



November 22, 2017

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.

HHSC 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>

Contents	
Federal Waivers and Modifications	2
CHIP Cost Sharing	5
Out of State Providers and Texas Providers not Enrolled in Medicaid	6
Prescriptions	9
Nursing Facility Guidance	12
Benefits	17
Texas Health Steps	20
Provider Enrollment	21
Electronic Visit Verification .	22

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, managed care organizations and the Texas Medicaid & Healthcare Partnership are required to extend the deadline to 120 days from the date of service. TMHP must extend the filing deadline for claims submitted by traditional, fee-for-service, Healthy Texas Women program, Family Planning Program and Children with Special Health Care Needs Services Program providers. This requirement extends to services delivered by providers located in a Federal Emergency Management Agency-declared disaster county between Aug. 25 and Nov. 30, 2017.

2. Will HHSC allow managed care organizations and TMHP to extend prior authorizations?

A. MCO

- Yes, MCOs may extend prior authorizations for authorizations expiring between Aug. 25 and Nov. 30, 2017, 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 managed care organizations 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 member 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 between Aug. 25 and Nov. 30, 2017 up to 90 days.

B. TMHP

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

4. Does HHSC plan to apply for federal waivers as they have done for past natural disasters?

- A. In the days and weeks after Hurricane Harvey struck, HHSC submitted several waivers related to Medicaid flexibilities and a CHIP state plan amendments. This included modifications and flexibilities under the 1115 Waiver, the 1135 Waiver, Appendix K of the 1915(c) waivers and the CHIP state plan. Additional information, including Texas waiver approvals can be found by navigating to <https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html>

5. 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>

6. Did the Centers for Medicare & Medicaid Services 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 an SNF stay provides temporary emergency coverage of SNF 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 SNFs 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>

7. 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, HHSC 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 HHSC 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.

8. 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.

9. Can members who have been displaced by Hurricane Harvey and are enrolled with a managed care organization 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 between Aug. 25 and Nov. 30, 2017. The direction applies to all Medicaid or CHIP-covered services, including NF 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.

CHIP Cost-Sharing

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

- A. HHSC 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 during this time period.

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

MCOs will compensate providers for waived CHIP copays. HHSC has directed MCOs to establish a process no later than Nov. 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.

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

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

- A. MCOs: The Temporary Pharmacy Agreement Form is valid through Nov. 22, 2017. Beginning Nov. 23, pharmacies will no longer be able to enroll using the temporary agreement form. Pharmacies enrolled through this process are still eligible for reimbursement for services rendered from Aug. 25 through Dec. 31, 2017.
- B. Traditional, Fee-For-Service Providers: The Temporary Pharmacy Agreement Form is valid through Nov. 22, 2017. Beginning Nov. 23, pharmacies will no longer be able to enroll using the temporary agreement form. Pharmacies enrolled through this process are still eligible for reimbursement for services rendered from Aug. 25 through Dec. 31, 2017.

12. Will managed care organizations 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 and valid through Dec. 31, 2017. 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 in-state and out-of-state providers. The Temporary Pharmacy Agreement Form is valid through Nov. 22. Beginning Nov. 23, pharmacies will no longer be able to enroll using the temporary agreement form. Pharmacies enrolled through this process are still eligible for reimbursement for services rendered from Aug. 25 through Dec. 31.

13. 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, providers enrolled under this process will be automatically disenrolled. 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).

The simplified enrollment process ends Nov. 22.

14. 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

15. 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 Dec. 31, 2017. The application can be found at http://www.tmhp.com/Pages/Topics/Hurricane_Main.aspx and providers can use this process to enroll through Nov. 22. Beginning Nov. 23, providers will no longer be able to enroll using the temporary enrollment form.
- 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.

16. 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 also located at www.tmhp.com.

Prescriptions

17. Will managed care organizations 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. 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 in-state and out of state providers. The Temporary Pharmacy Agreement Form is valid through Nov. 22. Beginning Nov. 23, pharmacies will no longer be able to enroll using the temporary agreement form. Pharmacies enrolled through this process are still eligible for reimbursement for services rendered from Aug. 25 through Dec. 31.

18. Will the Vendor Drug Program extend the available drugs beyond the Centers for Medicare & Medicaid Services 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 Nov. 30, 2017. Once a pharmacy is able to stock approved drugs, this allowance should be lifted. HHSC 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>

19. 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, HHSC implemented an emergency procedure for pharmacists to follow if a prescription rejects with an error code "79" ("Refill Too Soon") but only for people 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. HHSC 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, 2017 through Nov. 30, 2017.

20. 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.

Emergency refills requested due to Hurricane Harvey related reasons will no longer be accepted after Nov. 30, 2017.

21. 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. MCOs will be required to provide coverage for up to 90-day supply of prescription drugs for the duration of the Governor's declaration. 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.

Emergency refills requested due to Hurricane Harvey related reasons will no longer be accepted after Nov. 30, 2017.

22. 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**23. 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. HHSC recommends evacuating facilities establish an agreement with the accepting facilities as soon as feasible regarding housing and care of evacuees and 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.

24. 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.

25. 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.

26. 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 managed care organization, 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.

27. 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 through Nov. 30, 2017:

- 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 SNFs 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>

28. What are the Minimum Data Set assessment requirements for nursing facilities 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.

This flexibility ends on Nov. 22, 2017

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

- A. Yes. NF eligibility at the current Resource Utilization Groups 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 #28 under [Nursing Facility Guidance](#). See this FAQ document for additional information.

30. For facilities in FEMA-declared disaster counties, at what Resource Utilization Groups rate will they be paid for residents whose Minimum Data Set assessments and Long-Term Care Medicaid Information 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.

31. Is there an established process to expedite billing and payments? Are there concerns with payment delays from the managed care organizations? 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

32. 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.

33. 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 traditional, fee-for-service.
- 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.

- C. 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

34. What is the STAR+PLUS managed care organization's process for transitioning those receiving private duty nursing to STAR+PLUS at age 21 who have not been assessed for STAR+PLUS home and community-based services 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 people on the IDD waiver 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 those 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

35. 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 repellent 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.

36. 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.

37. Is there a website providers can direct members to for information about their managed care organization, including provider directories and member handbooks?

- A. Yes, the "Questions about your Benefits" webpage on the HHSC 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>

38. 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.

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

- A. 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 and members evacuated from NFs and other residential settings, and they are responding to members' requests for help.

40. How can members find primary care providers 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.

41. 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.

42. 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

43. 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

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

- A. Because of Hurricane Harvey, HHSC delayed the start of this requirement which was initially scheduled to implement in October pending clarification from CMS.

Beginning Jan. 15, 2018, claims for the payment of items and services ordered, referred or prescribed, must contain the National Provider Identifier (NPI) of the physician or other professional who ordered, referred or prescribed the items or services. Additionally, all ordering, referring or prescribing providers must be enrolled as participating providers in Texas Medicaid. These requirements impact the Medicaid, Healthy Texas Women and CSHCN Services programs only. However, these requirements do not apply to out-of-network providers that order, refer or prescribe only for managed care members.

HHSC is allowing a three-month grace period from Jan. 15, to April 16, 2018, during which claims not meeting these requirements will be initially denied and then reprocessed to allow providers additional time to complete enrollment and minimize client and provider impact.

The [Ordering, Referring, and Prescribing Providers Frequently Asked Questions](#) document is now available on this website. The document contains questions and answers regarding the new enrollment requirements for ordering, referring and prescribing providers.

Except for out-of-network providers who order items or services for managed care members, all providers who order, refer or prescribe for clients enrolled in Medicaid, Healthy Texas Women, or the CSHCN Services Program should begin the enrollment process immediately by completing the application online at: tmhp.com/Pages/ProviderEnrollment/PE_TX_Medicaid_New.aspx

Electronic Visit Verification

The following temporary electronic visit verification policies are for provider agencies who were impacted by Hurricane Harvey. The provider agency office or member's home must be located in a FEMA-declared county.

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

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

45. 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;

- Member first and last name;
- 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.

46. 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.

47. 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

48. 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 a 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.

49. Are there alternate ways for a consumer directed services 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. CDS employers also may have 90 days to submit corresponding timesheet records in accordance with program rules.