

## **ATTACHMENT K**

### **Medicaid Program Enrollment Requirements**

#### **ENROLLMENT INTO THE HCS PROGRAM AND TxHML PROGRAM**

- I. THE LA SHALL:
  - A. Designate staff to complete enrollments for the following waiver programs:
    - 1. Home and Community-based Services (HCS) Program; and
    - 2. Texas Home Living (TxHmL) Program.
  - B. Require designated staff to complete on-line DADS enrollment training, with at least one staff designated to receive the training annually thereafter. The training can be found at:  
<http://www.dads.state.tx.us/providers/mra/training/index.html>.
  - C. Ensure designated enrollment staff do not perform functions for the LA's provider operations.
- II. THE LA SHALL:
  - A. Complete the enrollment process for each authorized consumer into the HCS Program and TxHmL Program in accordance with DADS rules and within the timeframes below (the enrollment process is complete when the consumer status in CARE screen C61 is "active" or "denied"). The LA may request an extension of the timeframes and DADS will grant an extension for good cause:
    - 1. for a consumer residing in a nursing facility — 180 calendar days after the LA was notified of the program vacancy;
    - 2. for a consumer residing in a community ICF/IID or being discharged from a state mental health facility — 90 calendar days after the LA was notified of the program vacancy; and
    - 3. for a consumer residing in his or her own or family's home — 75 calendar days after the LA was notified of the program vacancy.
  - B. Access the Service Authorization System Online (SASO) to determine if the consumer is currently enrolled in a Medicaid waiver program, and if so, the LA shall:
    - 1. inform the consumer or LAR of the requirement to choose either the program the consumer is currently enrolled in or the program that the LA is offering; and
    - 2. provide program comparison information for Texas Long-term Service and Supports Waiver Programs found at:  
[http://www.dads.state.tx.us/providers/waiver\\_comparisons/index.html](http://www.dads.state.tx.us/providers/waiver_comparisons/index.html).

- C. Use the HCS PDP Form 8665, as well as the form's instructions and the information contained in the discovery tool and discovery guide in the HCS Handbook appendices, when conducting person-directed planning for a consumer enrolling in the HCS Program. (Form 8665 and the information contained in the discovery tool and discovery guide may be used for developing the person-directed plan for an individual enrolling in TxHmL.)
- D. Enter the consumer's enrollment information into the CARE Automated Enrollment and Billing System screens L01, L23 (if applicable), L02, L03, L09, and L05.
- E. Review each consumer enrolling in HCS to determine if the consumer is eligible for inclusion in the Money Follows the Person (MFP) Demonstration Project as follows.
1. A consumer is eligible for inclusion in the MFP Demonstration Project if the consumer meets all of the following criteria:
    - a. the consumer must reside continuously in an institutional setting (i.e., ICF/IID, nursing facility, hospital, or state hospital) for at least 90 days prior to the HCS enrollment date *and be enrolled in HCS from a nursing facility, a large ICF/IID (14 beds or more), or a medium ICF/IID (9-13 beds)*;
    - b. the consumer's 90-day stay in the institutional setting as required by a. above excludes any days funded by Medicare;
    - c. the consumer must be Medicaid eligible under Title XIX of the Social Security Act; and
    - d. the consumer must transition from the nursing facility or ICF/IID into a qualifying residence, which is the consumer's own home or family home, a foster companion care home, a three-person group home, or a four-person group home.
  2. A consumer is eligible for inclusion in the MFP Demonstration Project if:
    - a. the consumer is a resident of a medium ICF/IID (9-13 beds) or large ICF/IID (14 beds or more);
    - b. the facility owner has an approved plan to participate in the MFP Demonstration Voluntary Closure Pilot; and
    - c. the consumer meets the eligibility criteria described in paragraph 1. a.-d above.
  3. A consumer is eligible for inclusion in the MFP Demonstration Project if the consumer is under 22 years of age and:
    - a. is a resident of a small ICF/IID (1-8 beds);
    - b. meets the eligibility criteria described in paragraph 1. a.-c. above except that the ICF/IID may be a small facility; and

- c. transitions from the small ICF/IID into the consumer's own home or family home or a foster companion care home.
  4. If the consumer is eligible for the MFP Demonstration Project, the LA will provide the consumer or LAR with a brief explanation of the project using the information on the *Informed Consent for Participation* (Form 1580-IDD) and invite the consumer and LAR to participate in the project by signing the form. If the consumer or LAR agrees, the LA will follow the instructions on the form, including completion of the "For Official Use Only" section of the form. The LA must complete the form as soon as possible and fax it to DADS immediately after completion, but no later than two weeks before the consumer is discharged from the facility. NOTE: The LA is not required to comply with this provision for a resident of a state supported living center (SSLC) who is eligible for the MFP Demonstration Project. SSLC staff are responsible for the explanation and completion and faxing of Form 1580-IDD.
  5. If the consumer or LAR signs the form, the LA must enter "Y" on the CARE screen L01 for the question MFP DEMO Y\_ N\_.
  6. On a case-by-case basis, DADS may determine a consumer eligible for the MFP Demonstration Project and direct the LA to comply with II.E.4. and 5. for that consumer or LAR.
- F. If the consumer being offered a program vacancy in HCS or TxHmL is enrolled in STAR+PLUS:
1. inform the consumer that disenrollment in STAR+PLUS is required in order to enroll in HCS or TxHmL;
  2. ensure the consumer's Individual Plan of Care (IPC) begins on the first day of a month;
  3. ensure the consumer's enrollment data has been entered into CARE within seven (7) days prior to the end of the month before the consumer's scheduled enrollment date; and
  4. if the LA anticipates the consumer's HCS or TxHmL enrollment will not be completed within the timeframes listed in II.A. of this attachment, request that DADS approve an extension (using Form 1045 (Request for HCS/TxHmL Enrollment Extension)) to the time allowed for the enrollment.
- G. Comply with the instructions in this section when offering an HCS or TxHmL Program vacancy:

1. For a consumer whose enrollment process is not complete within the timeframes listed in II.A. of this attachment, the LA must have, within the same timeframes:
  - a. submitted to DADS a *Verification of Freedom of Choice* form with the consumer's or LAR's signature and date declining the HCS or TxHmL Program, as appropriate;
  - b. submitted to DADS documentation that the LA sent a letter of withdrawal in accordance with DADS rules; or
  - c. submitted a request to extend to the time allowed for the enrollment (using a Request for HCS/TxHmL Enrollment Extension (Form 1045)) that DADS has approved. NOTE: A Request for HCS/TxHmL Enrollment Extension (Form 1045) received by DADS after the 15<sup>th</sup> day of the last month of a quarter will not be approved for that quarter.
  
2. If the LA that is authorized to offer an HCS or TxHmL program vacancy to a consumer (the authorized LA) anticipates the consumer's HCS or TxHmL enrollment will not be completed by the required date, the LA must request that DADS grant an extension (using Form 1045) to the time allowed for the enrollment and provide a reason for the delay.

For HCS only: If the reason for the delay is related to determination of Medicaid eligibility, the LA must proceed with enrollment activities and data entry of all the enrollment screens in CARE, as required by II.D. above, prior to submitting a request for extension.

For TxHmL only: If the reason for the delay is related to determination of Medicaid eligibility, the LA must proceed with enrollment activities and data entry of all the enrollment screens in CARE, as required by II.D. above, prior to submitting a request for extension *unless the LA determines the individual is likely to be denied Medicaid. In which case, the LA must provide a reason for such determination on the extension request (Form 1045).*
  
3. For all HCS slots and those TxHmL slots that are *not* refinance slots: If the authorized LA attempts to contact the consumer or LAR and learns that the consumer or LAR has relocated to another local authority's local service area, the authorized LA must determine the consumer's designated LA using the "Guidelines for Determining and Changing Designated LA" (see Attachment O). If the authorized LA is the designated LA, then the authorized LA will continue with all enrollment activities. If the authorized LA determines that another LA is the designated LA, then the authorized LA must forward to the designated LA a copy of the authorization letter, the Provider Choice form, and a copy of any extensions already obtained. The authorized LA must notify the appropriate staff at DADS LA section of the transfer. Once the designated LA receives the information from the authorized LA, then the designated LA becomes the authorized LA and is responsible for meeting required timeframes for enrollment or requesting an extension.

For refinance TxHmL slots only: If the authorized LA attempts to contact the consumer or LAR and learns that the consumer or LAR has relocated to another local authority's local service area, the authorized LA must contact DADS for further instructions.

4. For all HCS slots and those TxHmL slots that are *not* refinance slots: If the authorized LA contacts the consumer or LAR and begins the enrollment process and the applicant or LAR selects a provider in a different local authority's local service area, then the authorized LA must conduct all pre-enrollment activities, such as explanation of services, obtaining signature on Verification of Freedom of Choice, conducting diagnostic activities and ID/RC, Medicaid eligibility information, initial person-directed plan (PDP), and proposed IPC. The authorized LA must:
  - a. request an extension on the enrollment if the enrollment will not be completed in the originally assigned or extended timeframe;
  - b. transfer the consumer to the local authority in which the selected provider operates;
  - c. provide the initial PDP to the provider and complete the IPC negotiations with the provider; and
  - d. send hard copies of all enrollment documents, including the provider choice form and any enrollment extensions already obtained, to the receiving LA.

Once the receiving LA receives the information from the authorized LA, then the receiving LA is responsible for meeting required timeframes for enrollment.

For HCS only: The receiving LA must complete the data entry of all enrollment screens in a timely manner and request an extension if enrollment is not expected to be approved by the required timeframe.

For TxHmL only: The receiving LA must complete the data entry of all enrollment screens in a timely manner and request an extension if enrollment is not expected to be approved by the required timeframe. An exception to the requirement to complete data entry of all enrollment screens prior to requesting an extension is when *the LA determines the individual is likely to be denied Medicaid. In which case, the LA must provide a reason for such determination on the extension request (Form 1045).*

- H. If the consumer being offered a program vacancy is currently receiving general revenue-funded services from the LA, inform the consumer and LAR that if the consumer or LAR declines the offer of waiver services identified by DADS (i.e., HCS or TxHmL) the LA will terminate the general revenue services in accordance with rules governing the HCS or TxHmL Program.
- I. Prior to enrollment, ensure the consumer and LAR are provided information about the Medicaid Estate Recovery Program as described in Attachment R (Medicaid Estate Recovery Program).

- J. Prior to enrollment, determine whether the consumer is a Medicare beneficiary. If the consumer is a Medicare beneficiary, the LA must comply with the following:
1. The LA must verify that the consumer:
    - a. is enrolled in a Medicare-sponsored prescription drug plan, which can be a stand alone drugs-only insurance plan or a Medicare Advantage Prescription Drug (MA-PD) plan; and
    - b. has been deemed eligible for extra help and if not, assist the consumer in applying for extra help using the SSA-1020 form found at [www.socialsecurity.gov](http://www.socialsecurity.gov).
  2. If the consumer is not already enrolled in a drug plan, the LA shall explain to the consumer and LAR that the consumer must enroll in a drug plan in order to receive prescription medications and that upon enrollment in the waiver program he or she will be auto-enrolled in a drug plan, which may or may not be the drug plan that is most beneficial. The LA shall:
    - a. encourage the consumer to enroll in a drug plan before enrollment if possible; and
    - b. offer assistance, and provide assistance if requested, to the consumer and LAR with evaluating the drug plans to identify the plan that is most beneficial to the consumer.
  3. The LA shall explain to the consumer and LAR that:
    - a. the consumer will get his or her prescription medications through a drug plan. Note: as a Medicaid wrap-around service, Medicaid will pay for a limited list of drugs that Medicare will not pay for, including benzodiazepines, barbiturates, and prescribed over-the-counter drugs;
    - b. the consumer will be automatically deemed eligible for the extra help, which will assist with his or her drug costs;
    - c. the consumer is not responsible for any cost sharing for his or her prescription medications;
    - d. the consumer will pay little or no premiums and no deductible;
    - e. the consumer will be responsible for paying for any prescription medications that are not covered by his or her drug plan or the Medicaid wrap-around service (as noted in a. above);
    - f. if the consumer is enrolling in TxHmL, the LA service coordinator can assist him or her with changing drug plans and filing an exception, appeal, or grievance with the drug plan; and
    - g. if the consumer is enrolling in HCS, the program provider can assist him or her with changing drug plans and filing an exception, appeal, or grievance with the drug plan.
  4. Note: The information contained in 1.-3. above pertains to a consumer with Medicare *and* Medicaid (referred to as “full-dual eligible”). A consumer with only Medicaid is not affected by the Medicare Prescription Drug Program and will continue to receive his or her drugs through Medicaid.

K. Explain to the consumer or LAR:

1. he or she must document the following on the *Verification of Freedom of Choice* form:
  - a. that he or she chooses the TxHmL or HCS Program rather than the ICF/IID Program or other services (or program); or
  - b. that he or she declines the TxHmL or HCS Program and chooses instead the ICF/IID Program or "Other". If the consumer or LAR chooses "Other," then the LA should encourage the consumer or LAR to identify the other services (or program) and the reason; and
2. for consumers offered enrollment in the TxHmL Program whose names are on the HCS Interest List, that the consumer's name will remain on the HCS Interest List regardless of whether the consumer or LAR chooses or declines participation in the TxHmL Program;

L. For a consumer who has declined to participate in the HCS or TxHmL Program:

1. submit to DADS a copy of the completed *Verification of Freedom of Choice* form; and
2. enter the decline status code in CARE if the consumer's name is on the HCS Interest List;

M. For a consumer who has chosen to participate in the HCS or TxHmL Program:

1. explain to the consumer or LAR that he or she may choose any contracted HCS or TxHmL Program provider, as appropriate to the program being offered, in the LSA that has not reached its service capacity as identified in CARE;
2. be objective in assisting a consumer or LAR in selecting an HCS or TxHmL Program provider, and not influence the consumer's or LAR's decision;
3. provide the consumer or LAR with a current list (i.e., dated within seven (7) days) from CARE (XPTR HC062096 for HCS and HC062097 for TxHmL) of all contracted TxHmL or HCS Program providers, as appropriate to the program being offered, in the LA's LSA that have not reached their service capacity. The list will also include local "applicant contact" information, if available, for use by the consumer or LAR; and
4. document the selection of the program provider on the *Documentation of Provider Choice* form and submit a copy of the form to DADS, along with a copy of the completed *Verification of Freedom of Choice* form.

- N. Not allow any of the LA's staff from its provider operations to initiate contact with the consumer or LAR prior to the completion of the *Documentation of Provider Choice* form.
- O. For a consumer who is being enrolled in the TxHmL Program, ensure the LA service coordinator facilitates the completion of the *Texas Home Living Program Service Coordination Notification* (Form 8586).
- P. Maintain the following completed forms in the consumer's record:
  - 1. *Verification of Freedom of Choice* form;
  - 2. *Documentation of Provider Choice* form; and
  - 3. *Texas Home Living Program Service Coordination Notification* (Form 8586), if applicable.

## **ENROLLMENT INTO THE ICF/IID PROGRAM**

### THE LA SHALL:

- A. Complete enrollment of a consumer into the ICF/IID Program in accordance with DADS rules;
- B. Prior to enrollment, ensure the consumer and LAR are provided information about the Medicaid Estate Recovery Program as described in Attachment R (Medicaid Estate Recovery Program); and
- C. Prior to enrollment, determine whether the consumer is a Medicare beneficiary. If the consumer is a Medicare beneficiary, the LA must do the following:
  - 1. The LA must verify that the consumer:
    - a. is enrolled in a Medicare-sponsored prescription drug plan, which can be a stand alone drugs-only insurance plan or a Medicare Advantage Prescription Drug (MA-PD) plan; and
    - b. has been deemed eligible for extra help and if not, assist the consumer in applying for extra help using the SSA-1020 form found at [www.socialsecurity.gov](http://www.socialsecurity.gov).
  - 2. If the consumer is not already enrolled in a drug plan, the LA shall explain to the consumer and LAR that the consumer must enroll in a drug plan in order to receive prescription medications and that upon enrollment in the ICF/IID Program he or she will be auto-enrolled in a drug plan, which may or may not be the drug plan that is most beneficial. The LA shall:
    - a. encourage the consumer to enroll in a drug plan before enrollment if possible; and

- b. offer assistance, and provide assistance if requested, to the consumer and LAR with evaluating the drug plans to identify the plan that is most beneficial to the consumer.
3. The LA shall explain to the consumer and LAR that:
  - a. the consumer will get his or her prescription medications through a drug plan. Note: as a Medicaid wrap-around service, Medicaid will pay for a limited list of drugs that Medicare will not pay for, including benzodiazepines, barbiturates, and prescribed over-the-counter drugs;
  - b. the consumer will be automatically deemed eligible for the extra help, which will assist with his or her drug costs;
  - c. the consumer will not have any cost-sharing responsibilities such as premiums, deductibles, co-payments, or co-insurance for drugs covered by the plan; and
  - d. the ICF/IID Program provider can assist the consumer or LAR with changing drug plans and filing an exception, appeal, or grievance with the drug plan.
4. Note that the information contained in 1.-3. above pertains to a consumer with Medicare *and* Medicaid. A consumer with Medicaid only is not affected by the Medicare Prescription Drug Program and will continue to receive his or her drugs through Medicaid.