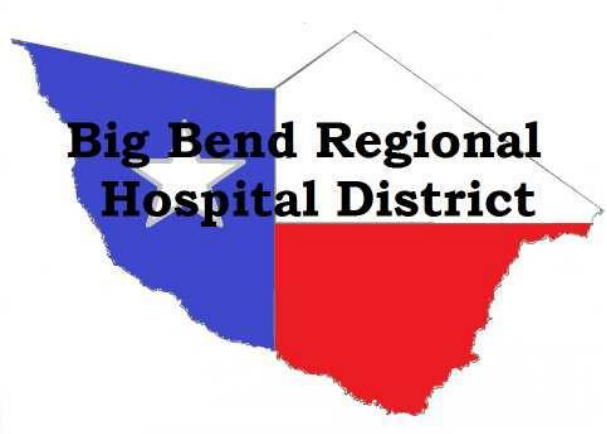
Big Bend Regional Hospital District



HANDBOOK

Effective – June 23, 2022

This handbook is effective February 17, 2022 and supersedes all prior handbooks or notices issued by the Big Bend Regional Hospital District for their Indigent Healthcare Program (Big Bend Health). This handbook contains all revisions from: June 19, 2009, August 27, 2009, April 17, 2012, May 17, 2012, July 2013, October 1, 2014, April 21, 2015, June 23, 2015, March 1, 2016, and March 25, 2021.

Big Bend Regional Hospital District (BBRHD) is the administrator of this healthcare plan. It is not insurance coverage and may not be accepted by some medical facilities or physicians. The BBRHD and the Big Bend Health are not responsible for services provided by non-network physicians or facilities or for services not allowed by this program.

Address any questions related to this Program to BBRHD at:

In Person:	105 West Holland Ave Alpine, TX 79830 (432) 837-7051 Office Hours: 9:00 AM – 12:00 Noon 1:00 PM - 5:00 PM (Monday – Friday, except holidays)
By Mail:	Big Bend Regional Hospital District P. O. Box 1439 Alpine, TX 79831
On the Web:	WWW.BBRHD.COM

Applications for the Big Bend Health programs are available at the Program's Offices and numerous locations, such as doctor's offices.

Applications are also available for download on the **BBRHD** web site.

This handbook is intended as a guide for patients and providers. Not all medical situations, condition, coverages, or exclusions may be contained in this manual. Big Bend Regional Hospital District has administrative control over this program and may from time to time modify, make administrative or operational changes, or suspend coverages as they deem necessary. In non-emergency situations patients and providers should determine if the Program covers anticipated services and to what extent before beginning medical treatment, most procedures require preauthorization.

This handbook or the appendices may be changed or revised as needed by Big Bend Regional Hospital District without a re-issuance of this handbook. Changes made to this handbook may be found at the BBRHD web site listed above.

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Section One – Program Administration

INTRODUCTION

Big Bend Regional Hospital District (District) is charged by Article IX, Section 9 of the Texas Constitution to provide certain health care services to the County's needy inhabitants. In addition, section 61.055 of the Texas Indigent Health Care and Treatment Act, (Ch. 61 Texas Health & Safety Code) requires the District to provide the health care services required under the Texas Constitution and the statute creating the District. The District's enabling legislation provides that the Board of Directors of the District shall have the power and authority to promulgate rules governing the healthcare services to be delivered by the District in Brewster and Presidio counties.

The District is committed to ensure that the needy inhabitants of the District receive healthcare services in an equitable and non-discriminatory manner through the District's program. The District believes medical care services can be provided in a manner that is fair and equitable, efficient and without undue expense of local taxpayer dollars, which fund such care.

The District has additional responsibilities related to the promotion and execution of health care for the citizenry at large, specifically as this relates to the contracted operation of the Big Bend Regional Medical Center which provides hospital services for both Presidio and Brewster Counties. While it is the Districts primary responsibility to provide for the counties' indigent first, the District can extend services to the counties' general population through healthcare initiatives which can be funded by tax revenues, property resource income, by fundraising, or grants.

These Big Bend Health program policies are promulgated and approved pursuant to the District's enabling legislation and are intended to provide guidelines and rules for the qualification and enrollment of participants into the District's healthcare program. These policies are intended to track and be in harmony with the indigent healthcare plan policies approved by the Texas Department of State Health Services and imposed upon non-hospital district counties pursuant to the Indigent Health Care and Treatment Act.

It is the intent of the District that these policies are to apply to "indigents" as defined in Ch. 61 of the Texas Health & Safety Code, such determination using the eligibility guidelines set forth in Chapter 61 and the rules adopted by Texas Health and Human Services. In addition, these policies are intended to ensure the delivery of quality and medically necessary healthcare services to program participants in a fair and non-discriminatory manner.

These policies are intended to cover the delivery of health care services to indigent residents of the District. Such residents are not employees of the District therefore these policies do not create benefits or rights under ERISA, COBRA, or other employment-related statutes, rules, or regulations.

These policies are intended to comply with medical privacy regulations imposed under HIPAA and other state regulations but are superseded by such statutes to the extent of any conflict. Compliance with ADA and other regulations pertaining to disabled individuals shall not be the responsibility of the District, but shall be the responsibility of those medical providers providing services to the District's needy inhabitants.

Big Bend Health Handbook

The Big Bend Health Handbook is sometimes referred to in other agreements as the "Big Bend Health Plan", "The Plan", "The Program", "Plan Document", "Program Document", or "the Handbook".

The purpose of the Handbook is to:

- ✓ Establish the eligibility standards and application, documentation, and verification procedures for **Big Bend Health.**
- ✓ Establish the responsibilities of the District as well as the responsibilities of the eligible client or applicant.
- ✓ Define basic and extended health care services.
- ✓ Provide guidelines and processes for medical providers to submit claims for covered services or to appeal claims which have been denied.

Big Bend Health consists of two independent plans which share common criteria for program eligibility, management, and oversight.

The first plan pertains to the medical treatment of clients, excluding prescription drug coverage. That part of the Big Bend Health will be referred to as "Medical Plan". Clients who qualify for the "Medical Plan" are also eligible for the "Prescription Plan".

The second plan within Big Bend Health pertains to the prescription drug coverage portion of the Program. In this document that part of Big Bend Health will be referred to as "Prescription Plan". This "Prescription Plan" is similar to the coverage that applies under Medicare Part D and is made available to "Medical Plan Clients" and to eligible clients who are covered by Medicare and by that fact are not eligible for the District's "Medical Plan".

In this document if a requirement or rule pertains only to one of the Plans within Big Bend Health, that fact will be specifically stated in the rule or requirement.

GENERAL ADMINISTRATION

BBRHD Responsibility

The District will:

- ✓ Administer a county-wide indigent health care program.
- ✓ Establish the eligibility criteria for the Program.
- ✓ Follow the policies and procedures described in this handbook, save and except that any contrary and/or conflicting provisions in any contract or agreement approved by the District's Board of Directors shall supersede and take precedence over any conflicting provisions contained in this Handbook.
- ✓ Establish an application process.
- ✓ Establish procedures for administrative hearings that provide for appropriate due process, including procedures for appeals requested by clients that are denied.
- ✓ Adopt reasonable procedures for minimizing the opportunity for fraud.
- ✓ Establish and maintain methods for detecting and identifying situations in which a question of fraud may exist.
- ✓ Establish administrative hearings to be conducted on disqualifying persons in cases where fraud appears to exist.
- ✓ Maintain the records relating to an application at least until the end of the third complete BBRHD fiscal year following the date on which the application is submitted.
- ✓ Validate the accuracy of all disclosed information, especially information that may appear fraudulent or dishonest.
- ✓ Not later than the beginning of BBRHD's fiscal year, the District shall specify the procedure it will use during the operating year to determine eligibility and the documentation required to support a request for assistance and shall make a reasonable effort to notify the public of the procedure.

Applicant or Eligible Resident Responsibility

The Applicant or Eligible Resident will:

- Present required documentation for the evaluation of eligibility.
- Complete the Form 3064 accurately.
- Sign and date the Form 3064.
- Provide all needed information requested by staff.
- Attend the scheduled interview appointment.
- Report changes, which affect eligibility, within 14 days after the date that the change occurred.
- Cooperate or follow through with an application process for any other source of medical assistance before being processed for the Program.
- Participate in an orientation presentation of the handbook defining access to health care.
- Not misrepresent facts or attempt to circumvent the policies of the District in order to become or remain eligible.
- Comply with District policies related to behavior guidelines.

Behavioral Guidelines[1]

BBRHD will establish behavioral guidelines that all applicants and eligible residents must follow in order to protect BBRHD employees, agents (such as third-party administrators), and providers.

Each situation where a violation of these guidelines was apparent will be carefully reviewed by the District. Failure to follow the guidelines will result in definitive action and up to and including refusal of coverage or termination of existing benefits.

The BBRHD explicitly prohibits:

- ✓ The use, possession, solicitation for, or sale of narcotics or other illegal drugs, alcohol, or prescription medication without a prescription in District facilities or on the premises or property of providers.
- ✓ The use, possession, solicitation for, or sale of legal or illegal drugs or alcohol away from the District premises.
- ✓ The presence of any detectable amount of prohibited substances in the eligible resident's system while on the premises of the District or on the premises or property of providers. "Prohibited substances" include illegal drugs or prescription drugs not taken in accordance with a prescription.

[1] *BBRHD, (2015, January 28). Meeting of Board of Directors. Minutes 01.28.2015. Alpine, TX.*

Minimizing Fraud

BBRHD will establish guidelines that are reasonable for minimizing the possibility of fraud in the Big Bend Health programs. Fraud occurs when individuals may try to take advantage of the system or procedures to receive money or benefits that are not deserved.

It is a crime to commit fraud and the BBRHD will aggressively pursue reports of fraud through the appropriate enforcement agencies including but not limited to the Office of Inspector General of Texas Health and Human Services.

The District is required by Section 61.043 of the Health & Safety Code to adopt reasonable procedures for minimizing the opportunity for fraud. The District's procedure for identifying and minimizing fraud will include:

1. Peer review of applications to detect irregularities, omissions, or errors.
2. Administrative review of random applications to detect or identify the potential for fraud in the application process.
3. Administrative review of the application process to improve the opportunities to detect and minimize the opportunity for fraud.
4. Conducting background checks of applicants where fraud is suspected to evaluate statements or facts contained in the application.
5. Review of medical requests and referrals determine the necessity of medical procedures and the validity of medical billings.
6. Periodic administrative review of the program related to expenditures, patient population, declinations, and medical procedures to evaluate the effectiveness of the program and that the program is equitable and not at an undue cost to taxpayers of the District.

Fraudulent activities include, but are not limited to:

- Forging or altering a prescription
- Allowing another person to use Big Bend Health benefits
- Doctor shopping in order to obtain multiple prescriptions
- Intentionally receiving unneeded services or supplies
- Accepting cash or gifts for receiving services
- Re-selling items provided by the program
- Deliberately giving incorrect information to receive benefits.

Reporting Fraudulent Activity:

Enrolled clients should report suspicious activities that may indicate a fraudulent action by the provider.

- Billing for services or items that were not provided.
- Billing for services or equipment that was more expensive than what was provided.
- Scheduling unnecessary office visits, x-rays, laboratory work or other services.
- Allowing an unlicensed person to perform treatment and billing as if a qualified individual had performed the service.

Due Process Fraud Hearings[2]

Administrative hearings conducted related to fraudulent activity shall provide for appropriate due process, including procedures for appeals.

Administrative hearings conducted on disqualifying persons in cases where fraud appears to exist shall be conducted by scheduling a date and time for the administrative hearing.

The decision related to the finding of fraud is decided upon by the Hearing Officer after reviewing the case. The Hearing Officer will reach their decision within fourteen (14) days after administrative hearing is adjourned.

Anytime during the 14-day determination period further information may be requested from the client by the District.

Should a client choose not to attend their scheduled administrative hearing, leave a hearing, or become disruptive during a hearing, the case may be decided without completing the administrative hearing.

The client will be notified of the District's decision in writing. If the District finds that fraud occurred, Clients will have their benefits revoked before their coverage period expires. Coverage will terminate on the date listed on Form 3082, Notice of Ineligibility.

[2] *BBRHD, (2015, January 28). Meeting of Board of Directors. Minutes 01.28.2015. Alpine, TX.*

SECTION TWO
ELIGIBILITY CRITERIA

Section Two - Eligibility Criteria

RESIDENCE

General Principles[3]

- A person must live in Presidio or Brewster County prior to filing an application.
- A person lives in Brewster or Presidio County if the person's home and/or fixed place of habitation is located in the county and he/she intends to return to the county after any temporary absences.
- A person with no fixed residence or a new resident in the county who declares intent to remain in the county is also considered a county resident if intent is proven.
    - Examples of proof of intent include the following:
        - ✓ Change of driver's license
        - ✓ Change of address
        - ✓ Lease agreement
        - ✓ Proof of employment
- A person does not lose his/her residency status because of a temporary absence from Presidio or Brewster County.
- A person cannot qualify for more than one entitlement program from more than one county simultaneously.
- An inmate of a county correctional facility, who is a resident of another Texas county, would not be required to apply for assistance to their county of residence. They may apply for assistance to the county of where they are incarcerated.

Persons Not Considered Residents

- An inmate or resident of a state school or institution operated by any state agency.
- An inmate, patient, or resident of a school or institution operated by a federal agency or incarcerated in a County facility under Federal or State charges.
- A minor student primarily supported by his parents whose home residence is in another county or state.
- A person living in an area served by a public facility.
- A person who moved into the county solely for the purpose of obtaining health care assistance.

[3] *BBRHD. (2015, June 23). Meeting of Board of Directors. Minutes 06.23.2015.*

Verifying Residence

All applications for participation in Big Bend Health programs will require that the District verify residency of applicant.

Proof may include but is not limited to:

- ✓ Mail addressed to the applicant, his spouse, or children;
- ✓ Texas driver's license or other official identification;
- ✓ Rent, mortgage payment, or utility receipt;
- ✓ Property tax receipt;
- ✓ Voting record or registration;
- ✓ School enrollment records;
- ✓ Lease agreement.

PO boxes are not allowed as a residency address. All clients must provide a current physical address of their residence.

Medical (hospital) bills, invoices, or claims may not be used to prove or verify a residence.

Documenting Residence

On Form 3064, document why information regarding residence is questionable and how questionable residence is verified.

Jail Inmates

Inmates in the Brewster County and Presidio County Jails may be granted indigent health coverage during their incarceration. Inmates that are incarcerated on charges from DHS, US Marshals, ICE, or Texas State Corrections are not eligible for indigent health coverage. If a covered inmate is extradited to another county or state, or released, their coverage as an inmate is immediately terminated.

Households

A household is a person living alone or two or more persons living together where legal responsibility for support exists, excluding disqualified persons.

General Principals

Legal responsibility for support exists between:

- Persons who are legally married (including common law marriage);
- A legal parent and a minor child;
- A managing conservator and a minor child.

Disqualified Persons

- A person who receives or is categorically eligible to receive Medicaid.
- A person who receives SSI benefits and is eligible for Medicare is ineligible for the Medical Plan but is eligible for the Prescription Plan.
- A person who receives Qualified Medicare Beneficiary (QMB), Medicaid Qualified Medicare Beneficiary (MQMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individual-1 (QI-1); or Qualified Disabled and Working Individuals (QDWI).
- A Medicaid recipient who partially exhausts some component of his Medicaid benefits.

A disqualified person is not a household member regardless of their legal responsibility for support.

One-Person Household

- A person living alone.
- An adult living with others who are not legally responsible for the adult's support.
- A minor child living alone or with others who are not legally responsible for the child's support.
- A Medicaid-ineligible spouse.
- A Medicaid-ineligible parent whose spouse and/or minor children are Medicaid-eligible.
- A Medicaid-ineligible foster child.
- An inmate in a county jail (not state or federal).

Group Households

Two or more persons who are living together and meet one of the following descriptions:

- Two persons legally married to each other (including common law marriage),
- One or both legal parents and their legal minor children,
- A managing conservator and a minor child and the conservator's spouse and other legal minor children, if any,
- Minor children, including unborn children, who are siblings, and
- Both Medicaid-ineligible parents of Medicaid-eligible children.

Verifying Households

All applications for participation in the PBCIHP will require that the District verify the Household status of applicant.

Proof may include but is not limited to:

- ✓ Lease agreement.
- ✓ Statement from a landlord, a neighbor, or other reliable source.

Documenting Household

On Form 3065, document why information regarding household is questionable and how questionable household is verified.

Resources

General Principles

A household must pursue all resources to which the household is legally entitled unless it is unreasonable to pursue the resource. Reasonable time (at least three months) must be allowed for the household to pursue the resource, which is not considered accessible during this time.

- Accessible resources are resources legally available to the household. Consider a joint bank account with a nonmember as inaccessible if the money in the account is used solely for the nonmember's benefit. The household must provide verification that the bank account is used solely for the benefit of the nonmember and that no eligible household member uses the money in the account for their benefit.

The resources of all household members are to be considered.

Household resources are either countable or they may be considered exempt.

All resources of a disqualified person and non-household members are exempt, but are included if processing an application for a sponsored alien.

A household is not eligible if the total countable household resources exceed[4]:

- $6,800.00 when a person who is aged[5] or disabled[6] and who meets relationship requirements
- $4,500.00 for all other households.

A household is not eligible if their total countable resources exceed the limit on or after:

- The first interview date;

or

[4] New resource limits approved BOD Meeting 2.17.2022.
[5] An aged person is someone aged 60 or older as of the last day of the month for which benefits are being requested.
[6] A person with disabilities is someone who is physically or mentally unfit for employment.

- The date Form 3065 is completed for cases processed without an interview.

In determining eligibility for a prior month, the household is not eligible if their total countable resources exceed the limit anytime during the prior month.

Alien Sponsor's Resources

Count the resources of an alien sponsor and sponsor's spouse for three years after the alien's entry date if the sponsor and spouse are living together.

Determine the sponsor's countable resource as follows:

1. Apply the policies contained in this section.
2. Subtract $1,500.
3. Consider the remainder as resources available to the household

Bank Accounts

Count the cash value of checking and savings accounts for the current month as income and for prior months as a resource unless exempt for another reason.

Burial Insurance (Prepaid)

Exempt up to $7,500 cash value of a prepaid burial insurance policy, funeral plan, or funeral agreement for each certified household member.

Count the cash value exceeding $7,500 as a liquid resource.

Burial Plots

Exempt all burial plots.

Crime Victim's Compensation Payments

Exempt.

Energy Assistance Payments

Exempt payments or allowances made under any federal law for the purpose of energy assistance.

Resources/Income Payments

If a payment or benefit counts as income for a particular month, do not count it as a resource in the same month. If you prorate a payment income over several months, do not count any portion of the payment resource during that time.

> **Example:** Income of students or self-employed persons that is prorated over several months. If the client combines this money with countable funds, such as a bank account, exempt the prorated amounts for the time you prorate it.

Homestead

Exempt the household's usual residence and surrounding property not separated by property owned by others. The exemption remains in effect if public rights of way, such as roads, separate the surrounding property from the home. The homestead exemption applies to any structure the person uses as a primary residence, including additional buildings on contiguous land, a houseboat, or a motor home, as long as the household lives in it. If the household does not live in the structure, count it as a resource.

Houseboats and Motor Homes

Count houseboats and motor homes according to vehicle policy, if not considered the household's primary residence or otherwise exempt.

Own or Purchasing a Lot

For households that currently do not own a home, but own or are purchasing a lot on which they intend to build, exempt the lot and partially completed home.

Real Property Outside of Texas

Households cannot claim real property outside of Texas as a homestead, except for migrant and itinerant workers who meet the residence requirements.

Homestead Temporarily Unoccupied

Exempt a homestead temporarily unoccupied because of employment, training for future employment, Illness (including health care treatment), casualty (fire, flood, state of disrepair, etc.), or natural disaster, if the household intends to return.

Sale of a Homestead

Count money remaining from the sale of a homestead as a resource.

Income- Producing Property

Exempt property that:

- Is essential to a household member's employment or self-employment (examples: tools of a trade, farm machinery, stock, and inventory). Continue to exempt this property during temporary periods of unemployment if the household member expects to return to work.
- Annually produces income consistent with its fair market value, even if used only on a seasonal basis.

  or
- Is necessary for the maintenance or use of a vehicle that is exempt as income producing or as necessary for transporting a physically disabled household member. Exempt the portion of the property used for this purpose.
- For farmers or fishermen, continue to exempt the value of the land or equipment for one year from the date that the self-employment ceases.

Insurance Settlement

Count proceeds or cash from insurance settlements, subtracting any amount spent or intended to be spent for the Household's bills for burial, health care, or damaged/lost possessions.

Lawsuit Settlement

Count proceeds or cash from any lawsuit settlement, subtracting any amount spent or intended to be spent for the household's bills for burial, legal expenses, health care expenses, or damaged/lost possessions.

Life Insurance

Exempt the cash value of life insurance policies.

Liquid Resources

Count all liquid or negotiable resources (if readily available). Examples include but are not limited to cash, a checking account, a savings account, a certificate of deposit (CDs), notes, bonds, and stocks.

Loans (Non-Educational)

Exempt the proceeds from non-educational loans from resources.

Consider the proceeds from financial assistance as a loan if there is an understanding that the loan will be repaid and the person can reasonably explain how he will repay it.

Count any financial assistance not considered or classified as a loan as being unearned income.

Lump-Sum Payments

Count lump sum payments received once a year or less frequently as resources in the month received, unless specifically exempt.

Countable lump-sum payments include but are not limited to lump- sum insurance settlements, lump-sum payments on child support, public assistance, refunds of security deposits on rental property or utilities, retirement benefits, and retroactive lump sum RSDI.

Count lump-sum payments received or anticipated to be received more often than once a year as unearned income in the month received.

Exception: Count any proceeds from contributions, gifts, and prizes as unearned income in the month received regardless of the frequency of receipt.

Exempt federal income tax refunds, earned income child credits, or other federal stimulus payments as income and resources for 12 months after receipt.

Personal Possessions

Exempt.

Real Property

Count the equity value of real property unless it is otherwise exempt. (Homestead)

Exempt any portion of real property directly related to the maintenance or use of a vehicle necessary for employment or to transport a physically disabled household member. Count the equity value of any remaining portion unless it is otherwise exempt.

Good Faith Effort to Sell

Exempt real property if the household is making a good effort to sell it.

Jointly Owned Property

Exempt property jointly owned by the household and other individuals not applying for or receiving benefits if the household provides proof that he cannot sell or divide the property without consent of the other owners and the other owners will not sell or divide the property.

Reimbursements

Count as a resource in the month after receipt.

Exempt a reimbursement earmarked and used for replacing and repairing an exempt resource. Exempt the reimbursement indefinitely.

Retirement Accounts

A retirement account is one in which an employee and/or his employer contribute money for retirement. There are several types of retirement plans. Some of the most common plans authorized under Section 401 (a) of the Internal Revenue Services (IRS) Code are the 401 (k) plan, Keogh, Roth Individual Retirement Account (IRA), and a pension or traditional benefit plan. Common plans under Section 408 of the IRS Code are the IRA, Simple IRA and Simplified Employer Plan.

A 401K plan allows an employee to postpone receiving a portion of current income until retirement.

An individual retirement account (IRA) is an account in which an individual contributes an amount of money to supplement his retirement income (regardless of his participation in a group retirement plan).

A Keogh plan is an IRA for a self-employed individual.

A Simplified Employee Pension (SEP) plan is an IRA owned by an employee to which an employer makes contributions or an IRA owned by a self-employed individual who contributes for himself.

A pension or traditional defined benefit plan is employed based and promises a certain benefit upon retirement regardless or investment performance.

Exclude all retirement accounts or plans established under:

- Internal Revenue Code of 1986, Sections 401(a), 403(a), 403(b), 408, 408A, 457(b), 501(c)(18);
- Federal Thrift Savings Plan, Section 8439, Title 5, United States Code;
- Other retirement accounts determined to be tax exempt under the Internal Revenue Code of 1986.

Count any other retirement accounts not established under plans or codes listed above.

Trust Fund

Exempt a trust fund if all of the following conditions are met:

- The trust arrangement is unlikely to end during the certification period;
  and
- No household member can revoke the trust agreement or change the name of the beneficiary during the certification period;
  and
- The trustee of the fund is either a Court, institution, corporation, or organization not under the direction or ownership of a household member or Court-appointed individual who has court-imposed limitations placed on the use of the funds and the trust investments do not directly involve or help any business or corporation under the control, direction, or influence of a household member.

Exempt trust funds established from the household's own funds if the trustee uses the funds:

- Only to make investments on behalf of the trust,
  or
- To pay the education or health care expenses of the beneficiary.

Vehicles

Exempt a vehicle necessary to transport physically disabled household members, even if disqualified and regardless of the purpose of the trip.

Exempt no more than one vehicle for each disabled member.

There is no requirement that the vehicle be used primarily for the disabled person.

Exempt up to $15,000 of the fair market value of primary or highest value vehicle. Count the value in excess of $15,000 toward the household's resource limit.

For secondary vehicles, exempt vehicles if the equity value is less than $4,650, regardless of the number of vehicles owned by the household. Count the value in excess of $4,650 toward the household's resource limit.[7]

Examples listed below:

$15,000	(FMV)
-12,450	(Amount still owed)
$2,550	(Equity Value)
-4,650	
$0	(Countable resource)

$9,000	(FMV)
- 0	(Amount still owed)
$9,000	(Equity Value)
-4,650	
$4,350	(Countable resource)

Income-producing Vehicles

Exempt the total value of all licensed vehicles used for income-producing purposes.

This exemption remains in effect when the vehicle is temporarily not in use.

A vehicle is considered income producing if it:

- Is used as a taxi, a farm truck, or fishing boat,
- Is used to make deliveries as part of the person's employment,
- Is used to make calls on clients or customers,
- Is required by the terms of employment, or
- Produces income consistent with its fair market value.

Solely Owned Vehicles

A vehicle, whose title is solely in one person's name, is considered an accessible resource for that person.

This includes the following situations:

- Consider vehicles involved in community property issues to belong to the person whose name is on the title.
- If a vehicle is solely in the household member's name and the household

[7] Vehicle value exemptions approved BOD Meeting 2.17.22.

member claims he purchased it for someone else, the vehicle is considered as accessible to the household member.

Exceptions: The vehicle is inaccessible if the titleholder verifies: [complete documentation is required in each of the situations below]

- That he/she sold the vehicle but has not transferred the title. In this situation, the vehicle belongs to the buyer. Note: Count any payments made by the buyer to the household member or the household member's creditors (directly) as self- employment income.
- That he/she sold the vehicle, but the buyer has not transferred the title into the buyer's name.
- The vehicle is considered as inaccessible to the household member
    - That the vehicle was repossessed.
    - That the vehicle was stolen.
    - That he/she filed for bankruptcy (Title 7, 11, or 13) and that the household member is not claiming the vehicle as exempt from the bankruptcy.

Note: In most bankruptcy petitions, the court will allow each adult individual to keep one vehicle as exempt for the bankruptcy estate. This vehicle is a countable resource.

A vehicle is accessible to a household member even though the title is not in the household member's name if the household member purchases or is purchasing the vehicle from the person who is the titleholder or if the household member is legally entitled to the vehicle through an inheritance or divorce settlement.

Jointly Owned Vehicles

Consider vehicles jointly owned with another person not applying for or receiving benefits as inaccessible if the other owner is not willing to sell the vehicle.

Leased Vehicles

When a person leases a vehicle, they are not generally considered the owner of the vehicle because the vehicle does not have any equity value, the person cannot sell the vehicle, and the title remains in the leasing company's name.

Exempt a leased vehicle until the person exercises his option to purchase the vehicle.

Once the person becomes the owner of the vehicle, count it as a resource.

The person is the owner of the vehicle if the title is in their name, even if the person and the dealer refer to the vehicle as leased. Count the vehicle as a resource.

How to Determine Fair Market Value of Vehicles

Determine the fair market value of licensed vehicles using the average trade-in or wholesale value listed in the current (i.e., within the last six months) National Automobile Dealers Association (NADA) *Used Car Guide*.

> Note: If the household claims that the listed value does not apply because the vehicle is in less-than-average condition, allow the household to provide proof of the true value from a reliable source, such as a bank loan officer or a local licensed car dealer.

Do not increase the basic value because of low mileage, optional equipment, or special equipment for the handicapped.

Accept the household's estimate of the value of a vehicle no longer listed in the NADA guide unless it is questionable and would affect the household's eligibility. In this case, the household must provide an appraisal from a licensed car dealer or other evidence of the vehicle's value, such as a tax assessment or a newspaper advertisement indicating the sale value if similar vehicles.

Determine the value of new vehicles not listed in the NADA guide by asking the household to provide an estimate of the average trade-in or wholesale value from a new car dealer or a bank loan officer. If this cannot be done, accept the household's estimate unless it is questionable and would affect eligibility.

Use the vehicle's loan value only if other sources are unavailable.

Request proof of the value of licensed antique, custom made, or classic vehicles from the household if you cannot make an accurate appraisal.

Penalty for Transferring Resources

A household is ineligible if, within three months before application or any time after certification, they transfer a countable resource for less than its fair market value to qualify for health care assistance.

This penalty applies if the total of the transferred resource added to other resources affects eligibility.

Base the length of denial on the amount by which the transferred resource exceeds the resource maximum when added to other countable resources.

Use the chart below to determine the length of denial.

Amount in Excess of Resource Limit	Denial Period
$ .01 to $ 249.99	1 month
$ 250.00 to $ 999.99	3 months
$1,000.00 to $2,999.99	6 months
$3,000.00 to $4,999.99	9 months
$5,000.00 or greater	12 months

If the spouses separate and one spouse transfers the other spouse's equity in property, it does not affect the eligibility of the spouse making the transfer.

Verifying Resources

Verify all countable resources.

Proof may include but is not limited to:
- ✓ Bank account statements.
- ✓ Award letters.

Documenting Resources

On Form 3065, document whether a resource is countable or exempt and how resources are verified.

INCOME

General Principles

A household must pursue and accept all income to which the household is legally entitled. Reasonable time (at least three months) must be allowed for the household to pursue the income, which is not considered accessible during this time.

The income of all household members is considered.

Income is either countable or exempt.

If attempts to verify income are unsuccessful because the payer fails or refuses to provide information and other proof is not available, the household's statement is used as best available information.

All income of a disqualified person is exempt (unless processing an application for a sponsored alien).

Earned income is income a person receives for a certain degree of activity or work. Earned income is related to employment and entitles the person to work-related deductions. Unearned income are payments received without performing work-related activities.

Adoption Payments

Exempt.

Alien Sponsor's Income

If the legal alien is required to have a sponsor, count the income of an alien sponsor as unearned income for three years after the alien's entry date.

Do not apply this policy to aliens who: are children under 18; have become naturalized U.S. citizens; have worked or can receive credit for 40 quarters of work; have a deceased sponsor; are refugees, paroles, asylum grantees, Amerasians, victims of severe trafficking, or Cuban/Haitian entrants; are battered alien spouses of U.S. citizens or legal permanent residents, children of battered aliens, and parents of battered children; aliens whose sponsors receive TANF or SSI; or the dependent child of a sponsor or sponsor's wife.

To budget the sponsor's income:

Consider all of the sponsor's and sponsor's spouse's gross countable income.

From that income, subtract the following deductions:

1. The lesser of 20% of the total monthly gross earned income (including net self-employment earned income), or $175;
2. An amount equal to the income limit for the sponsor's family size as it corresponds to 150% of the Federal Poverty Guideline listed in Appendix V. Include all members of the household the sponsor claims or could claim as tax dependents;
3. The total amount the sponsor pays to claimed tax dependents living outside the home;
4. The total alimony or child support the sponsor pays to persons living outside the home;
5. Count the remaining amount as unearned income for the alien.

Cash Gifts and Contributions

Count as unearned income unless they are made by a private, nonprofit organization on the basis of need; and total $300 or less per household in a federal fiscal quarter.

The federal fiscal quarters are January - March, April - June, July - September, and October-December.

If these contributions exceed $300 in a quarter, count the excess amount as income in the month received.

Exempt any cash contribution for common household expenses, such as food, rent, utilities, and items for home maintenance, if it is received from a non-certified household member who:

- Lives in the home with the certified household member,
- Shares household expenses with the certified household member, and
- No landlord/tenant relationship exists.

Child's Earned Income

Exempt a child's earned income if the child, who is under age 18 and not an emancipated minor, is a full-time student (including a home-schooled child) or a part-time student employed less than 30 hours a week.

Child Support Payments

Count as unearned income after deducting up to $75 from the total monthly child support payments the household receives.

Count payments as child support if a court ordered the support, or the child's caretaker or the person making the payment states the purpose of the payment is to support the child.

Count ongoing child support income as income to the child even if someone else living in the home receives it.

Count child support arrears as income to the caretaker.

Exempt child support payments as income if the child support is intended for a child who receives Medicaid, even though the parent actually receives the child support.

Child Support Received for a Non-Member

If a caretaker receives, ongoing child support for a non-member (or a member who is no longer in the home) but uses the money for personal or household needs, count it as unearned income. Do not count the amount actually used for or provided to the non-member for whom it is intended to cover.

Lump-Sum Child Support Payments

Count lump-sum child support payments (on child support arrears or on current child support) received or anticipated to be received more often than once a year, as unearned income in the month received. Consider lump-sum child support payments received once a year or less frequently as a resource in the month received.

Returning Parent

If an absent parent is making child support payments but moves back into the home of the caretaker and child, process the household change.

Crime Victim's Compensation Payments

Exempt.

These are payments from the funds authorized by state legislation to assist a person who has been a victim of a violent crime; was the spouse, parent, sibling, or adult child of a victim who died as a result of a violent crime; or is the guardian of a victim of a violent crime.

The payments are distributed by the Office of the Attorney General in monthly payments or in a lump sum.

Disability Insurance Payments

Count as unearned income. Count SSDI payments as unearned income, exempt SSI payments.

Dividends and Royalties

Count dividends as unearned income.

Exception: Exempt dividends from insurance policies as income.

Count royalties as unearned income, minus any amount deducted for production expenses and severance taxes.

Educational Assistance

Exempt educational assistance, including educational loans, regardless of source. Educational assistance also includes college work-study income.

Energy Assistance

Exempt the following types of energy assistance payments:

Assistance from federally funded, state or locally-administered programs, including HEAP, weatherization, Energy Crisis, and one-time emergency repairs of a heating or cooling device (down payment and final payment); Energy assistance received through HUD, USDA's Rural Housing Service (RHS), or Farmer's Administration (FmHA); Assistance from private, non-profit, or governmental agencies based on need.

If an energy assistance payment is combined with other payments of assistance, exempt only the energy assistance portion from income (if applicable).

Foster Care Payments

Exempt.

Government Disaster Payments

Exempt federal disaster payments and comparable disaster assistance provided by states, local governments, and disaster assistance organizations if the household is subject to legal penalties when the funds are not used as intended.

Examples: Payments by the Individual and Family Grant Program, Small Business Administration, and/or FEMA.

In-Kind Income

Exempt.

An in-kind contribution is any gain or benefit to a person that is not in the form of money/check payable directly to the household, such as clothing, public housing, or food.

Interest

Count as unearned income.

Job Training

Exempt all payments made under the Workforce Investment Act (WIA).

Exempt portions of non-WIA job training expenses earmarked as reimbursement s for training related expenses. Count any excess as earned income.

OJT payments received by a child who is under age 19 and under parental control of another household member are exempt.

Loans (Non-educational)

Count as unearned income unless there is an understanding that the money will be repaid and the person can reasonably explain how he/she will repay it.

Lump-Sum Payments

Count as income in the month received if the person receives it or expects to receive it more often than once a year.

Exception: If a person is scheduled to receive retroactive SSI benefits in installment payments (up to three, paid every six months), count the payments as a resource in the month received.

Exempt lump sums received once a year or less, unless specifically listed as income. Count them as a resource in the month received.

Exempt federal tax returns and Earned Income Tax Credits as income and resources for twelve months after receipt.

If a lump sum reimburses a household for burial, legal, or health care bills, or damaged/lost possessions, reduce the countable amount of the lump sum by the amount earmarked for these items.

Military Pay

Count military pay and allowances for housing, food, base pay, and flight pay as earned income, minus pay withheld to fund education under the G.I. Bill.

Mineral Rights

Count payments for mineral rights as unearned income.

Pensions

Count as unearned income.

A pension is any benefit derived from former employment, such as retirement benefits or disability pensions.

Reimbursement

Count as unearned income, minus the actual expenses.

Exempt a reimbursement for future expenses only if the household plans to use it as intended.

RSDI Payments

Count as unearned income the Retirement, Survivors, and Disability Insurance (RSDI) benefit amount including the deduction for the Medicare premium, minus any amount that is being recouped for a prior RSDI overpayment.

If a person receives an RSDI check and an SSI check, exempt both checks since the person is a disqualified household member.

If an adult receives a Social Security survivor's benefit check for a child, this check is considered the child's income.

Self-Employment Income

Count as earned income, minus the allowable costs of producing the self-employment income. (Use Form 149: Statement of Self Employment Income).

Self-employment income is earned or unearned income available from one’s own business, trade, or profession rather than from an employer.

However, some individuals may have an employer and receive a regular salary. If an employer does not withhold FICA or income taxes, even if required to do so by law, the person is considered self-employed.

Types of self-employment include:

- Odd jobs, such as mowing lawns, babysitting, and cleaning houses;
- Owning a private business, such as a beauty salon or auto mechanic shop;
- Farm income;
  and
- Income from property, which may be from renting, leasing, or selling property on an installment plan. Property includes equipment, vehicles, and real property.
  - If the person sells the property on an installment plan, count the payments as income. Exempt the balance of the note as an inaccessible resource.

SSI Payments

Only exempt Supplemental Security Income (SSI) benefits when the household is receiving Medicaid.

A person receiving any amount of SSI benefits who also receives Medicaid is, therefore, a disqualified household member.

TANF

Exempt Temporary Assistance to Needy Families (TANF) benefits.

Terminated Income

Count terminated income in the month received. Use actual income and do not use conversion factors if terminated income is less than a full month's income.

Income is terminated if it will not be received in the next usual payment cycle.

Income is not terminated if:

- Someone changes jobs while working for the same employer,
- An employee of a temporary agency is temporarily not assigned,
- A self-employed person changes contracts or has different customers without having a break in normal income cycle,
  or
- Someone received regular contributions, but the contributions are from different sources.

Third-Party Payments

Exempt the money received that is intended and used for the maintenance of a person who is not a member of the household.

If a single payment is received for more than one beneficiary, exclude the amount actually used for the non-member up to the non-member's identifiable portion or prorated portion, if the portion is not identifiable.

Tip Income

Count the actual (not taxable) gross amount of tips as earned income.

Add tip income to wages before applying conversion factors.

Tip income is income earned in addition to wages that is paid by patrons to people employed in service-related occupations, such as beauticians, waiters, valets, delivery staff, etc.

Do not consider tips as self-employment income unless related to a self-employment enterprise.

Trust Fund

Count as unearned income trust fund withdrawals or dividends that the household can receive from a trust fund that is exempt from resources.

Unemployment Compensation Payments

Count the gross amount as unearned income, minus any amount being recouped for an Unemployment Insurance Benefit (UIB) overpayment.

Count the cash value of UIB in a UI debit account, less amounts deposited in the current month, as a resource.

Exception: Count the gross amount if the household agreed to repay a food stamp overpayment through voluntary garnishment.

VA Payments

Count the gross Veterans Administration (VA) payment as unearned income, minus any amount being recouped for a VA overpayment.

Exempt VA special needs payments, such as annual clothing allowances or monthly payments for an attendant for disabled veterans.

Vendor Payments

Exempt vendor payments if made by a person or organization outside the household directly to the household's creditor or person providing the service.

Exception: Count as income money that is legally obligated to the household, but which the payer makes to a third party for a household expense.

Wages, Salaries, Commissions

Count the actual (not taxable) gross amount as earned income.

If a person asks his employer to hold his wages or the person's wages are garnished, count this money as income in the month the person would otherwise have been paid.

If, however, an employer holds his employees' wages as a general practice, count this money as income in the month it is paid.

Count an advance in the month the person receives it.

Workers' Compensation Payments

Count the gross payment as unearned income, minus any amount being recouped for a prior worker's compensation overpayment or paid for attorney's fees.

NOTE: The Texas Workforce Commission (TWC) or a court sets the amount of the attorney's fee to be paid.

Do not allow a deduction from the gross benefit for court-ordered child support payments.

Exception: Exclude worker's compensation benefits paid to the household for out-of-pocket health care expenses. Consider these payments as reimbursements.

Other Types of Benefits and Payments

Exempt benefits and payments from the following programs:

- AmeriCorps,
- Child Nutrition Act of 1966,
- Food Stamp Program (SNAP),
- Foster Grandparents,
- Funds distributed or held in trust by the Indian Claims Commission for Indian tribe members under Public Laws 92-254 or 93-135,
- Learn and Serve,
- National School Lunch Act,
- National Senior Service Corps (Senior Corps),
- Nutrition Program for the Elderly (Title III, Older American Act of 1965),
- Retired and Senior Volunteer Program (RSVP),

- Senior Companion Program,
- Tax-exempt portions of payments made under the Alaska Native Claims Settlement Act,
- Uniform Relocation Assistance and Real Property Acquisitions Act (Title II),
- Volunteers in Service to America (VISTA), and
- Women, Infants, and Children (WIC) Program.

Verifying Income

Verify countable income, including recently terminated income, at initial application and when changes are reported.

Verify countable income at review, if questionable.

Proof may include but is not limited to:

- ✓ Consecutive paycheck stubs (for everyone in your household) for the last 4 weeks,
- ✓ Form 3084, Employment Verification Form,
- ✓ W-2 forms,
- ✓ Notes for cash contributions,
- ✓ Business records,
- ✓ Social Security award letter,
- ✓ Court orders or public decrees (support documents),
- ✓ Sales records,
- ✓ Income tax returns,
- ✓ Statements completed, signed, and dated by the self-employed person.

Documenting Income

On Form 3065, document the following items.

- Exempt income and the reason it is exempt
- Unearned income, including the following items:
  - Date income is verified,
  - Type of income,
  - Check or document seen,
  - Amount recorded on check or document,
  - Frequency of receipt,
  - Calculations used.
- Self-employment income, including the following items:
  - The allowable costs for producing the self-employment income,
  - Other factors used to determine the income amount.
- Earned income, including the following items:

  - Payer's name and address,
  - Dates of each wage statement or pay stub used,
  - Date paycheck is received,
  - Gross income amount,
  - Frequency of receipt,
  - Calculations used.
- Allowable deductions.

A household is ineligible for a period of 6 months if they intentionally alter their income to become eligible for the Program (example: have employer lower their hourly or salary amount).

The following exceptions apply:
- Change in job description that would require a lower pay rate
- Loss of job
- Changed job

BUDGETING INCOME

General Principles

Count income already received and any income the household expects to receive. If the household is not sure about the amount expected or when the income will be received, use the best estimate.

Income, whether earned or unearned, is counted in the month that it is received.

Count terminated income in the month received. Use actual income and do not use conversion factors if terminated income is less than a full month's income.

Use at least four consecutive, most recent pay weeks to calculate fluctuating income.

The self-employment income projection, which includes the current month and 3 months prior, is the period of time that the household expects the income to support the family.

There are deductions for earned income that are not allowed for unearned income.

The earned income deductions are not allowed if the income is gained from illegal activities, such as prostitution and selling illegal drugs.

Steps for Budgeting Income

1. Determine countable income.
2. Determine how often countable income is received.
3. Convert countable income to monthly amounts.
4. Convert self-employment allowable costs to monthly amounts.
5. Determine if countable income is earned or unearned.
6. Subtract converted monthly self-employment allowable costs, if any, from converted monthly self-employment income.
7. Subtract earned income deductions, if any.
8. Subtract the deduction for Medicaid individuals, of applicable.
9. Subtract the deduction for legally obligated child support payments made by a member of the household group, if applicable.
10. Compare the monthly gross income to the PBCIHP monthly income standard.

Step 1 Determine countable income.
Evaluate the household's current and future circumstances and income.

Decide if changes are likely during the current or future months.

If changes are likely, then determine how the change will affect eligibility.

Step 2 Determine how often countable income is received, such as monthly, twice a month, every other week, weekly.

All income, excluding self-employment - Based on verifications or the person's statement as best available information, determine how often income is received. If the income is based hourly or for piecework, determine the amount of income expected for one week of work.

Self-employment Income - Compute self-employment income, using one of these methods:

> Annual - Use this method if the person has been self-employed for at least the past 12 months.
>
> Monthly - Use this method if the person has at least one full representative calendar month of self-employment income.
>
> Daily - Use this method when there is less than one full representative calendar month of self-employment income, and the source or frequency of the income is unknown or inconsistent.

Determine if the self-employment income is monthly, daily, or seasonal, since that will determine the length of the projection period.

The projection period is annual if the self-employment income is intended to support the household for at least the next 12 months. The projection period is 12 months whether the income is received monthly or less often.

The projection period is seasonal if the self-employment income is intended to support the household for less than 12 months since it is available only during certain months of the year. The projection period is the number of months the self-employment is intended to provide support.

Determine the allowable costs of producing self-employment income, which include:

- Capital asset improvements,
- Capital asset purchases, such as real property, equipment, machinery and other durable goods, i.e., items expected to last at least 12 months,
- Fuel,
- Identifiable costs of seed and fertilizer,
- Insurance premiums,
- Interest from business loans on income-producing property,
- Labor,
- Linen service,
- Payments of the principal of loans for income-producing property,
- Property tax,
- Raw materials,
- Rent,
- Repairs that maintain income-producing property,
- Sales tax,
- Stock,
- Supplies,
- Transportation costs. The person may choose to use the IRS mileage rate instead of keeping track of individual transportation expenses. Do not allow travel to and from the place of business.
- Utilities

NOTE: If the applicant conducts a self-employment business in his home, consider the cost of the home (rent, mortgage, utilities) as shelter costs, not business expenses, unless these costs can be identified as necessary for the business separately.

The following are not allowable costs of producing self-employment income:

- Costs not related to self-employment,
- Costs related to producing income gained from illegal activities, such as prostitution and the sale of illegal drugs,
- Depreciation,
- Net loss which occurred in a previous period,

- Work-related expenses, such as federal, state, and local income taxes, and retirement contributions.

Step 3 Convert countable incomes to monthly amounts, if income is not received monthly.
When converting countable income to monthly amounts, use the following conversion factors:

- Multiply weekly amounts by 4.33.
- Multiply amounts received every other week by 2.17.
- Add amounts received twice a month (semi-monthly).
- Divide yearly amounts by 12.

Step 4 Convert self-employment allowable costs to monthly amounts.
When converting the allowable costs for producing self-employment to monthly amounts, use the conversion factors in Step 3 above.

Step 5 Determine if countable income is earned or unearned.
For earned income, proceed with Step 6. For unearned income, skip to Step 8.

Step 6 Subtract converted monthly self-employment allowable costs, if any, from converted monthly self-employment income.

Step 7 Subtract earned income deductions, if any.
Subtract these deductions, if applicable, from the household's monthly gross income, including monthly self-employment income after allowable costs are subtracted:

1) Deduct $120.00 per employed household member for work-related expenses.
2) Deduct 1/3 of remaining earned income per employed household member.
3) Deduct the actual cost up to $200.00 per month per dependent for dependent childcare or incapacitated adult care, if necessary for employment.
    - $200 per month for each child under the age of 2
    - $175 per month for each child aged 2 or older
    - $175 per month for each adult with disabilities

Exception: For self-employment income from property, when a person spends an average of less than 20 hours per week in management or maintenance activities, count the income as unearned and only allow deductions for allowable costs of producing self-employment income.

Step 8 Subtract the deduction for Medicaid individuals, if applicable.
This deduction applies when the household has a member who receives Medicaid and, therefore, is disqualified from the household.

Using the following deduction chart to deduct an amount for support of the Medicaid member(s) as follows:

Subtract an amount equal to the deduction for the number (#) of Medicaid-eligible individuals.

Deductions for Medicaid-Eligible Individuals

# of Medicaid-Eligible Individuals	Single Adult or Adult with Children	Minor Children Only
1	$ 78	$ 64
2	$ 163	$ 92
3	$ 188	$ 130
4	$ 226	$ 154
5	$ 251	$ 198
6	$ 288	$ 241
7	$ 313	$ 267
8	$ 356	$ 293

Consider the remainder as the monthly gross income for the household

Step 9 Subtract the deduction for legally obligated child support payments made by a member of the household group.

Step 10 Compare the household's monthly gross income to the 150% FPIL monthly income standard[8].

Use the applicable Federal Poverty Income Limits chart in effect for Big Bend Health programs which can be found at Appendix II of this handbook.

A household is eligible if its monthly gross income, after rounding down cents, does not exceed the monthly income standard for the household's size.

[8] *BBRHD. (2014, October 1). Meeting of Board of Directors. Minutes 10.1.2014.*

SECTION THREE
CASE PROCESSING

Section Three – Case Processing

General Principles

The BBRHD will provide access to enrollment and the evaluation of eligibility not only into Big Bend Health programs but also in an effort to evaluate the possible candidacy of enrollment to another healthcare programs that an applicant might be eligible for.

Patient Advocates may assist enrollees in choosing and establishing with a primary designated provider within the first six-month enrollment period.

The Patient Advocates will meet with enrollees at six-month intervals for re-enrollment into the program. Re-enrollment consists of reviewing eligibility.

During re-enrollment, Patient Advocates may conduct a review of medications and coordinating enrollment in Pharmaceutical Company sponsored Patient Assistance programs for all long-term medication.

During re-enrollment Patient Advocates will review compliance with health maintenance program requirements.

New enrollees are responsible for coordinating ongoing medication prescriptions with the Patient Advocate and the designated provider to enable enrollment in Pharmaceutical Patient Assistance Programs where and when available.

Patient Advocates can contact enrollees by phone or written letter based on tracking data pertaining to the patients' health care activities, compliance with program requirements, six-month enrollment eligibility, and medication management.

The enrollment process

- ✓ Use the IHS software application, Big Bend Health Handbook, application and follow verification procedures.
- ✓ Issue Form 3064 to the applicant or his representative on the same date that the request is received.
- ✓ Accept an identifiable application.
- ✓ Assist the applicant with accurately completing the Form 3064 and obtaining all needed verifications if the applicant requests help.
- ✓ Anyone who helps fill out the Form 3064 must sign and date it.
- ✓ If the applicant is incompetent or incapacitated someone acting responsibly for the client (a representative) may represent the applicant in the application and the review process, including signing and dating the Form 3064 on the applicant's behalf. This representative must be knowledgeable about the applicant and his household. Document the specific reason for designating this representative.

- ✓ Determine eligibility based on residence, household, resources and income.
- ✓ Allow at least 14 days for requested information to be provided, unless the household agrees to a shorter timeframe, when issuing Form 3068.

  Note: The requested information is documented on Form 3068 and a copy is given to the household.
- ✓ All information requested by staff determining eligibility is needed to complete the application process and is the responsibility of the applicant.
- ✓ Use any information received from the provider of service when making the eligibility determination; but further eligibility information from the applicant may be required.
- ✓ The date that a complete application is received is the application completion date, which counts as Day 0.
- ✓ Determine eligibility not later than the 14th day after the application completion date based on the residence, household, resources, and income.
- ✓ Issue the appropriate written notice of the District's decision namely;

  Form 3077, Notice of Eligibility;
  Form 3082, Notice of Ineligibility;
  Form 3068, Request for information.
- ✓ If the District denies health care assistance, the written notice shall include the reason for the denial and an explanation of the procedure for appealing the denial.
- ✓ Review each eligible case record at least once every six months.
- ✓ Approved applications are valid for a period not to exceed six (6) months but no less than 1 month.
- ✓ Before the expiration date, all clients will receive a notice by mail that benefits will expire in the next two weeks.
- ✓ All clients must start the eligibility process all over again at the time of re-application.
- ✓ Use the "Prudent Person Principle" in situations where there are unusual circumstances in which an applicant's statement must be accepted as proof if there is a reasonable explanation why documentary evidence or a collateral contact is not available and the applicant's statement does not contradict other client statements or other information received by staff.
- ✓ Current eligibility continues until a change resulting in ineligibility occurs and a Form 3077 is issued to the household.
- ✓ Consult the hospital district's legal counsel to develop procedures regarding disclosure of information.

Rights of the Applicant

The applicant has the right to:

1) Have his application considered without regard to race, color, religion, creed, national origin, age, sex, disability, or political belief;
2) Request a review of the decision made on his application or re-certification for health care assistance;
   and
3) Request, orally and in writing, a fair hearing about actions affecting receipt or termination of health care assistance.

Applicant's Responsibilities

The applicant is responsible for:

- Program participants are responsible for maintaining and presenting the required documentation for evaluation by Big Bend Health staff.
- Completing the Form 3064.
- Signing and dating the Form 3064.
- Providing all needed information requested by staff.
  - ➢ If information is not available or is not sufficient, the applicant may designate a collateral contact for the information. A collateral contact could be any objective third party who can provide reliable information.
  - ➢ A collateral contact does not need to be separately and specifically designated if that source is named either on Form 3064 or during the interview.
- Attending the scheduled interview appointment.
  - ➢ All appointments will be set automatically by the Big Bend Health office and will be the applicant's responsibility to attend the scheduled appointment.
  - ➢ Applicants may only be up to 10 minutes late to their interview appointment before they **must** reschedule.
  - ➢ Failure to attend the appointment may result in denial of assistance. Patient Advocates may be available to meet with and enroll or re-enroll program participants in their own community both by appointment and at set times and locations in each community multiple times throughout the month.
- The client's application is valid for 30 days from the identifiable date and it is within that 30-day period that the client may reschedule another appointment with the eligibility office.
  - ➢ After the 30-day period, the client would have to fill out another application and begin the application process all over again.

- Reporting changes, which affect eligibility, within 14 days after the date that the change actually occurred.
  - ➢ Failure to report changes could result in repayment of expenditures paid.
- Any changes in income, resources, residency other than federal cost of living adjustments mandates re application and reconsideration of determination.
- To cooperate or follow through with an application process for any other source of medical assistance before being processed for the Program.
- Enrollment in the program requires clients to participate in an orientation presentation to go over word for word and sign sections of the handbook defining access to health care.

  Note: Misrepresentation of facts or any attempt by any applicant or interested party to circumvent the policies of the district in order to become or remain eligible is grounds for immediate and permanent refusal of assistance.

  Furthermore, if a client fails to furnish any requested information or documentation, the application will be denied.

Processing an Application

Steps for Processing an Application

1) Accept the identifiable application.
2) Check information.
3) Request needed information.
4) Determine if an interview is needed.
5) Interview.
6) Determine eligibility.
7) Issue the appropriate form.

Step 1 Accept the identifiable application.
On the Form 3064 document the date that the identifiable Form 3064 is received. This is the application file date.

Step 2 Check Information.
Check that all information is complete, consistent, and sufficient to make an eligibility determination.

Step 3 Request needed information.
Request any additional information that is needed pertaining to the four eligibility criterion;

1) Residence;
2) Household;
3) Resources;
4) Income.

Decision Pended. If eligibility cannot be determined because components that pertain to the eligibility criteria are missing, issue Form 3068, Request for Information, listing additional information that needs to be provided as well as listing the due date by which the additional information is needed. If the requested information is not provided by the due date, follow the Denial Decision procedure in Step 8. If the requested information is provided by the due date, proceed with Step 5. The application is not considered complete until all requested information in received.

Decision Pended for an SSI Applicant. If eligibility cannot be determined because the person is also an SSI applicant, issue Form 3068, Request for Information, listing additional information that needs to be provided, including the SSI decision, as well as listing the date by which the additional information is needed. Upon receipt of the SSI status letter from the Social Security, Administration office, the patient will be issued Form 3077, *Notice of Eligibility.*

Patient will receive benefits for six months. It is the responsibility of the patient to notify the Patient Advocate as soon as the determination letter is received. If the patient receives SSI benefits, the Program will request reimbursement from the SSI program.

Step 4 Determine if an interview is needed.
Eligibility may be determined without interviewing the applicant if all questions on Form 3064 are answered and all additional information has been provided.

Step 5 Conduct the interview.
Interview the applicant or his representative face-to-face or by telephone if an interview is necessary.

If an interview appointment is scheduled, provide the applicant with an Appointment Form 3067, indicating the date, time, place of the interview, and name of interviewer.

Applicants may only be up to 10 minutes late to their interview appointment before they **must** reschedule.

If the applicant fails to keep the appointment, reschedule the appointment, if requested before the time of the scheduled appointment, or follow the Denial Decision procedure in Step 7.

Step 6 Determine eligibility.

- ✓ Repeat Steps 2 and 3 as necessary.
- ✓ Determine eligibility based on the four eligibility criteria.
- ✓ Document information in the case record to support the decision.

At this step determine if any additional forms or notices need to be provided to the candidate, such as:

1) Acknowledgment of Receipt of Notice of Privacy Practices
2) Background Check Form
3) Medical History Form
4) Release Form
5) Subrogation Form
6) Representation and Acknowledgement Form
7) Statement of Support
8) Request for Domicile Verification
9) Employer Verification Form
10) Other Forms as may be developed and approved by Administrator
11) Assignment of Health Insurance Proceeds

Note: All applicants will undergo a background/credit check, as this is a mandatory process.

Candidates will be asked to clarify discrepancies.

Remember this is confidential material.

Step 7 Issue the appropriate form.

Issue Form 3082, Notice of Ineligibility;
or
Form 3077, Notice of Eligibility.

Incomplete Decision

If any of the requested documentation is not provided with the application is not complete. Issue Form 3068, Request for Information.

Denial Decision

If any one of the eligibility criteria is not met, the applicant is ineligible. Issue Form 3082, Notice of Ineligibility, including the reason for denial, the effective date of the denial, if applicable, and an explanation of the procedure for appealing the denial.

Reasons for denial include, but are not limited to:

1) Not a resident of the county.
2) A recipient of Medicaid, Medicare or other insurance for applicants seeking coverage under the medical plan.
3) Resources exceed the resource limit.
4) Income exceeds the income limit.
5) Failed to keep an appointment.
6) Failed to provide information requested.
7) Failed to return the review application.
8) Failed to comply with requirements to obtain other assistance.
   or
9) Voluntarily withdrew.

Eligible Decision

If all the eligibility criteria are met, the applicant is eligible.

Determine the applicant's Eligibility Effective Date:

- Current Eligibility begins on the first calendar day in the month that an identifiable application is filed or the earliest, subsequent month in which all eligibility criteria are met.
- Eligibility effective date for a new county resident begins the date the applicant is considered a county resident. For example, if the applicant meets all four eligibility criteria, but does not move to the county until the 15th of the month, the eligibility effective date will be the 15th of the month, not the first calendar day in the month that an identifiable application is filed.
- The applicant may be retroactively eligible in any of the three calendar months before the month the identifiable application is received if all eligibility criteria are met.

Issue Form 3077, Notice of Eligibility, including the Eligibility Effective Date.

All active cases will be reviewed every 6 months by the Patient Advocate.

Termination of Coverage

Expiration of Coverage

All eligible clients are given coverage for a specified length of time and will be notified by mail **two weeks** before benefits will expire. Coverage will terminate at the end of the specified length of time unless the client chooses to re-apply for coverage.

Termination

In certain circumstances, a client may have their benefits revoked before their coverage period expires. Clients will be notified by mail or phone two weeks before their benefits will be terminated, along with the explanation for termination.

Coverage will terminate on the date listed on Form 3082, Notice on Ineligibility.

> Note: Clients who are found to have proof of another source of healthcare coverage will be terminated on the day that the other payor source was identified.

Denial Decision Disputes

Responses Regarding a Denial Decision

If a denial decision is disputed by the household, the following may occur:

- The household may submit another application to have their eligibility re-determined,
- The household may appeal the denial,

  or
- The District may choose to re-open a denied application or in certain situations override earlier determinations based on new information.

The Household/Client Appeal Process

The Household/Client may appeal any eligibility decision by signing the bottom of Form 3082, Notice of Ineligibility within 90 days from the date of denial.

District will have 14 days from the date Form 3082 was received in the District office with the appropriate signature to respond to the client to let them know that the District received their appeal.

At this time, the client will be notified as to the next step in the appeal process either:

- ➢ An appeal hearing is not necessary if a mistake was made by the District. District and the client will take the appropriate steps required to remedy the situation.

  or
- ➢ If an appeal hearing is necessary, the Hearing Officer or appointee will schedule a date and time for the appeal hearing. The District will have 30 days in which to schedule the appeal hearing.

The decision as to whether or not an appeal is necessary is decided upon by the Hearing Officer after reviewing the case.

Anytime during the 14-day determination period further information may be requested from the client by The District.

Should a client choose not to attend their scheduled appeal hearing, leave a hearing, or become disruptive during a hearing, the case will be dropped and the appeal denied.

After the date of the appeal hearing, the District will have 30 days in which to make a decision. The client will be notified of the District's decision in writing.

An Administrative Review of the appeal hearing can be conducted through the District Board. The District Board shall issue a final decision in a timely fashion.

SECTION FOUR
SERVICE DELIVERY

Section Four Service Delivery

Notice

Eligible patients are reminded that services provided by physicians and medical facilities that do not participate in Big Bend Health programs are not covered by the Program unless pre- approved and authorized. Patients who have services performed at these out of network facilities or physicians will not be a covered by Big Bend Health and will be responsible for all payments to these providers.

Eligible patients are also reminded that only medically necessary emergencies should be handled through emergency room services. Patients are required to have non-emergency services provided through a designated doctor and not through hospital emergency room service.

General Principles

- BBRHD through Big Bend Health programs is the payor of last resort and shall provide assistance only if other adequate public or private sources of payment are not available.
- BBRHD is not secondary to any insurance benefits, exhausted benefits or for benefits available through Big Bend Health programs but not through Medicare, Medicaid, or other insurance coverages.
- BBRHD shall provide or arrange for the basic health care services established by Texas Health and Human Services or less restrictive health care services.
- Designated providers can refer to contracted specialty providers that accept Big Bend Health clients.
- Designated providers can refer a patient to specialists as part of the consult or work-up, the referral must be pre-approved by the District.
- All contracted providers are responsible for knowing the parameters of the Indigent Health standard of care as far as medical services covered, medical equipment, and drug formulary.
- Medical providers and clinical facilities participating in the Program are encouraged to utilize diagnostic services locally in the area.
- Diagnostic services include laboratory and imaging services.
- Out of area providers can utilize facilities that are contracted with the Program for imaging and laboratory studies.

The District may:

- Arrange for health care services through local health departments, other public health care facilities, private providers, or insurance companies regardless of the provider's location.
- Arrange to provide health care services through the purchase of insurance for eligible residents.
- Affiliate with other governmental entities, public hospitals, or hospital districts for administration and delivery of health care services.
- Use out-of-county providers.

Program Limits[9]

The maximum District liability for the Medical Plan each fiscal year of BBRHD is $30,000. The District may increase maximum liability for clients facing severe medical conditions. The Board of Directors may review details of the case taking into account medical necessity, availability of funds, medical treatment plan, and other information to determine feasibility of increasing annual limit and continuation of benefits.

Increases in program limits are not guaranteed and are intended for exceptional circumstances. Clients at maximum District liability may be referred to an alternate provider and the District will no longer be responsible for providing health care benefits.

or

The payment of 30 days of hospitalization or treatment in a SNF, or both whichever occurs first.

Note: 30 days of hospitalization refers to inpatient hospitalization.

The maximum District liability for the Prescription Plan each fiscal year of the BBRHD is $5,000.00.

Co-payments

Pursuant to Chapter 61 of the Texas Health and Safety Code, the District recognizes that it may request contribution toward cost of assistance.

All prescription medications will be subject to a $5.00 co-pay for each prescription. The District may impose a co-pay for other services at its discretion including, but not limited to:

[9] *BBRHD. (2021, March 25). Meeting of Board of Directors. Minutes 03.25.2021. Alpine, TX.*

- Diabetic training
- EMS transports
- ED visits
- Physical therapies
- OT
- PT
- ST
- Primary care visits
- Specialty care visits

Basic Healthcare Services in the Medical Plan

The basic healthcare services are:

- Physician services
- Annual physical examinations
- Medical screening services
  - Blood pressure
  - Blood sugar
  - Cholesterol screening
- Laboratory and x-ray services
- Family planning services
- Skilled nursing facility services
- Rural health clinic services
- Inpatient hospital services
- Outpatient hospital services
- Prescription Drugs

In addition to providing basic health care services, BBRHD provides other extended health care services through the Medical Plan that the District determines to be cost-effective.

Annual Physical Examinations

These are examinations provided once per client per calendar year by a Texas licensed physician or midlevel practitioner.

Family Planning Services

These preventive health care services assist an individual in controlling fertility and achieving optimal reproductive and general health.

Public health entities provide family planning services at little or no charge; therefore, the BBRHD reserves the right to redirect clients to utilized TDH services for family planning.

Immunizations

BBRHD indigent health enrollees will receive all of their immunizations through the Texas

Department of State Health Services when appropriate.

Inpatient Hospital Services

Inpatient hospital services must be medically necessary and be:

- Provided in an acute care hospital,
- Provided to hospital inpatients,
- Provided under the direction of a Texas licensed physician in good standing, and
- Provided for the medical care and treatment of patients.

The date of service for an inpatient hospital claim is the discharge date.

Laboratory and X-Ray Services

These are professional and technical laboratory and radiological services ordered and provided by, or under the direction of, a Texas licensed physician in an office or a similar facility other than a hospital outpatient department or clinic.

Medical Screening Services

These health care services include blood pressure, blood sugar, and cholesterol screening.

Texas Medicaid Women's Health Program covers an annual PAP smear and Clinical Breast Exam. The Program covers the exam, the pap laboratory processing fee, and a follow-up visit. If coverage is through this program is denied, PBCIHP will offer these services as part of our medical screening services.

Outpatient Hospital Services

Outpatient hospital services must be medically necessary and be:

- Provided in an acute care hospital or hospital-based ambulatory surgical center (HASC),
- Provided to hospital outpatients,
- Provided by or under the direction of a Texas licensed physician in good standing, and
- Diagnostic, therapeutic, or rehabilitative.

Physician Services

Physician services include services ordered and performed by a physician that are within the scope of practice of their profession as defined by Texas state law. Physician services must be provided in the doctor's office, the patient's home, a hospital, a skilled nursing facility, or elsewhere.

Rural Health Clinic (RHC) Services

RHC services must be provided in a freestanding or hospital-based rural health clinic and

provided by a physician, a physician assistant, and nurse practitioner.

Women's Health Services

At the time of program eligibility all women of childbearing age will be enrolled in the Texas Medicaid Women's Health Program which covers an annual PAP smear and Clinical Breast Exam. The Program covers the exam, the pap laboratory processing fee, and a follow-up visit.

The Patient Advocate will submit the program eligibility application to the Texas Medicaid Women's health program for the qualifying indigent health participant and confirm that the mandated provider provides the exam during the first six-month enrollment cycle. If coverage through Texas Medicaid Women's Health Program is denied, Big Bend Health will cover these services as Medical Screening Services.

Optional Extended Healthcare Services Under the Big Bend Health Medical Plan[10]

The extended health care services are:

- Advanced practice nurse services provided by
  - Nurse practitioner services (ANP)
  - Clinical nurse specialist (CNS)
  - Certified registered nurse anesthetist (CRNA)
  - Physician assistant services (PA)
- Ambulatory surgical center (freestanding) services
- Catastrophic Oncology Services
- Chiropractic services: Limited to twelve (12) treatments per coverage year and when deemed medically necessary.
- Durable medical equipment (DME) as outlined in handbook.
- Dental Care
- Emergency medical services (EMS) ground transport only.
- Federally qualified health center services (FQHC).
- Ground Transportation
- Hormonal Disorders
- Mental Health - Counseling services provided by:
  - Licensed clinical social worker (LCSW)
  - Licensed professional counselor (LPC)
- Medical supplies and equipment
- Vision Care
- Vocational evaluation, rehabilitation, or retraining

[10] *BBRHD. (2016, January 28). Meeting of Board of Directors. Minutes 01.28.2016. Alpine, TX.*

Advanced Practice Nurse (APN) Services

An APN must be licensed as a registered nurse (RN) within the categories of practice, specifically, a nurse practitioner, a clinical nurse specialist and a certified registered nurse anesthetist (CRNA), as determined by the Board of Nurse Examiners. APN services must be medically necessary, provided within the scope of practice of the APN, and covered in the Texas Medicaid Program.

Ambulatory Surgery Centers

Ambulatory surgery centers (ASC), also known as outpatient surgery centers or same day surgery centers, are health care facilities where surgical procedures not requiring an overnight hospital stay are performed.

These services must be provided in a freestanding ASC and are limited to items and services provided in reference to an ambulatory surgical procedure.

If more than one procedure code is listed, only the code with the highest HHSC payable amount should be paid.

Chiropractic Services[11]

Manipulation of the spine if medically necessary to correct a subluxation when provided by a chiropractor or other qualified provider.

Coverage is limited to twelve (12) visits per plan year.

Colostomy Medical Supplies and Equipment

These supplies and equipment must be medically necessary and prescribed by a Texas Licenses physician, PA or an APN in good standing, within the scope of their practice in accordance with the standards established by their regulatory authority.

The District requires the supplier to receive prior authorization.

Items covered are:

- Cleansing irrigation kits
- Colostomy bags/pouches
- Paste or powder
- Skin barriers with flange (wafer)

Durable Medical Equipment:

[11] *BBRHD. (2016, January 28). Meeting of Board of Directors. Minutes 01.28.2016. Alpine, TX.*

This equipment must be medically necessary and provided under a written, signed, and dated physician's prescription. The equipment must meet Medicare/Texas Title XIX Medicaid requirements. A PA or an APN may also prescribe these supplies and equipment if this is within the scope of their practice in accordance with the standards established by their regulatory authority.

Items can be rented or purchased, whichever is the least costly or most efficient.

Items covered with BBRHD authorization include[12]:

Digital Blood Pressure and Pulse Monitor	Cane, quad or 3 prong, with tips
Oxygen, gaseous, per cubic foot	Crutches, underarm, wood, with tips & pads
Oxygen contents, liquid, per pound	Walker, folding with wheels
Tubing (oxygen), per foot	Walker, folding, adjustable or fixed height
Mouthpiece	Portable oxygen (rental) – regulator, cart, and 2 tanks per month
Variable concentration mask	Nebulizer with compressor
Disposable kit (pipe style)	Nebulizer, durable, glass or autoclavable plastic, bottle
Disposable kit (mask style)	Wheelchair, standard
Mask with headgear	Oxygen concentrator, capable of delivering 85% or > (rental)
6' tubing	Elevating leg rests, pair
Filters	Orthopedic braces
Cane with tip	Wound care supplies

Dental Care[13]

Dental services must be medically necessary and provided by a Doctor or Dental Surgery (DDS), Doctor of Medicine in Dentistry (DMD) or a Doctor of Dental Medicine (DDM). Items covered are an annual routine dental exam, annual routine cleaning, one set of annual x-rays, and the least costly service for emergency dental conditions for the removal or filling of a tooth due to abscess, infection, or extreme pain.

Prior authorization may be required.

Emergency Medical Services

Emergency Medical Services (EMS) services are ground ambulance transport services, and do not extend to EMS services offered through air transport.

EMS is available and covered when the client's condition is life-threatening and requires the use of special equipment, life support systems, and close monitoring by trained

[12] *BBRHD. (2016, January 28). Meeting of Board of Directors. Minutes 01.28.2016. Alpine, TX.*

[13] BBRHD. (2021, March 25). *Meeting of Board of Directors. Minutes 03.25.2021. Alpine, TX.*

attendants while in route to the nearest appropriate (mandated) facility.

EMS interfacility transports from Alpine BBRMC to appropriate facility in Midland/Odessa or El Paso will be covered at prevailing Medicaid rate.[14]

BBRHD will reimburse for the following services/CPT codes at the prevailing Medicaid rate:

CPT	Description	Medicaid Rate
A0425	Ground mileage	Prevailing rate
A0427	Ambulance service, advanced life support, emergency transport, Level 1 (ALS1-Emergency)	
A0429	Ambulance service, basic life support, emergency transport (BLS-Emergency)	
A0433	Advanced life support, Level 2 (ALS2)	
A0434	Specialty care transport (SCT)	

BBRHD also acknowledges that medical care in the remote parts of Presidio and Brewster county is non-existent or limited. EMS providers bear a burden of providing urgent care for county residents even though some of the medical care may not ultimately require transport to the hospital. BBRHD will cover ambulance response and treatment with no transport for indigent clients at the following rates:

CPT	Description	BBRHD Rate
A0998	Ambulance response and treatment, no transport, within 20 miles of station	$100.00
A0998	Ambulance response and treatment, no transport, 20+ miles from station	$150.00

Federally Qualified Health Center (FQHC) Services

These services must be provided in an approved FQHC by a Texas licensed physician, a physician's assistant, or an advanced practice nurse, a clinical psychologist, or a clinical social worker.

Services and supplies must be usual, customary, and reasonable as well as medically necessary for diagnosis and treatment of an illness or injury.

Ground Transportation[15]

The Program has an arrangement with Big Bend Community Action Committee, Inc. (TRAX) to provide travel services for patients without the proper transportation resources

[14] *BBRHD (2022, June 23). Meeting of Board of Directors*

[15] *BBRHD. (2015, April 21). Meeting of Board of Directors. Minutes 4.21.2015.*

to and from medical appointments.

Ground transportation through TRAX must be authorized by the Patient Advocate for each trip for medical appointments. Transportation by TRAX which has not been pre-approved and reserved by the Patient Advocate will not be covered under the program.

TRAX will be the first option of assistance provided by the Program.

Procedures for Procuring Ground Transportation

1. Patients must inform their Patient Advocate of scheduled medical appointments as soon as possible for a Patient Advocate to make arrangements for transportation.
2. Patient Advocates will be scheduling round trips for patients to attend their scheduled appointment.
3. TRAX requires notification for transportation no less than 24 hours.
4. The Patient Advocate will need the medical provider's contact information to confirm the appointment scheduled for the patient.
5. It is the patient's responsibility to inform the Patient Advocate of rescheduled or canceled appointments for the Patient Advocate to make arrangements.
6. Patients are not able to schedule their own transportation arrangements through TRAX.
7. If TRAX is not able to transport the PBCIHP Patient to their scheduled medical appointment, the Patient Advocate will work towards an alternative solution to provide transportation assistance.

Transportation Limits

The Program will assist with transportation with a limit of $200.00 per year that does not count towards the maximum program benefits. Additional transportation funding can be made for certain client needs and treatment plans, but must be approved by the District once limit has been met.

Hormonal Disorders[16]

Treatment for hormonal disorders for both men and women after determination of medical necessity.

Medical Supplies and Equipment

These will be viewed as medical supplies that are customary and necessary for the convalescence of the medical condition.

Mental Health - Counseling Services

Mental health counseling will be available for depression, anxiety, PTSD, and other nonpsychotic mental disorders.

[16] *BBRHD. (2016, January 28). Meeting of Board of Directors. Minutes 01.28.2016. Alpine, TX.*

The hospital district allows for up to 10 counseling sessions in a 12-month enrollment period.

BBRHD requires prior authorization for all mental health counseling services.

Vision Care[17]

Every 24 months one examination of the eyes by refraction and one pair of prescribed, non-prosthetic eyewear may be covered. The District may reasonably limit the cost of frames and lenses, generally frames and lenses should be standard and represent the least expensive alternative. Diabetic eye exams may be provided on an annual basis. Vision care services and the purchase of eyewear may be limited to the District's preferred or authorized providers. Prior authorization is required.

Vocational Evaluation, Rehabilitation or Retraining[18]

Services related to vocational evaluation and training will be provide through the Texas Workforce Commission (TWC) and the Choice Program for qualified applicants.
"The Choices program assists applicants, recipients, non-recipient parents, and former recipients of Temporary Assistance for Needy Families (TANF) cash assistance to transition from welfare to work through participation in work-related activities, including job search and job readiness classes, basic skills training, education, vocational training, and support services."

[17] *BBRHD. (2021, March 25). Meeting of Board of Directors. Minutes 03.25.2021. Alpine, TX.*

[18] *BBRHD. (2016, January 28). Meeting of Board of Directors. Minutes 01.28.2016. Alpine, TX.*

Prescription Plan Coverage[19]

Basic Services

This service includes up to three prescription drugs per month. New and refilled prescriptions count equally toward the three prescription drugs per month total. Drugs must be prescribed by a Texas licensed physician or other practitioner within the scope of practice under law.

The quantity of drugs prescribed depends on the prescribing practice of the physician and the needs of the patient. However, each prescription is limited to a 30-day supply and dispensing only. The BBRHD co-payment is $5.00 per prescription per month.

Asthma Chambers - Active clients with a diagnosis of Asthma or COPD will be allowed under the RX program to have 1 asthma chamber per 12-month enrollment period, per active client with a copay. When dispensed the Asthma Chamber will not count towards the 3 per month prescription limit.

Optional Extended Prescription Plan Coverage

Diabetic Medical Supplies and Equipment:

These supplies and equipment must be medically necessary and prescribed by a Texas licensed physician, PA, or an APN within the scope of their practice in accordance with the standards established by their regulatory authority.

Items covered are:

- Test strips,
- alcohol prep pads,
- lancets,
- glucometers,
- insulin syringes,
- Humulin pens,
- needles required for the Humulin pens.

Insulin syringes, Humulin pens, and the needles required for Humulin pens are dispensed with a National Dispensing Code (NDC) number and are paid as prescription drugs; they do not count toward the three prescription drugs per month limitation.

Insulin and Humulin pen refills are prescription drugs and count toward the three prescription drugs per month limitation.

[19] *BBRHD. (2016, January 28). Meeting of Board of Directors. Minutes 01.28.2016. Alpine, TX.*

Diabetic Medical Supplies and Equipment:

TOS	Procedure Code	Description
9	A4250	Urine test or reagent strips or tablets, 100 tablets or strips
9	A4253	Blood glucose test or reagent test strips for home blood glucose monitors, 50 strips
9	A4772	Dextrostick or glucose test strips, per box
9	5261X	Protein reagent strips, per box of 50
9	5124X	Glucose tablets, 6 per box
9	5125X	Glucose gel/react gel, 3 dose pack
J	E0607	Home glucose monitor kit
9	A4245	Alcohol wipes, per box
9	A4258	Spring-powered device for lancet, each
9	A4259	Lancets, per box of 100

Medical & Prescription Program Exclusions and Limitations

The following services, supplies, and expenses are not covered benefits:

- Abortions; unless the attending physician certifies in writing that, in his professional judgment, the mother's life is endangered if the fetus were carried to term;
- Air conditioners, humidifiers and purifiers;
- Swimming pools, hot tubs, or waterbeds whether or not prescribed by a physician;
- Air Medical Transport;
- Ambulation aids;
- Autopsies;
- BiPAP (Bi-level Positive Airway Pressure);
- Charges exceeding the specified limit per client;
- Charges made by a nurse for services which can be performed by a person who does not have the skill and training of a nurse;
- Cosmetic (plastic) surgery to improve appearance, rather than to correct a functional disorder; here, functional disorders do not include mental or emotional distress related to a physical condition.
- CPAP (Continuous Positive Airway Pressure);
- Cryotherapy machine for home use;
- Custodial care;
- Dental care not medically necessary;
- Dentures;

- Drugs, which are:
  - ✓ Not approved for sale in the United States;
  - ✓ Prescriptions for drugs which are available over-the-counter;
  - ✓ Any medication that is purchased over-the-counter;
  - ✓ Outpatient prescription drugs not purchased through the prescription drug program;
  - ✓ Not approved by the Food and Drug Administration (FDA);
  - ✓ Dosages that exceed the FDA approval;
  - ✓ Approved by the FDA but used for conditions other than those indicated by the manufacturer.
- Exercise equipment (even if prescribed by a physician);
- Vibratory equipment;
- Hypnotherapy;
- Massage therapy;
- Recreational therapy;
- Enrollment in health or athletic clubs;
- Experimental or research programs;
- Family planning services are not payable if other entities exist to provide these services in Brewster/Presidio Counties;
- Hearing aids;
- Hospice Care;
- Hospital admission for diagnostic or evaluation procedures unless the test could not be performed on an outpatient basis without adversely affecting the health of the patient;
- Hospital beds;
- Hospital room and board charges for admission the night before surgery unless it is medically necessary;
- Infertility, infertility studies, in-vitro fertilization or embryo transfer, artificial insemination, or any surgical procedure for the inducement of pregnancy;
- Legal services;
- Marriage counseling, or family counseling;
- Medical services, supplies, or expenses as a result of a motor vehicle accident or assault unless BBRHD is the payor of last resort;
- More than one preventative physical exam per year per client;
- Obstetrical Care;
- Oriental pain control (Acupuncture or Acupressure);
- Other CPT codes with zero payment or those not allowed by county indigent guidelines;
- Outpatient psychiatric services (Counseling) that exceed 10 visits during a fiscal year;

- Parenteral hyperalimentation therapy as an outpatient hospital service unless the service is considered medically necessary to sustain life. Coverage does not extend to hyperalimentation administered as a nutritional supplement;
- Podiatric care unless the service is covered as a physician service when provided by a licensed physician or midlevel provider;
- Prosthetic or orthotic devices;
- Separate payments for services and supplies to an institution that receives a vendor payment or has a reimbursement formula that includes the services and supplies as a part of institutional care;
- Services or supplies furnished for the purpose of breaking a “habit”, including but not limited to overeating, smoking, thumb sucking;
- Services provided by an immediate relative or household member;
- Services provided outside of the United States;
- Services rendered as a result of (or due to complications resulting from) any surgery, services, treatments or supplier specifically excluded from coverage under this handbook;
- Sex change and/or treatment for transsexual purposed or treatment for sexual dysfunctions of inadequacy which includes implants and drug therapy;
- Sex therapy, hypnotics training (including hypnosis), any behavior modification therapy including biofeedback, education testing and therapy (including therapy intended to improve motor skill development delays) or social services;
- Social and educational counseling;
- Spinograph or thermograph;
- Surgical procedures to reverse sterilization;
- Take-home items and drugs or non-prescribed drugs;
- Transplants, including bone marrow;
- Treatment of flat foot (flexible pes planus) conditions and the prescription of supportive devices (including special shoes), the treatment of subluxations of the foot and routing foot care more than once every six months, including the cutting or removal of corns, warts, or calluses, the trimming of nails, and other routine hygienic care;
- Treatment of obesity and/or for weight reduction services or supplies (including weight loss programs);
- Vocational evaluation, rehabilitation or retraining;
- Voluntary self-inflicted injuries or attempted voluntary self-destruction while sane or insane;
- Whole blood or packed red cells available at no cost to patient;

- Care or treatment furnished by:
  - ✓ Christian Science Practitioner
  - ✓ Homeopath
  - ✓ Marriage, Family, Child Counselor (MFCC)
  - ✓ Naturopath.
  - ✓ Genetic counseling or testing;
- Private inpatient hospital room except when:
  - ✓ A critical or contagious illness exists that results in disturbance to other patients and is documented as such,
  - ✓ It is documented that no other rooms are available for an emergency admission,
    or
  - ✓ The hospital only has private rooms.
- Services or supplies provided in connection with cosmetic surgery unless they are authorized for specific purposes by the District or its designee before the services or supplies are received and are:
  - ✓ Required for the prompt repair of an accidental injury
  - ✓ Required for improvement of the functioning of a malformed body member
- Hysterectomies performed solely to accomplish sterilization:
  - ✓ A hysterectomy shall only be performed for other medically necessary reasons;
  - ✓ The patient shall be informed that the hysterectomy will render the patient unable to bear children;
  - ✓ A hysterectomy may be covered in an emergent situation if it is clearly documented on the medical record.
    - An emergency exists if the situation is a life-threatening emergency; or the patient has severe vaginal bleeding uncontrollable by other medical or surgical means; or the patient is comatose, semi-comatose, or under anesthesia;

Conflicts in Other Agreements:

The provisions set forth in this Handbook shall be subject to and superseded by any contrary and/or conflicting provisions in any contract or agreement approved by the District's Board of Directors.

To the extent of such conflict, the provisions in such contract or agreement shall control, taking precedence over any conflicting provisions contained in this Handbook.

SECTION FIVE
DISPUTES

SECTION FIVE - SERVICE DELIVERY DISPUTES

General Principles

Each Provider claiming benefits under the Program shall be responsible for supplying, at such times and in such manner as BBRHD in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Program.

If BBRHD in its sole discretion shall determine that the Provider has not Incurred a Covered Expense, provided a Covered Service, or that the benefit is not covered under the Program, or if the Provider shall fail to furnish such proof as is requested, no benefits shall be payable under the Program.

Submission of Claims by Providers

For claim payment to be considered, a claim should be received:

- Within 95 days from the approval date for services provided before the household was approved

  or

- Within 95 days from the date of service for services provided after the approval date.

The payment standard is determined by the date the claim is paid.

BBRHD PBCIHP mandated providers must provide services and supplies.

Any exception requires BBRHD approval for each service, supply, or expense.

Appeals of Adverse Benefits Determinations

All claims and questions regarding health claims should be directed to BBRHD.

BBRHD shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provision.

- ➢ Benefits under the Program will be paid only if BBRHD decides in its discretion that the Provider is entitled to them under the applicable Program rules and regulations in effect at the time services were rendered.

NOTE: PURSUANT TO TEXAS LOCAL GOVERNMENT CODE SECTION 271.154, THE EXHAUSTION OF THE APPEAL PROCEDURES SHALL BE A PRECONDITION TO THE INSTITUTION OF LITIGATION AGAINST BBRHD FOR PAYMENT OF A CLAIM ARISING FROM PROVIDER'S PROVISION OF SERVICES TO A BBRHD CLIENT. ANY SUIT FILED PRIOR TO THE EXHAUSTION OF THE FOLLOWING APPEAL PROCEDURES SHALL BE SUBJECT TO ABATEMENT UNTIL SUCH APPEAL PROCEDURES HAVE BEEN EXHAUSTED.

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Provider believes the claim has been denied wrongly, the Provider may appeal the denial and review pertinent documents, including the Covered Services and fee schedules pertaining to such Covered Services. The claims procedures of this Program afford a Provider with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination.

More specifically, the Program provides:

- Provider has at least 95 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and 60 days to appeal a second adverse benefit determination;
- Provider has the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- For an independent review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Program, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- For a review that takes into account all comments, documents, records, and other information submitted by the Provider relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
- That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Program fiduciary shall consult with one or more healthcare professionals who have appropriate training and experience in the field of medicine involved in the medical judgment, and who are neither individuals who were consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinates of any such individual;
- For the identification of medical or vocational experts whose advice was obtained on behalf of the Program in connection with a claim, even if the Program did not rely upon their advice;

and

- That a Provider will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Provider's claim for benefits to the extent such records are in possession of the BBRHD; information regarding any voluntary appeals procedures offered by the Program; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Program to the Client's medical circumstances.

First Appeal Level

Requirements for First Appeal

The Provider must file the first appeal in writing within 95 days following receipt of the notice of an adverse benefit determination. Otherwise, the initial determination stands as the final determination and is not appealable. To file an appeal, the Provider's appeal must be addressed as follows and either mailed or faxed as follows:

Big Bend Regional Hospital District
PO Box 1439
Alpine, TX 79831
Fax: 432-837-3261

It shall be the responsibility of the Provider to submit proof that the claim for benefits is covered and payable under the provisions of the Program.

Any appeal must include the following information:

- The name of the Client/Provider;
- The Client's social security number (Billing ID);
- The Client's Program Identification Number;
- All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Provider will lose the right to raise factual arguments and theories, which support this claim if the Provider fails to include them in the appeal;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the Provider has which indicates that the Provider is entitled to benefits under the Program.

If the Provider provides all of the required information, it will facilitate a prompt decision on whether Provider's claim will be eligible for payment under the Program.

Timing of Notification of Benefit Determination on First Appeal

BBRHD shall notify the Provider of the Program's benefit determination on review within the following timeframes:

Pre-service Non-Urgent Care Claims

Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 business days after receipt of the appeal

Concurrent Care Claims

The response will be made in the appropriate time period based upon the type of claim – Pre-service Non-urgent or Post-service.

Post-service Claims

Within a reasonable period of time, but not later than 30 days after receipt of the appeal

Calculating Time Periods

The period of time within which the Program's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Program, with all information necessary to make the determination accompanying the filing.

Notification of Determination on First Appeal

BBRHD may provide a Provider with notification, in writing or electronically, of a Program's adverse benefit determination on review, setting forth:
The specific reason or reasons for the denial;

- Reference to the specific portion(s) of the Handbook and/ or Provider Agreements on which the denial is based;
- A description of the Program's review procedures and the time limits applicable to the procedures for further appeal;
  and
- The following statement: "You and your Provider Agreement may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what additional recourse may be available is to contact BBRHD."

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, BBRHD may provide such access to, and copies of, documents, records, and other information used in making the determination of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as appropriate under the particular circumstances.

Second Appeal Level

Requirements for Second Appeal

Upon receipt of notice of the Program's adverse decision regarding the first appeal, the Provider has an additional 60 days to file a second appeal of the denial of benefits.

The Provider again is entitled to a "full and fair review" of any denial made at the first appeal, which means the Provider has the same rights during the second appeal as he or she had during the first appeal.

As with the first appeal, the Provider's second appeal must be in writing and must include all of the items and information set forth in the section entitled "Requirements for First Appeal" And shall additionally include a brief statement setting forth the Provider's rationale as to why the initial appeal decision was in error

Notification Determination on Second Appeal

BBRHD shall notify the Provider of the Program's benefit determination following the second appeal within the following timeframes:

Pre-service Non-Urgent Care Claims

Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 business days after receipt of the second appeal.

Concurrent Care Claims

The response will be made in the appropriate time period based upon the type of claim – Pre-service Urgent, Pre-service Non-urgent or Post-service.

Post-service Claims

Within a reasonable period of time, but not later than 30 days after receipt of the second appeal.

Calculating Time Periods

The period of time within which the Program's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Program, with all information necessary to make the determination accompanying the filing.

Notification of Determination on Second Appeal

The same information must be included in the Program's response to a second appeal as a first appeal, except for

(i) a description of any additional information necessary for the Provider to perfect the claim and an explanation of why such information is needed; and

(ii) A description of the Program's review procedures and the time limits applicable to the procedures. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on the second appeal, BBRHD may provide such access to, and copies of, documents, records, and other information used in making the determination of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate, including its determinations pertaining to Provider's assertions and basis for believing the initial appeal decision was in error.

Decision on Second Appeal to be Final

If, for any reason, the Provider does not receive a written response to the appeal within the appropriate time period set forth above, the Provider may assume that the appeal has been denied.

The decision by the **BBRHD** or other appropriate named fiduciary of the Program on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law.

All claim review procedures provided for in the Program must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one-year after the Program's claim review procedures have been exhausted or legal statute.

Appointment of Authorized Representative

A Provider is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial.

To appoint such a representative, the Provider must notify BBRHD of their designated representative.

In the event a Provider designates an authorized representative, all future communications from the Program will be with the representative, rather than the Provider, unless the Provider directs BBRHD, in writing, to the contrary.

SECTION FIVE
PROVIDER INFORMATION

AUTHORIZED/MANDATED PROVIDER INFORMATION

Policy Regarding Reimbursement Requests from Non-Mandated Providers for the Provision of Emergency and Non-Emergency Services

Continuity of Care

It is the intent of the District to assure continuity of care is received by the patients who are on the rolls of the Program. For this purpose, mandated provider relationships may be established and maintained for the best interest of the patients' health status.

The client/patient will be informed that BBRHD has a network of authorized providers at the time of eligibility processing in the Big Bend Health Office.

Additionally, they demonstrate understanding in a like fashion that failure to use mandated/approved providers, unless otherwise authorized, will result in them bearing independent financial responsibility for their actions.

Prior Approval

A health care provider who has not executed the District's Provider Agreement must obtain approval from the District before providing health care services, except mandatory emergency services, to an active patient. Failure to obtain prior approval or failure to comply with the notification requirements below will result in rejection of financial reimbursement for services provided.

Designated providers can refer to contracted specialty providers. If a specialty provider refers to other specialists as part of the consult or work-up, the specialist's referral needs the approval of BBRHD or from the original designated provider. All contracted providers are responsible for knowing the parameters of the Indigent Health standard of care as far as medical services covered, medical equipment, and drug formulary.

Mandatory Notification Requirements

The non-mandated provider shall attempt to determine if the patient resides within District's service area when the patient first receives services if not beforehand as the patient's condition may dictate.

The provider, the patient, and the patient's family shall cooperate with the District in determining if the patient is an active client on the Program rolls.

Each individual provider is independently responsible for their own notification on each case as it presents.

If a non-mandated provider delivers emergency or non-emergency services to a Program patient who the provider suspects might be an active client on the Program rolls with the District, the provider shall notify the District that services have been or will be provided to the patient.

The notice shall be made:

- By telephone not later than the 72nd hour after the provider determines that the patient resides in the District's service area and is suspect of being an active client on the District rolls;
  and
- By mail postmarked no later than the fifth working day after the date on which the provider determines that the patient resides in the District's service area.

Authorization

The District may authorize health care services to be provided by a non-mandated provider to a Program patient only:

- In an emergency (as defined below and interpreted by the District);
- When it is medically inappropriate for the District's mandated provider to provide such services;
  or
- When adequate medical care is not available through the mandated provider.

Emergency Defined

An "emergency medical condition" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- ✓ Placing the patient's health in serious jeopardy;
- ✓ Serious impairment of bodily functions;
  or
- ✓ Serious dysfunction of any bodily organ or part.

Emergency Medical Services - Reimbursement

In such event, the District shall provide written authorization to the non-mandated provider to provide such health care services as are medically appropriate, and thereafter the District shall assume responsibility for reimbursement for the services rendered by the non-mandated provider at the reimbursement rates approved for the District's mandated provider, generally but not limited to, being those reimbursement rates approved by the Texas Department of State Health Services pursuant to the County Indigent Health Care And Treatment Act. Acceptance of reimbursement by the non-mandated provider will indicate payment in full for services rendered.

If a non-mandated provider delivers emergency or non-emergency services to a patient who is on the Program rolls of the District and fails to comply with this policy, including the mandatory notice requirements, the non-mandated provider is not eligible for reimbursement for the services from the District.

Return to Mandated Provider

Unless authorized by the District to provide health care services, a non-mandated provider, upon learning that the District has selected a mandated provider, shall see that the patient is transferred to the District's selected mandated provider of health care services.

Appeal

If a health care provider disagrees with a decision of the District regarding reimbursement and/or payment of a claim for treatment of a person on the rolls of the Program, the provider will have to appeal the decision to the District's Board of Directors and present its position and evidence regarding coverage under this policy.

The District will conduct a hearing on such appeal in a reasonable and orderly fashion. The health care provider and a representative of the Program will have the opportunity to present evidence, including their own testimony and the testimony of witnesses. After listening to the parties' positions and reviewing the evidence, the District's Board of Directors will determine an appropriate action and issue a written finding.

APPENDIX I
GLOSSARY OF TERMS

GLOSSARY

Adult - A person at least age 18 or a younger person who is or has been married or had the disabilities of minority removed for general purposes.

Accessible Resources - Resources legally available to the household.

Aged Person - Someone aged 60 or older as of the last day of the month for which benefits are being requested.

Alien Sponsor – a person who signed an affidavit of support (namely, INS Form I-864 or I-864-A) on or after December 19, 1997, agreeing to support an alien as a condition of the alien's entry into the United States.

Not all aliens must obtain a sponsor before being admitted into the U. S.

Application Completed Date – The date that Form 100 and all information necessary to make an eligibility determination is received.

Approval Date- The date that the hospital district issues Form 3077, Notice of Eligibility, and **PBCIHP** Identification Card, is issued to the client.

Assets - All items of monetary value owned by an individual.

Budgeting - The method used to determine eligibility by calculating income and deductions using the best estimate of the household's current and future circumstances and income.

Candidate - Person who is applying for Program benefits who has NEVER been on the Program before.

Claim – Completed HCFA-1500, HCFA- 1450 (UB-92), pharmacy statement with detailed documentation, or an electronic version thereof.

Claim Pay Date - The date that the hospital district writes a check to pay a claim.

Client – Eligible resident who is actively receiving healthcare benefits on PBCIHP.

Common Law Marriage - relationship in which the parties age 18 or older are free to marry, live together, and hold out to the public that they are husband and wife.

A minor child in Texas is not legally allowed to enter a common law marriage unless the claim of common law marriage began before September 1, 1997.

Complete Application - A complete application (Application for Big Bend Health, Form 3064) includes validation of these components:

- ✓ The applicant's full name and address,
- ✓ The applicant's county of residence is Brewster/Presidio County,
- ✓ The names of everyone who lives in the house with the applicant and their relationship to the applicant,
- ✓ The type and value of the household's resources,
- ✓ The household's monthly gross income,
- ✓ Information about any health care assistance that household members may receive,
- ✓ The applicant's Social Security number,
- ✓ The applicant's signature with the date the Form 3064 is signed, and
- ✓ All needed information, such as verifications.

If the applicant is married and his spouse is a household member, the spouse may also sign and date the Form 3064 even if the spouse is a disqualified household member.

The date that Form 3064 and all information necessary to make an eligibility determination is received is the application completion date.

Co-payments – The amount requested from the client to help contribute to their healthcare expenses. Also known and referenced as "co-pays" in some Program documents.

County – A county not fully served by a public facility, namely, a public hospital or a hospital district; or a county that provides indigent health care services to its eligible residents through a hospital established by a board of managers jointly appointed by a county and a municipality.

Days - All days are calendar days, except as specifically identified as workdays.

Denial Date – The date that Form 3082, Notice of Ineligibility, is issued to the

candidate. **Disabled Person -** Someone who is physically or mentally unfit for

employment.

The District (District) – Big Bend Regional Hospital District

Domicile - A residence

DSHS - Department of State Health Services (Texas DSHS)

Earned Income - Income a person receives for a certain degree of activity or work. Earned income is related to employment and, therefore, entitles the person to work-related deductions not allowed for unearned income.

Eligible Presidio/Brewster County Resident - An eligible county resident must reside in Brewster/Presidio County and meet the resource and income requirements.

Eligibility Effective Date - The date that a client becomes qualified for benefits.

Eligibility End (Expiration) Date – The date that a client's eligibility ends

Eligibility Staff - Individuals who determine Program eligibility may be District personnel, or persons under contract with the District to determine Program eligibility.

Emancipated Minor - A person under age 18 who has been married. The marriage must not have been annulled.

Emergency medical condition - Is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy,
- Serious impairment of bodily functions, or
- Serious dysfunction of any bodily organ or part.

Equity - The amount of money that would be available to the owner after the sale of a resource. Determine this amount by subtracting from the fair market value any money owed on the item and the costs normally associated with the sale and transfer of the item.

Expenditure - Funds spent on basic or extended health care services.

Expenditure Tracking - A hospital district should track monthly basic and extended health care expenditures.

Extended Services – District approved extended health care services that the District determines to be necessary and cost-effective and chooses to provide.

Fair Market Value - The amount a resource would bring if sold on the current local market.

Fiscal Year (Program Year) - The twelve-month period beginning October 1 of each calendar year and ending September 30 of the following calendar year.

Governmental Entity - A county, municipality, or other political subdivision of the state, excluding a hospital district or hospital authority.

Gross Income - Income before deductions.

GRTL - The County's General Revenue Tax Levy (GRTL) is used to determine eligibility for state assistance funds.

Hospital District - A hospital district created under the authority of the Texas Constitution Article IX, Sections 4 – 11, the Big Bend Regional Hospital District.

Identifiable Application- An application is identifiable if it includes: the applicant's name, the applicant's address, the applicant's social security number, the applicant's date of birth, the applicant's signature, and the date the applicant signed the application.

Identifiable Application Date- The date on which an identifiable application is received from an applicant.

Inaccessible Resources - Resources not legally available to the household. Examples include but are not limited to irrevocable trust funds, property in probate, security deposits on rental property and utilities.

Income - Any type of payment that is of gain or benefit to a household.

Managing Conservator - A person designated by a court to have daily responsibility for a child.

Mandated Provider - A health care provider, selected by the District, who agrees to provide healthcare services to eligible clients.

Married Minor - An individual, age 14-17, who is married. These individuals must have parental consent or court permission. An individual under age 18 may not be a party to an informal (common law) marriage.

Medicaid - The Texas state-paid insurance program for recipients of Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), and health care assistance programs for families and children.

Midlevel Practitioner – An Individual healthcare practitioner other than a physician, dentist or podiatrist, who is licensed, registered, or otherwise, permitted in the State of Texas who practices professional medicine.

Minor Child - A person under age 18 who is not or has not been married and has not had the disabilities of minority removed for general purposes.

Net income - Gross income minus allowable deductions.

Personal Possessions - appliances, clothing, farm equipment, furniture, jewelry, livestock, and other items if the household uses them to meet personal needs essential for daily living.

Public Facility - A hospital owned, operated, or leased by a hospital district.

Public Hospital - A hospital owned, operated, or leased by a county, city, town, or other political subdivision of the state, excluding a hospital district and a hospital authority. For additional information, refer to Chapter 61, Health and Safety Code, Subchapter C.

Real Property - Land and any improvements on it.

Reimbursement - Repayment for a specific item or service.

Relative - A person who has one of the following relationships biologically or by adoption:

- Mother or father,
- Child, grandchild, stepchild,
- Grandmother or grandfather,
- Sister or brother,
- Aunt or uncle,
- Niece or nephew,
- First cousin,
- First cousin once removed, and
- Stepmother or stepfather.

Relationship also extends to:

- The spouse of the relatives listed above, even after the marriage is terminated by death or divorce,
- The degree of great-great aunt/uncle and niece/nephew, and
- The degree of great-great-great grandmother/grandfather.

Resources - Both liquid and non-liquid assets a person can convert to meet his needs. Examples include but are not limited to bank accounts, boats, bonds, campers, cash, certificates of deposit, gas rights, livestock (unless the livestock is used to meet personal needs essential for daily living), mineral rights, notes, oil rights, real estate (including buildings and land, other than a homestead), stocks, and vehicles.

Service Area - The geographic region in which a hospital district has a legal obligation to provide health care services. The service area for the BBRHD is the geographical boundaries of Brewster and Presidio Counties in Texas.

Status Date – The date when the hospital district makes a change to a client's status.

TDSHS – Texas Department of State Health Services

Temporary Absence – When a client is absent from Presidio/Brewster County for less than or equal to 30 days.

Termination Date - The date that the District ends a client's benefits.

Tip Income - Income earned in addition to wages that is paid by patrons to people employed in service-related occupations, such as beauticians, waiters, valets, pizza delivery staff, etc.

Unearned Income - Payments received without performing work-related activities.

V.A. Veteran – A veteran must have served at least 1 day of active-duty military time prior to September 7, 1980 and if service was after that date, at least 24 months of active duty military time to eligible for medical services through the Department of Veteran affairs (Form DD214 may be requested).

APPENDIX II
FEDERAL POVERTY GUIDELINES

Federal Poverty Level Chart

2022 Federal Poverty Guideline (Monthly income limit)*	
Persons in Family/Household	**Poverty Guideline (150% FPG)**
1	**$1,699**
2	**$2,289**
3	**$2,879**
4	**$3,469**
5	**$4,059**
6	**$4,649**
7	**$5,239**
8	**$5,829**

*Effective April 13, 2022 per TDSHS release. BOD approved on 5/26/2022.

APPENDIX III
FORMULARY

BBRHD Formulary List

Adoption of a much more inclusive formulary that represent the norm such as the Big Bend Health formulary, Medicaid, Department of corrections, are all templates to be referenced in the development of our own formulary.

Cost saving measures such as the use of Branded medication approved only in cases where there is documentation of failure of previously used generic alternatives.

Having the District pay for unrestricted formulary use for a three to six-month period while the correct response to therapy is established with any given medication after which the patient's medication prescriptions would be moved from the Programs expenditure to a Pharmaceutical company Patient assistance program for the payment of medications.

Utilizing already existing programs will allow Big Bend Health participants access to prolonged use of first line branded and Generic medications.

Using Patient Assistance programs will spare the rarified three medications extending ill patients access to an adequate number of medications for the care and treatment of their conditions.

Such Program management will require additional expenditure of District or contracted staff to manage Program participant's medications. Efficient management will result in allowing a wider array of medication choices for prescribers, patients, and pharmacist while reducing the financial burden of the medication cost part of Big Bend Health spending.