Medicaid Hospice Provider Manual

1000, Introduction

Revision 11-1; Effective May 11, 2011

1100 Role of the Texas Department of Aging and Disability Services (DADS)

Revision 08-1; Effective November 12, 2008

DADS staff work directly with Medicaid hospice providers in the following areas:

- Conduct audits on contracts with hospice providers.
- Issue Medicaid contracts to hospice providers that have met the Medicaid contract requirements.
- Authorize hospice services based on the receipt of the individual's required hospice eligibility documents. DADS must receive these documents before hospice payments can be made.
- Conduct on-site visits to each hospice provider to ensure contract requirements are met and determine if the quality of care being given meets state and federal standards and is appropriate for each individual's particular need.
- Determine reimbursement rates for hospices based on the wage index set by the Centers for Medicare and Medicaid Services.

1200 Participation in Medicaid and/or Medicare

Revision 08-1; Effective November 12, 2008

Medicare

The Department of Aging and Disability Services (DADS) Home and Community Support Services Agencies (HCSSA) section is responsible for the state licensure and for the Centers for Medicare and Medicaid Services Medicare certification of hospice agencies. DADS uses federal Medicare hospice regulations as the basis for Texas hospice licensure and certification and for subsequent annual surveys. **Home health agencies with a hospice service designation, and any agency/facility that calls itself a hospice that is not fully licensed and Medicare certified as a hospice agency, are not eligible to participate in the Medicaid Hospice Program.**

Dually Certified

Dually certified providers participate in both the Medicaid and Medicare Hospice Programs. Dually certified providers must be certified under both programs and adhere to both Medicare and Medicaid requirements. Providers must be licensed and Medicare certified to become a Medicaid provider.

Medicaid hospice is an optional benefit as outlined under the Social Security Act, §1902 (a)(10)(A)(i)-(vii). DADS Community Services Contracts is responsible for Medicaid contracting. A provider agency must follow rules and guidelines that comply with all applicable state and local laws. Providers are responsible for becoming familiar with the following regulations and guidelines:

- State Operations Manual, Chapter 2, Section 2082, Election of Hospice Benefit by Resident of SNF, NF, ICF/MR or Non-certified Facility
- State Medicaid Manual, Section 4305, Hospice Services
- 42 Code of Federal Regulations, Chapter 418, Hospice Care
- 40 Texas Administrative Code (TAC), Chapter 49, Contracting for Community Care Services
- 40 TAC, Chapter 30, Medicaid Hospice Program
- 40 TAC, Chapter 97, Home and Community Support Service Agencies
- 1 TAC, Chapter 371, Subchapter C, Utilization Review, §371.212 and §371.214.

In addition, the following provider rules address hospice services:

- 40 TAC, Chapter 19, §19.1926 Medicaid Hospice
- 40 TAC, Chapter 9, Subchapter E, Division 9, §274 Hospice Services.

All state rules can be accessed at: www.dads.state.tx.us/rules/tac.html.

1300 Medicaid/Medicare Fraud

Revision 06-2; Effective December 12, 2006

Section 1909 of the Social Security Act explicitly states the penalties applied to providers that commit certain fraudulent acts in the administration of Medicaid programs. DADS urges providers to become familiar with this section of the act and abide by it. Providers involved in fraudulent practices are subject to review, fraud referral, and/or administrative sanctions that could result in withholding of vendor payments, termination or suspension of Medicaid contracts. The Attorney General's office investigates suspected Medicaid provider fraud that could result in a felony conviction. The following are examples of activities that may result in administrative sanctions against providers such as vendor hold, termination, or suspension from the Medicaid program:

- presenting any false or fraudulent claim for services or merchandise;
- submitting false information to obtain greater compensation than the provider is legally entitled;
- submitting false information to meet Medicaid contracting requirements;
- failing to disclose and/or make available upon demand to DADS or its authorized agent records of services provided to Medicaid recipients and of payments made for those services;
- failing to comply with the terms of the Medicaid provider contract;
- rebating or accepting a fee or portion of a fee or charge for a Medicaid recipient referral;
- being excluded from Medicare because of fraudulent or abusive practices;
- charging individuals for Medicaid-allowable services over and above that paid by DADS, except when specifically allowed by DADS;
- failing to correct deficiencies in provider operations after receiving written notice of the deficiencies from DADS;
- being convicted of a criminal offense relating to performance of a provider agreement with the state;
- failing to repay or make arrangements to repay identified overpayments;
- failing to abide by applicable civil rights statutes.

Report knowledge of suspected Medicaid fraud or abuse of provider services to:

Medicaid Program Integrity
Health and Human Services Commission
P.O. Box 13247
Austin, TX 78711-3247
800-436-6184

Arrangements between NFs and hospice providers are vulnerable to fraud and abuse practices. National trends include health care fraud and potential violations of the Medicare anti-kickback statute, both of which can influence the referral of NF residents for hospice services. Report suspected fraud involving NFs and hospices to:

Centers for Medicare and Medicaid Services
Regional Office of Inspector General
U.S. Department of Health and Human Services
1301 Young Street, Room 833
Dallas, TX 75202
214-767-8406

or

Department of Health and Human Services
Office of Inspector General
P.O. Box 23489, L'Enfant Plaza Station
Washington D.C., 20026-3489
800-447-8477

1400 Services Not Covered by Medicaid Hospice

Revision 11-1; Effective May 11, 2011

Texas Medicaid & Healthcare Partnership (TMHP) pays for Medicaid services unrelated to the terminal illness. Unrelated Medicaid services include, but are not limited to, lab and x-ray, and physician services regardless of hospice status. TMHP pays non-hospice providers directly for services to an individual receiving Medicaid hospice. Non-hospice providers must submit claims to TMHP with documentation from the hospice that indicates billed services are not related to the terminal illness or that the individual was discharged from the hospice at the time services were rendered. If an individual was discharged at the time of service, the non-hospice provider obtains a copy of Form 3071, Individual Election/Cancellation/Update, from the hospice to support the claim of discharge.

In accordance with Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), individuals under 21 years of age are not required to waive Medicaid payment for treatments related to the terminal illness. Non-hospice providers rendering treatment for the terminal illness or related conditions are not required to submit documentation to indicate whether the services provided are related or unrelated to the terminal illness when the individual is under 21 years old.

Refer to TMHP's *Texas Medicaid Provider Procedures Manual* for further information about Medicaid services. Providers can call the TMHP Customer Service Department at 800-925-9126 or 512-514-3000 for general inquiries about the Medicaid program.

1500 Grievances and Complaints

Revision 06-2; Effective December 12, 2006

Providers must inform individuals and families of their right to file complaints with DADS. Complaints may be reported to DADS at 800-458-9858.

2000, Contracts

Revision 06-2; Effective December 12, 2006

2100 Medicaid Contract

Revision 06-2; Effective December 12, 2006

Hospice providers must apply to DADS to participate as a Medicaid hospice provider. Only a provider with a fully executed, current Medicaid contract with DADS may receive state and federal reimbursement for services to Medicaid and dually eligible individuals on hospice. The Medicaid contract is considered an open-ended contract.

The same legal business entity that applied for the Medicare hospice certification applies for Medicaid contracts. DADS Community Services Contracts will enter into a contract with the provider upon completion of the application. Providers must meet the requirements specified in 40 Texas Administrative Code (TAC), Chapter 49, Contracting for Community Care Services, and 40 TAC, Chapter 30, Medicaid Hospice Program.

2200 Advertising and Solicitation of Individuals

Revision 06-2; Effective December 12, 2006

DADS may investigate complaints of solicitation of coerced individuals. Validated complaints may lead to adverse actions. Such actions may lead to termination of the provider's contract.

3000, Eligibility

Revision 09-1; Effective February 27, 2009

3100 Recipient Financial Eligibility

Revision 06-2; Effective December 12, 2006

The purpose of this subsection is to provide hospice staff with a basic understanding of Medicaid eligibility determinations for general discussions with families, nursing facility (NF) staff, hospital staff and other service providers. However, Health and Human Services Commission (HHSC) Medicaid eligibility (ME) staff are the experts in this area. Consult ME staff and keep them informed on all issues related to the eligibility of an applicant or recipient.

The Social Security Administration (SSA) through Supplemental Security Income (SSI) or HHSC determines if an individual is eligible for Medicaid. Hospice is only one program that can be paid by Medicaid. Some Medicaid recipients are not eligible for nursing facility (NF) services or for the home and community-based waiver services, because of transferred assets (that is, recipient deletes name from joint bank account, transfers home to a relative, etc.). Not all Medicaid recipients are eligible for all Medicaid services. Each individual Medicaid service has certain criteria that must be met in order to qualify.

The ME determination process for non-SSI eligible individuals begins when an application is submitted to HHSC ME. The process involves an investigation of the applicant's financial status, proof of citizenship, and ends with a decision of approval or denial. If an institutionalized applicant or one who seeks home and community-based waiver services is determined eligible, the ME staff determines the amount of income he must apply toward the cost of his care (copay). Denial of Medicaid eligibility may be appealed through a request to the HHSC ME staff.

Determining Medicaid eligibility may be a complex and lengthy process that varies with each applicant. ME staff must complete the process within 45 days, except in unusual situations. Payment does not begin until DADS establishes a record of eligibility in its central computer.

HHSC staff use Form 1230, Notification of Eligibility - Regular Medicaid Benefits, to inform the recipient and the hospice provider of the individual's eligibility for Medicaid benefits and the initial amount of copay, if applicable. HHSC Form H4808, Notice of Change in Applied Income/Notice of Denial of Medical Assistance, is used for subsequent denials and copay adjustments. The hospice provider receives these and any other appropriate eligibility forms directly from HHSC ME staff.

When an individual is a full vendor SSI Medicaid recipient and receives Medicaid hospice services in an NF or ICF/MR-RC, the hospice provider is responsible for notifying SSA. SSA must have this information so the SSI payment to the recipient can be reduced to $30 a month, which is the federal benefit rate (FBR) for an institutionalized individual.

ME staff determine financial eligibility for medical assistance only (MAO). Eligibility determination is a complex procedure— do not attempt to advise applicants, recipients or their families. Direct any questions about a recipient's eligibility for Medicaid benefits to the ME staff at HHSC. The following information is intended to be a guide for referral of individuals to ME staff.

HHSC issues Form H3087, Medicaid Identification, to eligible Medicaid recipients each month. This card ensures that the recipient, whose name appears on it, is eligible for services for the specific dates indicated on the card. Individuals may be eligible if they meet certain income and resource requirements. Aged or disabled individuals with very low or no income should apply to SSA for SSI benefits to obtain Medicaid coverage.

Ask to see and review the hospice individual's Medicaid Identification before the Medicaid hospice election and at the first of each month thereafter to verify the individual's Medicaid eligibility.

HHSC considers payments for services the responsibility of the individual receiving the service if:

- the services received are not a benefit covered by Medicaid,
- the applicant is not eligible for medical services under the Medicaid program, or
- the applicant has been denied eligibility before the date of service.

3200 Three-Month Prior Eligibility

Revision 06-2; Effective December 12, 2006

Applicants for medical assistance may be eligible for Medicaid coverage as early as the first day of the third month before the month of application for assistance. Eligibility depends on the applicant's unpaid or reimbursable bills for Medicaid-covered medical services provided during the three-month period. The applicant also must meet all other eligibility criteria during that period. A bona fide agent may apply for coverage on behalf of a deceased individual. Applications for prior coverage must be filed with HHSC.

For certified SSI applicants, Medicaid coverage is automatically added for the month before the first SSI payment. Medicaid coverage also is available for the two preceding months, if all eligibility requirements were met and the applicant had unpaid, reimbursable medical bills. An application must be filed with HHSC for prior-month eligibility determination.

For denied SSI applicants with unpaid, reimbursable medical bills, the retroactive period is the three months before the SSI application month. An application must be filed with HHSC for prior-month eligibility determination.

HHSC encourages providers to maintain open communication with individuals, NF staff and family members so the hospice provider will be immediately aware if and when an individual may be eligible for Medicaid. When an individual applies for Medicaid, Medicaid eligibility may be established both prospectively, and for the three months prior to the application, if the individual met all Medicaid eligibility criteria during the prior three months. If an individual becomes eligible for Medicaid for the three months prior to application, the NF is required to refund any payments received for NF care to the individual. The NF bills HHSC for those three months and will be paid the NF rate for those three months. Once ME has been established, the individual can elect Medicaid hospice. If the individual is dually eligible, they must elect both the Medicaid and Medicare hospice programs. For more information regarding dual eligibility, see Item 3640, Dually Eligible Recipients. For the prospective period of Medicaid eligibility, the room and board payment for the NF must pass through the hospice, since the individual has elected out of the Medicaid NF program. This does not negate the provider's responsibility when an individual is dually eligible. For information regarding room and board, see Item 4540, Room and Board. For information regarding per diem rates, see Item 6310, Hospice-Nursing Facility Per Diem Rate.

3300 Supplemental Security Income (SSI) and Medicaid

Revision 08-1; Effective November 12, 2008

When an individual is in a lower income situation (TP12, manual certification or TP13, automated certifications), SSA staff determine the applicant's Medicaid eligibility as an SSI recipient. The recipient is then eligible for Medicaid services, which includes hospice, in the home, community, NF, hospital, ICF/MR-RC and other type facilities. **Only SSI Medicaid hospice individuals are eligible for Medicaid in an NF without**

being in a Medicaid-contracted bed. An SSI recipient in the NF who is not in a Medicaid bed still may be eligible for SSI; however, HHSC will not pay room and board for his care.

When an individual qualifies under higher income limits (TP14), the HHSC ME staff determine the applicant's eligibility for Medicaid. **The individual is eligible for Medicaid services only when he resides in a Medicaid-contracted bed in an NF**. Under these circumstances, the hospice provider follows the HHSC copay procedures, outlined under Section 3400, Copay. Form 3071, Individual Election/Cancellation/Update, substitutes for the medical necessity requirement in determining eligibility. HHSC ME staff must have verification of the applicant's Form 3071 and Minimum Data Set (MDS), if applicable, in order to approve and continue the Medicaid eligibility status of the applicant or individual. This may be a copy of a statement from the provider. ME staff may contact NFs for trust fund information or earnings information.

A private-pay NF resident can occupy a Medicaid, Medicare or a non-participating bed. A facility cannot make a private-pay resident move to accommodate a Medicare or Medicaid resident.

3400 Copay

Revision 09-1; Effective February 27, 2009

An individual on hospice may have a copay if he resides in an NF or ICF/MR-RC. Copay is the amount Medicaid recipients pay for part of their NF care. The copay is based on the amount of income they receive in excess of $60 a month and certain other allowable deductions. Certain Veterans Administration (VA) beneficiaries are allowed to keep an additional $90 a month. HHSC ME staff calculates the copay.

Hospice providers are responsible for collecting copay from individuals. The amount is the same each month, regardless of the number of days in the month. If an individual does not live in an NF every day during a month, except for therapeutic home visits, the copay amount is prorated. The copay amount is divided by the number of days in the month, and the result is multiplied by the number of days the individual is in an NF. **Example:** If an individual with a $93 monthly copay enters an NF on Sept. 21, and is discharged on Oct. 11, the copay collected from the individual will be $31 for September ($93 divided by 30 = $3.10 x 10 days = $31) and $30 for October ($93 divided by 31 = $3.00 x 10 days = $30).

Copay amounts may change occasionally, because of changes in an individual's financial status or corrections of income information. If an individual is overcharged copay, the hospice provider receives a corrected billing statement and must refund the amount of the overcharge to the individual. Report all apparent discrepancies regarding copay to ME staff.

The following forms relate to copay:

- Form 1259, Correction of Applied Income, notifies the hospice provider of prospective changes in an SSI recipient's copay and of past over or under collections and of copay amounts to be reconciled.
- Form H4808, Notification of Change in Applied Income/Denial of Medical Assistance, notifies the MAO recipient of HHSC's decisions to prospectively increase or reduce the amounts of copay payable to the hospice provider or to deny medical assistance.

Occasionally, there are problems with the receipt of amount of SSI checks received by recipients. When problems occur and there is no immediate solution, contact SSA. Notify the ME staff if an institutionalized individual, who receives SSI, also received income from other sources.

Promptly notify the ME staff of any changes in an individual's income (including non-recurring payments), resources of any individual or transfers of assets, so that appropriate and timely corrections to copay can be

made. The hospice provider is responsible for ensuring that copay problems are handled according to the requirements and in the protective interest of the individual.

3500 Medicaid Eligibility and Other Programs

Revision 06-2; Effective December 12, 2006

The applicant must meet the requirement for 30 consecutive days (in a Medicaid bed) in one or more Medicaid NFs and ICF/MR-RC's, and must meet all other Medicaid eligibility criteria before that applicant can be Medicaid certified. After the 30 days, the applicant may be Medicaid eligible from the first day of application. Death, hospital stays after admission, and therapeutic home visits not exceeding three days do not break the 30-consecutive-day period. If the individual dies in the NF, ICF/MR-RC or hospital before the 30 consecutive days have passed, the requirement is considered to be met.

ME staff also determine eligibility for certain federally mandated, community-based Medicaid programs that use the SSI limits with certain special income disregards. These are Type Programs 03, 18 and 22 (Social Security cost-of-living exclusion programs).

3600 Eligibility for Participation in the Medicaid Hospice Program

Revision 02-3; Effective Upon Receipt

The Medicaid Hospice Program is available to applicants who satisfy the requirements listed below, regardless of type of residence.

3610 Hospice Election and Physician Certification

Revision 06-2; Effective December 12, 2006

Hospice providers must advise applicants to apply for Medicaid at either an HHSC office or the nearest SSA office, whichever is appropriate, in order to become a Medicaid recipient. HHSC or SSA determines and approves the financial eligibility of applicants. Providers must verify Medicaid eligibility. Contact the local DADS Community Care Aged and Disabled (CCAD) case manager and HHSC ME staff to advise them that a potential or current Medicaid recipient is interested in or has elected the Medicaid Hospice Program. Keep the HHSC ME staff and DADS CCAD case manager informed as changes occur in the applicant's hospice status, financial condition, marital status, living arrangements, etc. Providers must maintain contact with HHSC ME staff in order to be informed regarding an individual's Medicaid eligibility status, especially in those instances where an individual is dually eligible for Medicare and Medicaid.

Applicants must elect hospice care by signing and dating Form 3071, Individual Election/Cancellation/Update, with an approved Medicaid hospice provider.

The elections remain in effect unless the individual and the hospice representative sign and date Form 3071 to cancel hospice coverage in both programs.

A physician provides a written statement on Form 3074, Physician Certification of Terminal Illness, which certifies that an applicant has a prognosis of six months or less to live. This prognosis must be current in order for Medicaid coverage to start and to continue.

In order to receive payment, providers must correct and resubmit all rejected election forms and physician certifications to the Texas Medicaid & Healthcare Partnership (TMHP). **TMHP must have Form 3071 and Form 3074 before payments can be made for Medicaid hospice services and room and board. For more information regarding form submission, see Section 4200, Claims Management System (CMS).**

3620 Changing Hospices

Revision 06-2; Effective December 12, 2006

To change the Medicaid hospice provider designation, the old and new hospice providers complete Form 3071, Individual Election/Cancellation/Update, **as an update** for each provider and submit it to the Texas Medicaid & Healthcare Partnership (TMHP). For more information regarding form submission, see Section 4200, Claims Management Systems (CMS).

Note: When an individual is transferred from one hospice provider to another, the transferring hospice **cannot** bill for services on the date of transfer. The receiving hospice bills for services on that day.

Change of ownership of a hospice provider is not considered a change in a hospice individual's designated hospice provider. **Note:** A change of ownership that results in a new contract number requires an updated Form 3071 in order to transfer all individual information to the new provider.

3630 Hospice Cancellation

Revision 06-2; Effective December 12, 2006

When the Medicaid hospice individual cancels the Medicaid Hospice Program election, designated staff complete Form 3071, Individual Election/Cancellation/Update. The individual or responsible party and the hospice provider representative sign and date Form 3071. The provider submits Form 3071 to the Texas Medicaid & Healthcare Partnership (TMHP). For more information regarding form submission, see Section 4200, Claims Management Systems (CMS).

When a physician signs and dates a statement that an individual on Medicaid hospice is not suitable for the Medicaid Hospice Program, DADS places the Medicaid hospice coverage and payments on hold. The Medicaid hospice coverage remains on hold until the hospice provider validates the six-month certification and individual election with another physician's statement and individual's Medicaid hospice election. If this is not accomplished in 30 days, DADS cancels the individual's coverage under the Medicaid Hospice Program retroactive to the original date the physician stated that the individual was not suitable for the Medicaid Hospice Program.

When an individual dies, complete Form 3071 without the signature and date by the individual. Complete all other applicable items.

3640 Dually Eligible Recipients

Revision 06-2; Effective December 12, 2006

A resident in a Medicaid-certified NF who is dually eligible may elect to participate in either the Medicaid or Medicare Hospice Program. When a dually eligible NF resident elects hospice under either Medicaid or Medicare, the hospice benefit must be elected or revoked under both programs and each program notified as to the resident's decision. The hospice and NF must have a written agreement under which the hospice takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the individual.

Providers must submit Form 3071, Individual Election/Cancellation/Update, and Form 3074, Physician Certification of Terminal Illness, for dually eligible individuals regardless of their place of residence. For more information regarding form submission, see Section 4200, Claims Management Systems (CMS).

In order to receive payment from DADS for room and board for dually eligible residents, **a hospice provider must have a valid Medicaid provider agreement**.Information on room and board is outlined in Item 4540, Room and Board. Information on Medicaid eligibility is outlined in Section 3200, Three-Month Prior Eligibility.

Information on hospice program requirements for dually eligible individuals for both the Medicaid and Medicare programs may be found in several Centers for Medicare and Medicaid Services publications:

- *State Operations Manual*, Section 2082, Election of Hospice Benefit by Resident of SNF, NF, ICF/MR or Non-Certified Facility;
- *Hospice Manual*, Section 204.2, Skilled Nursing Facility and Nursing Facilities Residents and Dually Eligible Beneficiaries; and *State Medicaid Manual*, Section 4305, Hospice Services.

4000, Billing and Payment

Revision 11-1; Effective May 11, 2011

4100 General Information

Revision 11-1; Effective May 11, 2011

A provider must have a DADS Medicaid contract to receive Medicaid payment for hospice services. DADS pays the Medicaid hospice provider at periodic intervals, depending on when the provider bills for approved services. Payments are based on the hospice care setting applicable to the type and intensity of hospice services provided to the Medicaid hospice recipient for that day.

DADS Provider Claims Services authorizes hospice services, according to department, state and federal regulations, for contracted providers that furnish Medicaid services to DADS consumers. Provider Claims Services does not develop program policy, but is responsible for applying established policy when performing the authorization for reimbursement function.

Payment for hospice services is controlled by receipt of information. Payment will not occur until the following conditions are verified:

- the Medicaid Eligibility (ME) specialist or the Social Security Administration (SSA) certifies that the recipient is Medicaid eligible for the hospice program;
- the Texas Medicaid & Healthcare Partnership (TMHP) receives Form 3071, Individual Election/Cancellation/Update;
- TMHP receives Form 3074, Physician Certification of Terminal Illness;
- if applicable, Minimum Data Set (MDS) assessment is received by TMHP; and
- if applicable, the Level of Need (LON) Assessment.

Medicaid hospice providers have the option of submitting the hospice eligibility forms, Form 3071 and Form 3074, through a web-based, online system called Long Term Care (LTC) Online Portal. This new system has a web portal interface to submit forms, corrections, status inquiries and retrieve status reports. Providers interested in the web-based portal should contact TMHP at 800-626-4117.

Providers who choose to submit paper eligibility forms must submit them to:

Texas Medicaid & Healthcare Partnership
TMHP LTC Unit
P.O. Box 200765
Austin,TX 78720-0765

Eligibility forms are validated when received at TMHP. If any deficiencies are noted, the document is returned to the provider with an explanation. **The hospice provider will not receive payments until Medicaid eligibility is verified and Form 3071 and Form 3074 are received at TMHP.** All eligibility forms are processed according to the date they are received. Forms returned to the provider for a deficiency and then resubmitted are processed according to the new receipt date.

TMHP processes hospice forms in 14 workdays for individuals who have Medicaid eligibility. Only individuals who have Medicaid eligibility can be seen in the electronic Claims Management System (CMS) Medicaid Eligibility Services Authorization Verification (MESAV) file. Forms received for individuals who have pending eligibility are suspended in a pending file at DADS until DADS has been notified that the individual is eligible for hospice services. Direct questions about service authorizations or forms that cannot be seen on CMS to TMHP at 800-626-4117.

All payments under the Medicaid Hospice Program are only for services **related to** the treatment of an individual's terminal illness. DADS continues to pay through other service programs for services **not related to** the treatment of a individual's terminal illness. **Exception:** In accordance with Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L.111-148), individuals under 21 years of age are not required to waive Medicaid payment for treatments related to the terminal illness.

4200 Claims Management Systems (CMS)

Revision 06-2; Effective December 12, 2006

CMS was established to be the reimbursement method for all Long Term Care Programs effective Sept. 1, 1999. Hospice providers use CMS to submit claims to DADS, which are submitted through TDH Connect. For more information on how to bill electronically, call 800-626-4117.

Form 1290, Long Term Care Claim, is a paper voucher used for reimbursement if the electronic software supplied by TMHP is not obtained.

Form 1290 must be completed for each client and mailed to:

Texas Medicaid & Healthcare Partnership
Attention: Long Term Care MC-B02
P.O. Box 200105
Austin,TX 78720-0105

If you need assistance filling out the paper claim form or want to obtain the electronic CMS software, call 800-626-4117. A TMHP representative will assist you.

Do not mail Form 1290 to DADS.

4300 Withholding Payments

Revision 08-1; Effective November 12, 2008

Actions that may result in withholding of hospice payments, include, but are not limited to:

- ownership changes;
- failure to submit Form 3071, Individual Election/Cancellation/Update, Form 3074, Physician Certification of Terminal Illness, and Minimum Data Set (MDS) or LON assessment (if applicable);
- failure to verify that an individual is Medicaid eligible; or
- failure to submit or obtain signatures in the required time frames for Form 3071, Form 3074 and MDS assessment (if applicable).

Reasons for non-payment that cannot be corrected:

- Form 3074 is not received within the required time frame. Payments cannot be made before this date.
- Hospice providers cannot receive Medicaid hospice payment for dually eligible individuals.
- Medicaid eligibility does not exist for the time period billed.
- The type of Medicaid eligibility approved for a recipient does not include hospice services.
- Form 3071 is effective after the date requested for payment.
- Form 3071 indicates that this client was discharged from the hospice program.
- Form 3071 or financial eligibility indicates that this client died. Payment cannot be made after this date.

Missing and expired documentation are usually the reasons for non-payment of hospice claims. Be sure all hardcopy forms are legible and complete. Incomplete, incorrect and difficult-to-read forms are returned to providers for correction and could cause delay in payment. Review the form for completeness before submission to TMHP to eliminate problems.

Obtain copay data directly from the local HHSC ME staff for more precise claims processing. Hospice staff should work closely with other DADS and HHSC staff in order to alleviate rejected claims because of the simultaneous provision of other Medicaid services, Medicaid eligibility approval or incorrect hospice data in the CMS and DADS systems.

4400 Third-Party Reimbursement

Revision 06-2; Effective December 12, 2006

Hospice providers cannot retain money collected from third-party payers, such as private insurance companies, on behalf of Medicaid recipients. Under terms of the contract between the provider and DADS, the provider agrees to accept DADS' vendor rate as payment in full on behalf of Medicaid recipients.

Title XIX of the Social Security Act (42 CFR 433, Subpart D) requires DADS to use all third-party payment resources before spending Medicaid funds. DADS also is required to seek reimbursement from liable third parties if Medicaid payments were made before the identification of a third-party payment resource.

When a recipient files an application for Medicaid or receives services from DADS, the recipient automatically grants the right of financial recovery for the cost of medical care to DADS. When a recipient is determined eligible for Medicaid, the provider is no longer entitled to receive financial reimbursement for the cost of the recipient's care from any other source. DADS is to be reimbursed for any insurance payment the provider received on behalf of a Medicaid recipient. State law provides that the filing of an application for, or receipt of, Medicaid benefits constitutes an automatic assignment to DADS of the applicant's or recipient's right of recovery from personal insurance, other sources or other persons for personal injury caused by the other person's negligence or wrongdoing.

The DADS Third Party Resource Unit (TPR), Provider Claims Services is responsible for recouping Medicaid expenditures from third-party resources for long term care claims. TMHP is responsible for collecting payments from third-party resources for medical expenditures, such as hospitals, laboratories and physician services.

Notify the HHSC ME staff of information concerning a recipient's third-party resources. Refer questions about third-party resources or insurance reimbursement to the TRP Unit at:

Provider Claims Services
Third Party Resource
Mail Code W-400
P.O. 149030
Austin,TX 78714-9030

4500 Medicaid

Revision 06-2; Effective December 12, 2006

4510 Payments

Revision 06-2; Effective December 12, 2006

DADS makes payment for hospice services to providers once TMHP has processed the claim. TMHP and DADS will not pay the Medicaid hospice provider until all hospice forms and documents have been submitted, as outlined in Section 4100, General Information, and Section 4300, Withholding Payments. TMHP staff verify and approve all hardcopy hospice forms for data entry and payments to hospice providers. Forms must be mailed to the TMHP address below. Mailings to a different address, an incomplete address or any variation of this address **may cause claims processing delays** of four weeks or more.

Texas Medicaid & Healthcare Partnership
TMHP LTC Unit
P.O. Box 200765
Austin,TX 78720-0765

Address hospice billing questions to the TMHP Help Desk at 800-626-4117.

For dually eligible recipients, Medicare is always the primary payer. Medicaid pays only for service normally billed to Medicare if the recipient has exhausted his Medicare benefits. Documentation that shows Medicare denial must be submitted to DADS before the Medicaid program pays for these services.

4520 Physician Services

Revision 06-2; Effective December 12, 2006

In addition to the per diem rate, the Medicaid Hospice Program pays providers according to customary and reasonable Medicaid physician charges. The program pays for direct patient care services provided to Medicaid hospice recipients by physicians who are on staff with the provider. The Medicaid Hospice Program does not pay when a physician provides patient care services on a volunteer basis or when physician services are provided by physicians who are not on staff with the Medicaid hospice provider. Physician payment amounts through the Medicaid Hospice Program are included in the Medicaid hospice cap amount, which varies each federal fiscal year. All claims for higher amounts are reduced to the Texas Medicaid Reimbursement Methodology (TMRM) amounts for physician services.

A provider is responsible for managing all physician services for inclusion in the hospice plan of care and to ensure physicians are paid on a timely basis. The Medicaid hospice provider has a liability to pay hospice physicians for physician services rendered.

The Texas Medicaid Program, through TMHP, makes payments directly to non-hospice physicians for physician services furnished to Medicaid hospice recipients. TMHP pays regardless of hospice status. TMHP Medicaid payment amounts to non-hospice physicians are not counted in the Medicaid Hospice Program cap.

4530 Physician Services on Day of Discharge

Revision 06-2; Effective December 12, 2006

Under the State Medicaid Manual, Section 4307, Payment for Physicians Services Under Hospice, a provider can be paid for physician services on day of discharge, if the physician is a hospice employee under arrangement by the hospice and direct patient services are provided.

To request payment for physician services on the day of discharge, providers must submit proof that the physician is a hospice employee under arrangement by the hospice and that direct patient services were provided. The information must be submitted to:

Medicaid Hospice Program Specialist
Mail Code W-521
P.O. Box 149030
Austin,TX 78714-9030

Program staff notifies the hospice provider of the approval or denial of the request for payment for physician services on the day of discharge. The hospice provider will be able to see the authorization on their Medicaid Eligibility Services Authorization Verification (MESAV) request.

4540 Room and Board

Revision 08-1; Effective November 12, 2008

DADS pays the hospice provider a room and board rate that is 95% of the Texas Medicaid NF per diem rate for each Medicaid or dually eligible individual on hospice residing in the NF. This rate is required by Section 1902 (a)(13)(D) of the Social Security Act and is an additional per diem rate paid on routine home care and continuous home care days. The payment amounts are not subject to the Medicaid hospice cap on overall Medicaid hospice payments. When the rate is paid to the hospice provider, all Medicaid NF per diem payments for NF care cease. The hospice provider pays the 95% rate to the NF for room and board. For more information regarding NF per diem rates, see Item 6310, Hospice – Nursing Facility Per Diem Rate. For more information on Medicaid eligibility, see Section 3200, Three-Month Prior Eligibility.

NF and hospice providers complete and submit a signed and dated Minimum Data Set (MDS) assessment, to TMHP as justification for payment of the room and board rate. For a hospice recipient or applicant currently residing in the facility with a current MDS assessment, no action is required until the next required MDS assessment. For a hospice recipient or applicant newly admitted to the facility, the hospice and the NF must complete and submit an MDS assessment as required by 40 TAC §19.801, Resident Assessment. An MDS assessment received after the required date will have the stamp-in date as the effective date.

The room and board rate also applies to those individuals participating in the Intermediate Care Facility for Persons with Mental Retardation or Related Conditions (ICF/MR-RC) Program. The Medicaid Hospice Program pays the hospice provider per diem rate for each individual on hospice, who is a Medicaid hospice recipient residing in an ICF/MR-RC. The per diem rate is 95% of the reimbursement amount for the individual who resides in an ICF/MR-RC. This information is extrapolated from Form 3650, Level of Care. For additional information, contact Policy Development, Regulatory Services, Department of Aging and Disability Services.

4550 Coinsurance for Drugs

Revision 06-2; Effective December 12, 2006

The Texas Medicaid Hospice Program pays the Medicaid hospice provider (for Medicare-Medicaid recipients only) a coinsurance of 5% for prescription drugs and biologicals, not to exceed $5 per prescription.

4560 Coinsurance for Respite Care

Revision 05-1; Effective December 2, 2005

The Texas Medicaid Hospice Program pays the Medicaid hospice provider (for Medicare-Medicaid recipients only) a coinsurance of 5% for each day of respite care in a hospice coinsurance period under the Texas Medicaid Hospice Program.

4570 Skilled Nursing Facility (SNF) Payment and the Dually Eligible Individual on Hospice

Revision 08-1; Effective November 12, 2008

When a dually eligible individual on hospice requires an SNF bed for treatment unrelated to his terminal illness, Medicaid hospice room and board payments end. An SNF bed is only appropriate for those aspects unrelated to the terminal illness. The first 20 days are paid by Medicare at 100%. Days 21-100 (or upon discharge, whichever occurs first) are paid by coinsurance through DADS TDHconnect/TMHP. Part of this coinsurance is considered the room and board payment. The nursing facility (NF) submits Form 3619, Medicare/SNF Patient Transaction Notice. A Minimum Data Set (MDS) assessment is not required during this period. The hospice provider **must** submit Form 3071, Individual Election/Cancellation/Update, to TMHP as an **update** for admission into the SNF bed. The date in box No. 3 is the date the individual is admitted into the SNF bed.

Coinsurance for drugs will apply to dually eligible individual on hospice who are in an SNF bed. For more information, see Item 4550, Coinsurance for Drugs.

When the individual is readmitted into the regular NF coverage, an MDS, will be completed if necessary. The hospice provider **must** submit Form 3071 to TMHP as an **update** for discharge from the SNF bed. The date in box No. 3 is the date the individual is discharged from the SNF bed.

Please note that coinsurance for respite services does not apply to dually eligible individuals on hospice residing in an NF.

5000, Reimbursement Rates

Revision 06-2; Effective December 12, 2006

5100 General Information

Revision 05-1; Effective December 2, 2005

The Medicaid Hospice Program establishes and pays prospective hospice per diem rates that are no lower than the Medicare Hospice Program rates (Part A of Title XVIII of the Social Security Act). Medicaid rates are calculated on a yearly basis, based on information provided by the Centers for Medicare & Medicaid Services. The Medicaid hospice per diem rates are calculated by using the Medicare hospice methodology, but adjusted to disregard cost offsets allowed for Medicare deductibles and coinsurance amounts. HHSC does not apply or follow Medicare hospice rate freezes. Retroactive adjustments are not allowed other than for the

- application of the cap on overall Medicaid hospice payments,
- limitation on payments for inpatient care days, and
- recoupment of inaccurate payments made to providers.

The rates are effective from October 1 through September 30 of each federal fiscal year.

5200 Hospice Per Diem Rates

Revision 06-2; Effective December 12, 2006

The Medicaid program pays one of four per diem rates. Rates are paid for any particular hospice day based on the hospice care setting (of a Medicaid only recipient) applicable to the type and intensity of the hospice services provided for that day. The four Medicaid per diem rates are:

- routine home care,
- continuous home care,
- inpatient respite care, and
- general inpatient care.

DADS pays one of the per diem rates for each day an individual on Medicaid hospice qualifies for the Medicaid Hospice Program, regardless of the volume of services provided on any given day.

The following table identifies the services that can be billed for individuals on DADS Medicaid hospice based on their eligibility type and residence.

Service	Bill Code	Medicaid		Medicaid/Medicare	
		Home	Nursing Facility	Home	Nursing Facility
One of the following:	-	-	-	-	-
Routine Home Care	T0100	X	X	-	-
Continuous Home Care	T0200	X	X	-	-
Inpatient Respite Care*	T0300	X	X	-	-
General Inpatient Care	T0301	X	X	-	-
*Limit to 5 consecutive days	-	-	-	-	-
-	-	-	-	-	-
Physician Direct Care	T0302	X	X	-	-
-	-	-	-	-	-
Nursing Facility Room and Board	T0201 to T0212	-	X	-	X
-	-	-	-	-	-
Medicare Pharmacy Coinsurance	T0400	-	-	X	X
-	-	-	-	-	-
Medicare Respite Coinsurance	T0401	-	-	X	X

Conversion Table from Old to New Service Codes

Service	Old Texas LTC Local/Bill Code	Service Code	HCPC Code
Routine Home Care	T0100	1	T2042
Continuous Home Care	T0200	1	T2043
Inpatient Respite Care	T0300	1	T2044
General Inpatient Care	T0301	1	T2045
-	-	-	-
Physician Direct Care	T0302	30	See TMHP crosswalk
Medicare Pharmacy Coinsurance	T0400	32	T0400
Medicare Respite Coinsurance	T0401	33	T0401
-	-	-	-
Nursing Facility and ICF/MR Room and Board	N0201/ N0212	31	T2046

5210 Routine Home Care

Revision 05-1; Effective December 2, 2005

The routine home care rate is paid for each day an individual on Medicaid hospice has elected the Medicaid Hospice Program through a Medicaid hospice provider. DADS does not pay the routine home care rate for day of discharge; however, DADS will pay the routine home care rate for day of death.

5220 Continuous Home Care

Revision 05-1; Effective December 2, 2005

The continuous home care rate is paid by the hour. Payment can be up to 24 hours a day for each day an individual on Medicaid hospice has elected the Medicaid Hospice Program through a Medicaid hospice provider. This rate is for individuals who are not in an inpatient facility, and who receive continuous home care services.

The Medicaid hospice continuous care per diem payment rate varies depending on the number of hours of continuous services provided.

5230 Inpatient Respite Care

Revision 05-1; Effective December 2, 2005

Providers may provide respite care only on an occasional basis. If an individual resides in the home, goes into the NF for respite care and returns home after the respite care, the individual need not be in an NF Medicaid bed. Respite care days are subject to the limitation on total hospice inpatient care days. DADS pays respite care for a

maximum of five consecutive days, including the date of admission but not the date of discharge. DADS will pay the inpatient respite care rate for the day of death.

5240 General Inpatient Care

Revision 05-1; Effective December 2, 2005

General inpatient care is paid for each day an individual on Medicaid hospice elects to receive care through a Medicaid hospice provider. Rates are paid for general inpatient care in approved inpatient facilities. An approved inpatient facility is a Medicaid hospice provider that meets the conditions of participation for providing direct inpatient care, a hospital or an NF that meets the standards regarding 24-hour nursing services and patient areas. Individuals may receive pain control, or acute or chronic symptom management that cannot be managed in other settings. Services must conform to a written plan of care.

DADS pays the Medicaid hospice inpatient care rate for the date of admission and all subsequent inpatient days. DADS does not pay the general inpatient care rate for day of discharge; however, DADS will pay the general inpatient care rate for day of death. General inpatient care days are subject to the limitation on total hospice inpatient care days.

6000, Hospice Care in Long Term Care Facilities

Revision 08-1; Effective November 12, 2008

A Medicaid recipient may elect to receive hospice care in any long term care facility such as a nursing facility (NF), intermediate care facility for persons with mental retardation or related conditions (ICF/MR-RC), or hospital. Long term care facilities must comply with all requirements for participation in the Medicaid and Medicare programs that apply to the facility. Long term care facilities do not have to participate in the hospice program; however, if a resident expresses a desire to participate in hospice and the facility does not contract with hospice providers, the facility should assist the resident in locating a facility that is willing to participate in the hospice program. The hospice rules and policies are similar for all long term care facilities, with some variances because of licensing requirements and payment rates.

6100 Agreements with Long Term Care Facilities

Revision 06-2; Effective December 12, 2006

A hospice provider must enter into an agreement with a long term care facility that is interested in participating in the hospice program. The agreement must contain at least the following:

- description of the hospice and contractor roles in the admission process, individual/family assessment, and the interdisciplinary group care conferences.
- services to be provided.
- a stipulation that services related to the terminal illness may be provided only with the express authorization of the hospice.
- the manner in which the contracted services are coordinated, supervised and evaluated by the hospice.
- requirements for documenting services that are furnished in accordance with the agreement.
- qualifications of the personnel providing the services.

- the Medicaid hospice provider's responsibilities, which are the professional management of an individual's hospice care, the provision of all hospice services on a timely basis as indicated on the Medicaid hospice plan of care, and collection and management of the copay.
- the hospice provider maintains records on the hospice plan of care, including the services provided by hospice staff, in the current NF clinical or ICF/MR-RC resident record. The hospice provider maintains a summary of an individual's long term care facility care plan and records in the hospice provider's plan of care case record.
- the long term care facility agrees to provide certain services to the individual on Medicaid hospice on a timely basis that complement and support the hospice services under the Medicaid hospice plan of care.
- the Medicaid hospice provider agrees to pay the NF or ICF/MR-RC provider the DADS Medicaid room and board rate that is paid to the hospice. If the hospice provider agrees to pay the facility more than this rate, the rate cannot go above the 100% rate and the agreement must specify the additional service the facility will provide. Anything above the 100% rate is considered Medicaid fraud and is reported to the federal government.

6200 Hospice Responsibilities in Long Term Care Facilities

Revision 05-1; Effective December 2, 2005

When a Medicaid recipient elects hospice in a long term care facility, the hospice provider is responsible for:

- the Medicaid hospice election and cancellation process;
- complying with the hospice rules and policies;
- working with the long term care staff to arrange an individual's admission into the facility, if applicable;
- working with the staff in the long term care facility to assure all forms are completed in order to start, continue or cancel the hospice program;
- notifying the Social Security Administration (SSA) when a Supplemental Security Income (SSI) recipient is admitted onto hospice;
- retaining the professional management responsibility for the provision of hospice care according to the hospice plan of care by qualified individuals;
- maintaining a separate hospice section in the current NF clinical or ICF/MR-RC resident record that contains documentation of all the hospice services provided by hospice staff, hospice admission assessments, physician certifications and cancellations, documentation on Medicaid eligibility, advance directives and other legal documents;
- assuring continuity of individual/family care; and
- payment to the long term care provider for room and board.

6300 Hospice and Nursing Facility (NF) Care

Revision 08-1; Effective November 12, 2008

A Medicaid recipient may elect the Medicaid Hospice Program:

- in a home setting and be admitted to an NF as an individual on hospice at a later time;
- and be admitted to an NF as an individual on hospice at the same time; or

- while residing in an NF when the hospice election is made.

The NF and hospice staff should maintain ongoing communication regarding an individual's care and changes in condition. Both entities must maintain hospice records in the individual's current clinical record. Coordinate any changes in the hospice plan of care with the NF staff.

The Medicaid hospice provider is responsible for all items outlined under Section 6200, Hospice Responsibilities in Long Term Care Facilities, as well as the following:

- collecting and managing copay;
- completing Minimum Data Set (MDS) assessment with the NF nursing staff, and maintaining copies of the assessment in the individual's hospice record and current clinical record at the NF;
- ensuring that the MDS is electronically submitted to TMHP within the required time frames as outlined in 40 TAC §30.60 and 40 TAC §19.801.

The NF is responsible for the following areas:

- managing the trust fund.
- completing the MDS with the hospice nursing staff.
- ensuring that the MDS is electronically submitted to TMHP within the required time frames.
- completing Form 3618, Resident Transaction Notice, and submitting it to TMHP, indicating a discharge to hospice. A copy is kept on file with the NF.
- all NF requirements for participation in the Medicaid and Medicare program.

6310 Hospice - Nursing Facility Per Diem Rate

Revision 08-1; Effective November 12, 2008

When a Medicaid recipient elects the Medicaid Hospice Program in an NF, the hospice program pays a per diem rate that is 95% of the NF rate as outlined under Item 4540, Room and Board.

The Medicaid Hospice Program pays the rate to Medicaid hospice providers under the following conditions:

- Medicaid and dually eligible recipients elect the Medicaid Hospice Program and reside in an NF. Information on Medicaid eligibility is outlined in Section 3200, Three-Month Prior Eligibility.
- Form 3618, Resident Transaction Notice was submitted to DADS, indicating a discharge to hospice. A copy is kept on file in the NF. If Form 3618 is not completed and submitted by the NF, and if DADS pays both the NF and the hospice provider, DADS will recoup the payment that was made to the NF. If the NF is not a provider in the Medicaid Nursing Facility Program, or if the individual on Medicaid hospice is not in a Medicaid contracted bed, Form 3618 is not required.
- Hospice providers have a written agreement with the NF to provide hospice care in the facility, as outlined under Section 6100, Agreements with Long Term Care Facilities.
- Minimum Data Set (MDS) assessment was completed by the hospice and NF providers and submitted, as necessary, to TMHP. Retain a copy in the hospice record and the current clinical record at the NF.

When an NF resident elects into the hospice program, he is electing out of the NF program. NFs must stop billing DADS for these residents as of the date of the individual's hospice election and instead, look to the hospice for the room and board payment. Regardless whether the individual is Medicaid or dually eligible, DADS pays the hospice 95% of the Resource Utilization Group (RUG) rate for that resident's room and board, as outlined under Item 4540, Room and Board. The hospice then passes that amount on to the NF.

In order to receive payment from DADS for room and board for dually eligible recipients, a hospice provider must have a valid Medicaid provider agreement.

Information on hospice program requirements for dually eligible recipients for both the Medicaid and Medicare programs may be found in several Centers for Medicare and Medicaid Services publications:

- State Operations Manual, Section 2082, Election of Hospice Benefit by Resident of SNF, NF, ICF/MR-RC or Non-Certified Facility;
- The Hospice Manual, Section 204.2, Skilled Nursing Facility and Nursing Facilities Residents and Dually Eligible Beneficiaries; and
- State Medicaid Manual, Section 4305, Hospice Services.

6320 Vendor Drug

Revision 06-2; Effective December 12, 2006

Individuals on hospice who reside in NFs have access to unlimited prescriptions unrelated to the terminal illness.

6400 Hospice and Intermediate Care Facilities for Persons with Mental Retardation and Related Conditions (ICF/MR-RC)

Revision 06-2; Effective December 12, 2006

Persons who receive services from the ICF/MR-RC Program may receive hospice services.

A Medicaid recipient residing in an ICF/MR-RC may elect the Medicaid Hospice Program. When an ICF/MR-RC resident elects into the hospice program, he is electing out of the ICF/MR-RC Program. ICF/MR-RC providers must stop billing DADS for these residents as of the date of election and instead, look to the hospice for the room and board payment. The hospice passes the room and board payment to the ICF/MR-RC. For more information on the per diem rate, see Item 4540, Room and Board.

The hospice and ICF/MR-RC staff should:

- maintain ongoing communication regarding an individual's care and condition;
- maintain hospice records in the individual's resident record; and
- coordinate any changes in the hospice plan of care with the ICF/MR-RC staff.

7000, Reserved for Future Use

Reserved for future use.

8000, Administration

Revision 06-2; Effective December 12, 2006

8100 End of Life Decisions

Revision 05-1; Effective December 2, 2005

8110 Advance Directives

Revision 06-2; Effective December 12, 2006

The Patient Self Determination Act requires that an individual receive, at the time of admission, written information concerning his right under state law to make decisions concerning his medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

Advance directives are instructions given by an individual to his family and doctor that explain what medical treatment he does and does not want if he is unable to make decisions due to accident, illness or mental incapacity. Examples of advance directives are the:

- Living Will, or Directive to Physicians, governed by Chapter 166 of the Health and Safety Code; and
- Medical Power of Attorney for Health Care, governed by Chapter 166 of the Health and Safety Code.

In those instances where the individual is incompetent, unable to make decisions or has not issued an advance directive, the provider must follow the Health and Safety Code, §166.039, Procedure When Person Has Not Executed or Issued a Directive and is Incompetent or Incapable of Communication.

9000, Community Services

Revision 05-1; Effective December 2, 2005

Individuals who receive hospice care and reside in the community may be eligible to use community services. Contracted providers in the community, such as home health and community support services agencies, furnish services not related to the terminal illness. The following items describe the types of community services available in most areas. Contact local Department of Aging and Disability Services (DADS) offices for more information.

9100 Non-Medicaid Community Care Services

Revision 05-1; Effective December 2, 2005

9110 Adult Foster Care (AFC)

Revision 05-1; Effective December 2, 2005

Adult foster care (AFC) provides a 24-hour living arrangement with supervision in an adult foster home for consumers who, because of physical, mental, or emotional limitations, are unable to function independently in their own homes.

Providers of AFC must live in the household and share a common living area with consumers. With the exception of family members, no more than three adults may live in the foster home unless it is licensed by DADS.

Services may include minimal help with personal care, help with activities of daily living, and provision of, or arrangement for, transportation. The consumer pays the provider for room and board.

9120 Client Managed Personal Attendant Services (CMPAS)

Revision 05-1; Effective December 2, 2005

Personal assistant services are provided to consumers with physical disabilities who are mentally competent and willing to supervise their attendant or who have someone who can provide the personal assistant□s supervision. Consumers interview, select, train and supervise their personal assistants. Licensed personal assistance services agencies determine client eligibility; the care needed; develop a pool of potential personal assistants; and provide emergency back-up personal assistants. Services include: personal assistance services and additional services may include health-related tasks prescribed by a physician.

9130 Day Activity and Health Services (DAHS) Title XX

Revision 05-1; Effective December 2, 2005

Day Activity and Health Services (DAHS) facilities provide daytime services Monday through Friday to consumers residing in the community to provide an alternative to placement in NFs and other institutions. Services are designed to address the physical, mental, medical, and social needs of consumers. Services include:

- noon meal and snacks,
- nursing and personal care,
- physical rehabilitation,
- social, educational and recreational activities, and
- transportation.

9140 Emergency Response Services (ERS)

Revision 05-1; Effective December 2, 2005

Emergency Response Services (ERS) provides an electronic monitoring system to functionally impaired adults who live alone or are socially isolated in the community. In an emergency, the consumer can press a call button to signal for help. The electronic monitoring system, which has a 24-hour, seven-day-a-week monitoring capability, helps ensure that the appropriate person or service agency responds to an alarm call from a consumer.

9150 Home Delivered Meals

Revision 05-1; Effective December 2, 2005

The Home Delivered Meals Program provides a nutritious meal that is taken to the consumer's home, which helps ensure a consumer receives at least one healthy meal per day.

9160 In-Home and Family Support (IHFSP)

Revision 05-1; Effective December 2, 2005

The In-Home and Family Support Program (IHFSP) provides direct grant benefits to consumers with physical disabilities and/or the consumer's family to purchase services that enable them to live in the community. Eligible consumers are empowered to choose and purchase services from the following:

- assistance with purchase or lease of special equipment or architectural modifications to a home;
- counseling and training programs;
- home health aide and homemaker services;
- household assistance;
- medical services and other health services related to a consumer□s disability;
- other disability related services prior-approved by DADS;
- personal attendant care for assistance with activities of daily living;
- pre-approved transportation and room and board cost incurred by a person with a physical disability or the family during evaluation or treatment;
- respite care;
- transportation services.

9170 Residential Care Program (RC)

Revision 05-1; Effective December 2, 2005

The Residential Care (RC) Program provides services to eligible adults who require access to care on a 24-hour basis but do not require daily nursing intervention. Services include personal care, home management, escort, 24-hour supervision, social and recreational activities, and transportation.

Supervised living is a state-funded 24-hour living arrangement in which the consumer is expected, if able, to contribute to the total cost of his care. The consumer keeps a monthly allowance for personal and medical expenses, and the remainder of his income is contributed to the total cost of his care.

Services provided under the RC program are delivered through either residential care or emergency care.

Emergency care is a state- or Title XIX-funded living arrangement that provides services to eligible consumers while caseworkers seek a permanent care arrangement. Emergency care consumers do not contribute toward the cost of their care.

9180 Respite Care

Revision 05-1; Effective December 2, 2005

The Respite Care Program provides short-term services for elderly and disabled adults who require care and/or supervision while their care givers receive temporary relief. Services may be provided inside or outside of the home. Services may be provided in:

- an NF or hospital and include personal care, nursing intervention, supervision, meal preparation, and a room;
- an adult foster care home or an assisted living facility and include personal care, housekeeping, supervision, meal preparation, transportation, and a room;
- an adult day health care facility and include personal care, nursing services, supervision, meal preparation, and transportation;
- the consumer's own home by a home care attendant and include personal care, housekeeping, meal preparation, supervision, and transportation;
- the consumer's own home by a sitter and include housekeeping, meal preparation, and supervision.

9190 Special Services

Revision 05-1; Effective December 2, 2005

9191 Special Services to Persons with Disabilities

Revision 05-1; Effective December 2, 2005

Special Services to Persons With Disabilities provides special services to community care clients in a variety of settings. These services are designed to assist consumers in developing the skills needed to remain in the community as independently as possible. Services include counseling, homemaking and housekeeping assistance and personal assistance services.

9192 Special Services to Persons with Disabilities 24-Hour Attendant Care

Revision 05-1; Effective December 2, 2005

Special Services to Persons With Disabilities 24-Hour Attendant Care makes attendant care available to consumers on a 24-hour basis. Consumers live independently in clustered living arrangements and use this service to achieve habilitate or rehabilitative goals.

9200 Non-waiver Medicaid Community Care Services

Revision 05-1; Effective December 2, 2005

9210 Day Activity and Health Services (DAHS) Title XIX

Revision 05-1; Effective December 2, 2005

Day Activity and Health Services (DAHS) facilities provide daytime services Monday through Friday to clients who reside in the community as an alternative to placement in NFs and other institutions. Services are designed to address the physical, mental, medical, and social needs of clients. Services include:

- noon meal and snacks,
- nursing and personal care,
- physical rehabilitation,
- social, educational, and recreational activities, and
- transportation.

9220 Primary Home Care (PHC)

Revision 05-1; Effective December 2, 2005

Primary Home Care (PHC) is a non-technical, personal care service available to eligible adults and children whose health problems cause them to be functionally limited completing activities of daily living. A practitioner must provide a statement that the consumer has a current medical need or assistance.

PHC provider agencies also provide family care services. Family care also is a non-skilled, non-technical service provided to eligible consumers who are functionally limited in performing daily activities.

PHC services are provided by an attendant through a licensed home and community support services agency under the personal assistance services (PAS) category of licensure.

9300 Medicaid Waiver Programs

Revision 05-1; Effective December 2, 2005

9310 Community Based Alternatives (CBA)

Revision 05-1; Effective December 2, 2005

The Community Based Alternatives (CBA) program provides home and community-based services to aged and disabled adults as cost-effective alternatives to institutional care in nursing facilities (NFs).

DADS staff provides case management. Waiver services include:

- adaptive aids and medical supplies,
- adult foster care,
- assisted living/residential care services,
- consumer directed services,
- emergency response services,
- home delivered meals,
- minor home modifications,
- nursing services,
- occupational therapy,
- personal assistance services,
- physical therapy,
- respite care,
- speech pathology services, and
- transition assistance services.

9320 Community Living Assistance and Support Services (CLASS)

Revision 05-1; Effective December 2, 2005

The Community Living Assistance and Support Services (CLASS) program provides home and community-based services to persons with related conditions as a cost-effective alternative to Intermediate Care Facility for Persons with Mental Retardation or Related Conditions (ICF/MR-RC) institutional placement. A related condition is a qualifying disability, other than mental retardation, which originated before age 22 and effects their ability to function in daily life.

The CLASS service model focuses on consumer independence and integrating consumers into everyday community life. The CLASS program has two service providers: one provides independent case management, and one provides all other services, which include:

- adaptive aids and medical supplies,
- case management,
- consumer directed services,
- habilitation,
- minor home modifications,
- nursing services,
- occupational therapy,
- physical therapy,
- psychological services,
- respite care,
- speech pathology,
- specialized therapies,
- support family services, and
- transition assistance services.

9330 Program of All Inclusive Care for the Elderly (PACE)

Revision 05-1; Effective December 2, 2005

PACE provides community-based services to frail elderly people who qualify for NF placement. The program uses a comprehensive care approach to provide an array of services for a capitated monthly fee that is below the cost of comparable institutional care.

Covered services include any and all needed health-related services needed. These services include in-patient and out-patient medical care, specialty services such as dentistry and podiatry, social services, in-home care, meals, transportation, day activity, and housing assistance.

9340 Consolidated Waiver Program (CWP)

Revision 05-1; Effective December 2, 2005

The Consolidated Waiver Program (CWP) provides home and community-based service to consumers who are eligible for nursing facility care or intermediate care facility for persons with mental retardation or a related condition (ICF/MR-RC) as a cost-effective alternative to institutional placement. Services include:

- case management,

- adaptive aides and medical supplies,
- adult foster care,
- assisted living/residential care,
- audiology,
- behavior communication specialist,
- child support services,
- consumer directed services,
- dental treatment,
- dietary services,
- emergency response services,
- family surrogate services,
- habilitation (residential, day, supported employment and prevocational),
- home delivered meals,
- independent advocacy,
- intervention services,
- minor home modifications,
- nursing services,
- orientation and mobility services,
- personal assistance services,
- prescribed drugs,
- psychological,
- respite (in and out of home),
- social work,
- therapies (physical, occupational, speech),
- transportation, and
- 24-hour residential habilitation.

9350 Deaf Blind with Multiple Disability (DBMD) Program

Revision 05-1; Effective December 2, 2005

The Deaf Blind with Multiple Disability (DBMD) Program provides home and community-based services to consumers who are deaf-blind with multiple disabilities as a cost-effective alternative to ICF-MR/RC institutional placement. The DBMD Program focuses on increasing opportunities for consumers to communicate and interact with their environment. Services include:

- adaptive aides and medical supplies,
- assisted living/residential care,
- case management,
- chore provider,
- consumer directed services,
- dietary services,
- habilitation,
- intervention,
- minor home modifications,
- nursing services,
- occupational therapy,
- orientation and mobility,
- physical therapy,
- respite care,

- speech, hearing and language therapy.

9360 Home and Community Based Services (HCS) Program

Revision 05-1; Effective December 2, 2005

The HCS Program for consumers with mental retardation provides individualized services and supports to consumers living in their family home, their own homes, or other community settings such as small group homes where no more than four people live. Services include:

- case management,
- adaptive aids,
- minor home modifications,
- counseling and therapies,
- dental treatment,
- nursing,
- residential assistance,
- respite,
- day habilitation,
- supported employment.

9370 Texas Home Living (TxHmL) Program

Revision 05-1; Effective December 2, 2005

The TxHmL Program provides selected essential services and supports to consumers with mental retardation who live in their family homes or their own homes. The cost of covered services has a cap and may include:

- adaptive aids,
- minor home modifications,
- specialized therapies,
- behavioral support,
- dental treatment,
- nursing,
- community support,
- respite,
- day habilitation,
- employment assistance,
- supported employment.

9380 Medically Dependent Children Program (MDCP)

Revision 05-1; Effective December 2, 2005

The Medically Dependent Children Program (MDCP) provides a variety of services, which are cost-neutral, to support families caring for children who are medically dependent and to encourage de-institutionalization of children in nursing facilities. Services include case management by regional DADS staff, adaptive aids, adjunct support services, minor home modifications, respite and transition assistance services.

Appendices

Appendix I, Helpful Telephone Numbers

Revision 08-1; Effective November 12, 2008

CARE Form System (3618, 3619, and 3652)	800-727-5436
Distribution (fax)	512-438-3548
Facility Enrollment	512-438-2630
Hospice Complaints	800-458-9858
ICF/MR-RC Complaint Hotline	800-458-9858
Medicaid Fraud	888-752-4888
Medicaid Hospice	512-438-3015
Nursing Home Hotline	800-458-9858
Protective and Regulatory Hotline (PRS)	800-252-5400
Provider Claims Services	512-438-2200
Texas Medicaid and Healthcare Partnership-Long Term Care	800-626-4117
Vendor Drug Hotline	800-435-4165

Appendix II, Abbreviations Dictionary

Revision 08-1; Effective November 12, 2008

AI	Applied Income
CCAD	Community Care Aged and Disabled
CFR	Code of Federal Regulations
CM	Contract Management
CMS	Claims Management System
DADS	
DME	Durable Medical Equipment
DSHS	Texas Department of State Health Services
HHSC	Texas Health and Human Services Commission
ICF-MR/RC	Intermediate Care Facilities for Persons with Mental Retardation and Related Conditions

MAO	Medical Assistance Only
MDS	Minimum Data Set
ME	Medicaid Eligibility
MED	Medicaid Eligibility Date
NF	Nursing Facility
PIN	Payee ID Number (14 digits)
RUG	Resource Utilization Group
SSA	Social Security Administration
SSI	Supplemental Security Income
TMHP	Texas Medicaid and Healthcare Partnership
UR	Utilization Review

Appendix III, Directive to Physicians and Family or Surrogates

Revision 05-1; Effective December 2, 2005

Visit the web site below for this information:

Advance Directives

Appendix IV, Disclosure Statement for Medical Power of Attorney

Revision 05-1; Effective December 2, 2005

Disclosure Statement for Medical Power of Attorney:

https://hhs.texas.gov/laws-regulations/forms/miscellaneous/mpoa-medical-power-attorney

Visit the web site below for additional information:

https://hhs.texas.gov/laws-regulations/forms/advance-directives

Appendix V, Out of Hospital Do Not Resuscitate Order

Revision 05-1; Effective December 2, 2005

For information about the Texas Department of State Health Services Out of Hospital Do Not Resuscitate Program and forms, visit the web site at http://www.dshs.texas.gov/emstraumasystems/dnr.shtm.

Appendix VI, Mutually Exclusive Services

Appendix VII, List of Excluded Individuals and Entities (LEIE)

Appendix VIII, Advance Directives

Appendix IX, Solicitation Prohibition

Forms

ES = Spanish version available.

Form	Title	
1290	Long Term Care Claim	
2076	Authorization to Release Medical Information	ES
3071	Individual Election/Cancellation/Update	
3074	Physician Certification of Terminal Illness	
H4808	Notice of Change in Applied Income/Notice of Denial of Medical Assistance	

Revisions

19-2, Updated Contact Us Page

Revision Notice 19-2; Effective December 2, 2019

The following change(s) were made:

Section	Title	Change
Contact Us	Contact Us	Updates Contact Us page to include new emails and phone numbers when people have questions.

19-1, Appendix Added

Revision Notice 19-1; Effective May 1, 2019

The following change(s) were made:

Section	Title	Change
Appendix IX	Solicitation Prohibition	Adds a new appendix shared with other handbooks regarding solicitation information.

11-1, May 11, 2011, Policy Update

Revision Notice 11-1; Effective May 11, 2011

The following sections were changed:

Revised	Title	Change
1400	Services Not Covered by Medicaid Hospice	Adds information to explain that individuals under 21 years old are not required to waive Medicaid payment for treatments related to terminal illness.
4100	General Information	Adds exception to explain that individuals under 21 years old are not required to waive Medicaid payment for treatments related to terminal illness.

09-1, February 27, 2009, Copay

Revision Notice 09-1; Effective February 27, 2009

The following change(s) were made:

Section	Title	Change
3400	Copay	This revision updates the copay amount.

MHPM Contact Us

Revision 19-2; Effective December 2, 2019

For questions regarding:

The Medicaid Hospice Provider Manual or Medicaid hospice policy, email HospicePolicy@hhsc.state.tx.us.

A licensure application or renewal, call HHSC Licensing and Credentialing at 512-438-2630.

State or federal regulations or regulatory policy, call 512-438-3161 or email PolicyRulesTraining@hhsc.state.tx.us.

- Regulatory Services Regional Contacts

Contracting to provide services and receive reimbursement, call 512-438-3234 or email IDDWaiverContractEnrollment@hhsc.state.tx.us.

- Community Services Regional Contacts

Outcome and Assessment Information Set, call the OASIS help desk at 833-769-1945 or email OASIS.help@hhsc.state.tx.us.

Long Term Care Provider Claims, call 512-438-2200, option 1.

Rates, call the customer information center at 512-424-6637 or email RAD-LTSS@hhsc.state.tx.us

Utilization review or a record request, email Medicaid Hospice Utilization Review at MHUR@hhsc.state.tx.us.

For technical or accessibility issues with this handbook, please email form.handbook.request@hhs.texas.gov.