, and receive Medicaid benefits for services that are not a benefit of Medicare or exceed Medicare benefit limitations.

Medicare Part A and Part C (Noncontracted MAPs Only)

For QMB and MQMB clients who are eligible for Medicare Part A, including clients enrolled in MAPs, claims may be reimbursed to providers for the client's Medicare coinsurance and deductible up to the Medicaid allowed amount for the service less the amount paid by Medicare.

For Medicare Part C, the coinsurance and deductible payment guidelines apply for noncontracted MAPs only.

Medicare Part B

For QMB and MQMB clients who are eligible for Medicare Part B, Texas Medicaid reimburses the lesser of the following to providers:

- The coinsurance and deductible payment.
- The amount remaining after the Medicare payment amount is subtracted from the allowed Medicaid fee or encounter rate for the service (If this amount is less than the deductible, then the full deductible is reimbursed instead.)

If the Medicare payment is equal to, or exceeds the Medicaid allowed amount or encounter payment for the service, Texas Medicaid does not make a payment for coinsurance.

Note: *If the Medicare payment is equal to or exceeds the Medicaid allowed amount or encounter payment for the service, no additional payment is made for coinsurance and deductible.*

QMB clients are not eligible for Medicaid coverage for benefits that are not covered by Medicare, and QMB clients are not eligible for THSteps or CCP Medicaid benefits.

QMB and MQMB coverage guidelines do not impact clients who are living in nursing facilities and who receive a vendor rate for client care through DADS.

Claims for Medicare copayments can also be submitted to TMHP.

Refer to: Subsection 2.7.4, "Exceptions" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for information about exceptions for Medicare Part B and Part C (noncontracted MAPs).

Subsection 6.12.2.2, "Health Maintenance Organization (HMO) Copayments" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for information about HMO copayments.

for more information about filing claims for MQMBs and QMBs.

4.10.1 QMB/MQMB Identification

The term "QMB" or "MQMB" on the Your Texas Benefits Medicaid website indicates the client is a Qualified Medicare Beneficiary or a Medicaid Qualified Medicare Beneficiary. The Medicare Catastrophic Coverage Act of 1988 requires Medicare premiums, deductibles, and coinsurance payments to be paid for individuals determined to be QMBs or MQMBs who are enrolled in Medicare Part A and meet certain eligibility criteria (see 1 TAC §§358.201 and 358.202).

Refer to: Your Texas Benefits Medicaid card (English and Spanish) on the TMHP website at www.tmhp.com.

4.10.2 Medicare Part B Crossovers

The following qualify as Medicare Part B crossover claims: QMB, MQMB, and client TPs 13 or 14, with base plan 10, and category R.

If the provider has not accepted Medicare assignment, the provider may receive payment of the Medicare deductible or coinsurance according to current guidelines on behalf of the QMB, MQMB, client TPs 13 or 14, base plan 10, and category R client. If the provider has collected money from the client and also received reimbursement from TMHP, the provider is required to refund the client's money.

The Social Security Act requires that Medicaid payment for physician services under Medicare Part B be made on an assignment-related basis.

If Medicaid does not reimburse all or a part of the deductible or coinsurance, the provider is not allowed to bill the client.

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

4.10.3 Clients Without QMB or MQMB Status

Medicare is primary to Medicaid, and providers must bill Medicare first for their claims. Medicaid's responsibility for coinsurance and deductibles is determined in accordance with the Medicaid benefits and limitations including the 30-day spell of illness. TMHP denies claims if the client's coverage reflects Medicare Part A coverage and Medicare has not been billed first.

Providers must check the client's Medicare card for Part A coverage before billing Texas Medicaid.

Refer to: Subsection 2.7, "Medicare Crossover Claim Reimbursement" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

4.10.4 Medicare Part C

Providers can receive information about a client's Medicare Part C eligibility through TexMedConnect or EDI. In response to an eligibility inquiry, providers receive the client's Medicare Part C eligibility effective date, end date, and add date.

HHSC contracts with some Medicare Advantage Plans (MAPs) and offers a per-client-per-month payment. The payment to the MAP includes all costs associated with the Medicaid cost sharing for dual-eligible clients. MAPs that contract with HHSC will reimburse providers directly for the cost sharing obligations that are attributable to dual-eligible clients enrolled in the MAP. These payments are included in the capitated rate paid to the HMO and must not be billed to TMHP or a Medicaid client.

TMHP now processes certain claims for clients enrolled in a Medicare Advantage Plan (Part C).

Refer to: Subsection 6.12, "Filing Medicare Primary Claims" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

A list of MAPs that have contracted with HHSC is available in the "EDI" section of the TMHP website at www.tmhp.com. The list will be updated as additional plans initiate contracts.

4.11 Health Insurance Premium Payment (HIPP) Program

The HIPP Program reimburses for the cost of medical insurance premiums. A Medicaid client is eligible for the HIPP Program when Medicaid finds it more cost effective to reimburse a Medicaid client's group health insurance premiums than to reimburse his or her medical bills directly through Medicaid.

By ensuring access to employer sponsored health insurance, individuals who are eligible for the HIPP Program may receive services that are not normally covered through Medicaid. Also, members of the family who are not eligible for Medicaid may be eligible for the HIPP Program.

Providers can benefit from this program by helping the uninsured population, saving money for the state of Texas, and receiving a higher payment from the group health insurance carrier. Providers can increase HIPP Program enrollment by displaying brochures to educate their Medicaid clients about the program.

For more information, call the TMHP-HIPP Program at 1-800-440-0493 or visit www.gethipptexas.org.

4.12 Long-Term Care Providers

A nursing facility, home health services provider, or any other similar long-term care services provider that is Medicare-certified must:

- Seek reimbursement from Medicare before billing Texas Medicaid for services provided to an individual who is eligible to receive similar services under the Medicare program.

- Appeal Medicare claim denials for payment, as directed by the department.

A nursing facility, home health services provider, or any other similar long-term care services provider that is Medicare-certified is not required to seek reimbursement from Medicare before billing Texas Medicaid for a person who is Medicare-eligible and has been determined to not be homebound.

4.13 State Supported Living Centers

Inpatient hospital care for individuals who are eligible for Supplemental Security Income (SSI) Medicaid and reside in a State Supported Living Center (SSLC) must be billed to TMHP. Medicaid providers who render off-campus acute care services to Medicaid-eligible SSLC residents are also required to submit claims directly to Medicaid. This is applicable only to residents of the SSLCs operated by DADS.

Claims and prior authorization requests for acute care services that are rendered to these clients must be submitted directly to Medicaid.

Providers may contact DADS for assistance or information about billing procedures for state school services.

4.14 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Your Texas Benefits Medicaid card (English and Spanish)
Informational Claims Submission Form
Other Insurance Form
Authorization for Use and Release of Health Information
Authorization for Use and Release of Health Information (Spanish)
Tort Response Form