Montgomery County Hospital District

Medical Assistance Plan

Handbook
Procedures and Guidelines

Revised April 1, 2026

Board Reviewed/Approved

MONTGOMERY COUNTY HOSPITAL DISTRICT

MEDICAL ASSISTANCE PLAN HANDBOOK

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Note: Appendices may be changed or revised as needed with authorization from the Chief Operating Officer, Chief Financial Officer, and/or Chief Executive Officer of the District.

TECHNICAL ASSISTANCE

The MCHD Medical Assistance Plan (MAP) may be contacted at:

MCHD Healthcare Assistance Office
1400 South Loop 336 West
Conroe, Texas, 77304

Office Hours:
Monday through Thursday:
7:30am - 4:30pm

Friday:
7:30am - 11:30am

Office: (936) 523-5100
Fax: (936) 539-3450

http://www.mchd-tx.org/

Individual staff members can be contacted at (936) 523-5000.

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As not all situations are covered in this manual and thereby the Chief Operating Officer, Chief Financial Officer, and/or Chief Executive Officer for Montgomery County Hospital District have administrative control over the Medical Assistance Plan and are authorized to overrule and make management decisions for special circumstances, as they deem necessary.

SECTION ONE
PLAN ADMINISTRATION

INTRODUCTION

The Montgomery County Hospital 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 Montgomery County Hospital District to provide the health care services required under the Texas Constitution and the statute creating the District. The District's enabling legislation in section 5(a) provides that the Board of Directors of the District shall have the power and authority to promulgate rules governing the health care services to be delivered by the District in Montgomery County.

The Board of Directors of the Montgomery County Hospital District is committed to ensure that the needy inhabitants of the County receive quality health care services in an equitable and non-discriminatory manner through the District's Medical Assistance Plan. The Board of Directors believes quality medical care services can be provided to the County's needy inhabitants in a manner that is fair and equitable, efficient and without undue expense of local taxpayer dollars, which fund such care. The Board of Directors has adopted Plan rules for the provision of health services to those persons qualifying as “indigents” per chapter 61 of the Texas Health & Safety Code, and such indigent Plan rules strictly comply with the requirements of chapter 61 and the rules promulgated by the Texas Department of State Health Services thereunder.

In addition to the services provided to indigents, the Board of Directors have approved Plan rules for the provision of certain health care services to persons who are determined not to be indigent per the definitions contained in chapter 61 and the rules adopted by the Department, but whose income and resources fall between indigent (21% of federal poverty income limit, such limit known as “FPIL”) and 150% of FPIL, it being found by the Board of Directors that such persons, while not meeting the chapter 61 definition of indigent, generally lack

financial resources in amounts sufficient to obtain basic health care services. The Plan rules for services to persons who are found to be above 21% of FPIL but below 150% of FPIL are set forth in this Handbook.

These Medical Assistance Plan Policies are promulgated and approved pursuant to section 5(a) of the District's enabling legislation and are intended to provide guidelines and rules for the qualification and enrollment of participants into the District's Medical Assistance Plan. In many instances, these policies track the indigent health care 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. In addition, these policies are intended to ensure the delivery of quality and medically necessary healthcare services to Plan participants in a fair and non-discriminatory manner.

These Medical Assistance Plan Policies are intended to cover the delivery of health care services to needy 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. As a hospital district, only certain provisions of the Indigent Healthcare and Treatment Act (Ch. 61 Texas Health & Safety Code) apply to services provided by the District, including these Policies.

These policies may be amended from time to time by official action of the District's Board of Directors.

- MCHD's Enabling Legislation may be found in Appendix II.

- Chapter 61, Health and Safety Code may be found in Appendix III or online at: http://www.dshs.state.tx.us/cihcp/cihcp_info.shtm.

MCHD MAP Handbook

The MCHD MAP Handbook is sometimes referred to in other agreements as the “MAP Plan”, “Plan”, or “Plan Document.”

The purpose of the MCHD MAP Handbook is to:

- Establish the eligibility standards and application, documentation, and verification procedures for MCHD MAP,

- Define basic and extended health care services.

GENERAL ADMINISTRATION

MCHD Responsibility

The District will:

- Administer a county wide indigent health care Program
- Serve all of and only Montgomery County's Needy Inhabitants
  - Needy inhabitants is defined by the district as any individual who meets the eligibility criteria for the Plan as defined herein and who meet an income level from 21-150% of FPIL
- Provide basic health care services to eligible Montgomery County residents who have a medical necessity for healthcare
- 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. (See Exclusions And Limitations section below).
- 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
  - For establishing and maintaining methods for detecting and identifying situations in which a question of fraud may exist, and
  - For 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 MCHD fiscal year following the date on which the application is submitted

- Montgomery County Hospital District will validate the accuracy of all disclosed information, especially information that may appear fraudulent or dishonest. Additionally, any applicant may be asked to produce additional information or documentation for any part of the Eligibility process

- Public Notice. Not later than the beginning of MCHD's operating 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

- Establish an optional work registration procedure that will contact the local Texas Workforce Commission (TWC) office to determine how to establish their procedure and to negotiate what type of information can be provided. In addition, MCHD must follow the guidelines below

  1. Notify all eligible residents and those with pending applications of the Plan requirements at least 30 days before the Plan begins.

  2. Allow an exemption from work registration if applicants or eligible residents meet one of the following criteria:

     - Receive food stamp benefits,
     - Receive unemployment insurance benefits or have applied but not yet been notified of eligibility,
     - Physically or mentally unfit for employment,
     - Age 18 and attending school, including home school, or on employment training program on at least a half-time basis,
     - Age 60 or older,
     - Parent or other household member who personally provides care for a child under age 6 or a disabled person of any age living with the household,
     - Employed or self-employed at least 30 hours per week,
     - Receive earnings equal to 30 hours per week multiplied by the federal minimum wage.

  If there is ever a question as to whether or not an applicant should be exempt from work registration, contact the local Texas Workforce Commission (TWC) office when in doubt.

  3. If a non-exempt applicant or MCHD MAP eligible resident fails without good cause to comply with work registration requirements, disqualify him from MCHD MAP as follows:

  - For one month or until he agrees to comply, whichever is later, for the first non-compliance;
  - For three consecutive months or until he agrees to comply, whichever is later, for the second non-compliance; or
  - For six consecutive months or until he agrees to comply, whichever is later, for the third or subsequent non-compliance.

- Establish Behavioral Guidelines that all applicants and MAP clients must follow in order to protect MCHD employees, agents such as third party administrators, and providers. Each situation will be carefully reviewed with the Chief Operating Officer, Chief Financial Officer, and/or Chief Executive Officer for determination. Failure to follow the guidelines will result in definitive action and up to and including refusal of coverage or termination of existing benefits.

SECTION TWO
ELIGIBILITY CRITERIA

RESIDENCE

General Principles

- A person must live in the Montgomery County prior to filing an application.

- 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.
- A person lives in Montgomery County if the person's home and/or fixed place of habitation is located in the county and he 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 can include the following: change of driver's license, change of address, lease agreement, and proof of employment.

- A person does not lose his residency status because of a temporary absence from Montgomery County.

- A person cannot qualify for healthcare assistance from more than one county simultaneously.

- A person living in a Halfway House may be eligible for MAP benefits after he has been released from the Texas Department of Corrections if the state only paid for room and board at the halfway house and did not cover health care services.

    - If this person otherwise meets all eligibility criteria and plans to remain a resident of the county where the halfway house is located, this person is eligible for MAP.

    - If this person plans to return to his original county of residence, which is not the county where the halfway house is located, this person would not be considered a resident of the county and therefore not eligible for MAP.

- 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,
- 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, and
- A person who moved into the county solely for the purpose of obtaining health care assistance.

Verifying Residence

Verify residence for all clients.

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,
- School enrollment records, and
- Lease agreement.

No PO boxes are allowed to verify a residence, so all clients must provide a current physical address.

No medical (hospital) bills, invoices, nor claims may be used to prove/verify a residence.

Documenting Residence

On HCAP Form 101, document why information regarding residence is questionable and how questionable residence is verified.

CITIZENSHIP

General Principles

- A person must be a natural born citizen, a naturalized citizen, or a documented alien that has a green card and has had that status for at least 5 years as per citizenship guidelines of this text.

- All applicants must fill out HCAP Form F, Proof of Citizenship for MCHD MAP, which documents the citizenship status of the applicant.

Applicants must be one of the following:

- a U.S. citizen (natural born or naturalized), or

- an alien lawfully admitted before 8/22/96 who meets one of the following requirements:

    - a refugee admitted under Section 207 of INA,
    - a victim of severe trafficking admitted under Section (101)(a)(15)(T) of INA
    - an asylee admitted under Section 208 of INA,
    - an alien whose deportation is withheld under Sections 243(h) or 241(b)(3) of INA,
    - a Cuban/Haitian entrant paroled under Section 212(d)(5) of INA,
    - an Amerasian Legal Permanent Resident (LPR),
    - a parolee granted status under Section 212(d)(5) of INA for at least one year,
    - a Conditional Entrant admitted under Section 203(a)(7) of INA, or
    - an LPR other than an Amerasian.

- an alien lawfully admitted on or after 8/22/96 who meets one of the following requirements:
  - a refugee admitted under Section 207 of INA,
  - a victim of severe trafficking admitted under Section (101)(a)(15)(T) of INA
  - an asylee admitted under Section 208 of INA,
  - an alien whose deportation is being withheld under Section 243(h) or 241(b)(3) of INA,
  - a Cuban/Haitian Entrant paroled under Section 212(d)(5) of the INA, or
  - an Amerasian Legal Permanent Resident (LPR).
    - **NOTE: The aliens listed above meet the alien eligibility requirement for 5 years from their legal entry date into the United States**
  - an alien legally admitted for permanent residence who is:
    - an honorably discharged U.S. veteran, or
    - U.S. active duty military personnel, or
    - the spouse, un-remarried surviving spouse, or minor unmarried dependent child of an honorably discharged U.S. veteran or U.S. active duty military personnel.

- An alien who is the spouse or child of an honorably discharged U.S. veteran or U.S. active duty personnel and who has filed a petition with BCIS as being battered by the spouse or parent who no longer lives in the home.

- A documented alien that has a green card and has had that status for at least 5 years and does not meet any of the above criteria.

HOUSEHOLD

General Principles

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

- Legal responsibility for support exists between:

    - Persons who are legally married under the laws of the State of Texas (including common-law marriage),

        - In Texas, a common-law is considered a legal marriage. A man and a woman who want to establish a common-law marriage must sign a form provided by the county clerk. In addition, they must (1) agree to be married, (2) cohabit, and (3) represent to others that they are married. The only way to dissolve a common-law marriage is through a formal divorce proceeding in a court of law

    - Persons who are legally married under the laws of the State of Texas and not divorced,

        - Persons that are separated from their spouse and not divorced are considered part of the household because the law states that if you are not legally divorced, everything you have is still considered community property.

            - Applicant may provide proof of income and resources for absent spouse, or

            - If applicant cannot provide proof of income and resources for absent spouse, they must:

                1. Present three verifiable domicile forms, HCAP Form 103, Request for Domicile Verification (provided by District) and,

                2. Sign HCAP Form 104, the MAP Affidavit of Marital Status and Financial Support regarding separation from spouse.

3. Review of background check:

    a. If background check illustrates that there are no joint income/resources between applicant and absent spouse, continue with eligibility process as normal.

    b. If background check identifies joint income/resources between applicant and absent spouse, the applicant may be given a single 3 month period to pursue all income and resources from absent spouse.

        i. Upon recertification, the applicant must prove or disprove any discrepancies identified on the background check.

        ii. Once all requested documents are provided, completed, and accepted, the client may then become recertified for MAP benefits.

- A legal parent and a minor child (including unborn children), or
- A managing conservator and a minor child.

- Eligibility for the Medicaid program automatically disqualifies a person from the Medical Assistance Plan.

MCHD MAP Household

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

<u>Disqualified Persons</u>

- A person who receives or is categorically eligible to receive Medicaid,
- A person who receives TANF benefits,
- A person who receives SSI benefits and is eligible for Medicaid,
- 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), and
- A Medicaid recipient who partially exhausts some component of his Medicaid benefits,

A disqualified person is not a MCHD MAP household member regardless of his legal responsibility for support.

MCHD MAP 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,
- An inmate in a county jail (not state or federal).

MCHD MAP Group Households – two or more persons who are living together and meet one of the following descriptions:

- Two persons legally married to each other,
- Two persons who are legally married and not divorced,
- 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 Household

All households are verified.

Proof may include but is not limited to:

- Lease agreement or

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

Documenting Household

On HCAP Form 101, 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.
    - The applicant must not be eligible or potentially eligible for any other resource. Example: Medicaid, Medicare, Insurance, group health insurance, VA Veteran medical benefits, or any other source. MCHD's Medical Assistance Plan is payor of last resort!
- The resources of all MCHD MAP household members are considered.
- Resources are either countable or exempt.
- Resources from disqualified and non-household members are excluded, but may be included if processing an application for a sponsored alien.
- A household is not eligible if the total countable household resources exceed:
    - $3,000.00 when a person who is aged or has disabilities and who meets relationship requirements lives in the home or
    - $2,000.00 for all other households.
- A household is not eligible if their total countable resources exceed the limit on or after:
    - A household is not eligible if their total countable resources exceed the limit on or after the first interview date or the process date 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.
- 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

CIHCP household must provide verification that the bank account is used solely for the nonmember's benefit and that no CIHCP household member uses the money in the account for their benefit. If a household member uses any of the money for their benefit or if any household member's money is also in the account, consider the bank account accessible to the household.

Alien Sponsor's Resources

Calculate the total resources accessible to the alien sponsor's household according to the same rules and exemptions for resources that apply for the sponsored alien applicant. The total countable resources for the alien sponsor household will be added to the total countable resources of the sponsored alien applicant.

Please refer to Texas Health and Safety Code, Chapter 61, §61.012.

Sec.61.012. REIMBURSEMENT FOR SERVICES.
(a) In this section, "sponsored alien" means a person who has been lawfully admitted to the United States for permanent residence under the Immigration and Nationality Act (8 U.S.C. Section 1101 et seq.) and who, as a condition of admission, was sponsored by a person who executed an affidavit of support on behalf of the person.

(b)A public hospital or hospital district that provides health care services to a sponsored alien under this chapter may recover from a person who executed an affidavit of support on behalf of the alien the costs of the health care services provided to the alien.

(c)A public hospital or hospital district described by Subsection (b) must notify a sponsored alien and a person who executed an affidavit of support on behalf of the alien, at the time the alien applies for health care services, that a person who executed an affidavit of support on behalf of a sponsored alien is liable for the cost of health care services provided to the alien.

(b) Section 61.012, Health and Safety Code, as added by this section, applies only to health care services provided by a public hospital or hospital district on or after the effective date of this act.

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.

Exemption: Resources/Income Payments

If a payment or benefit counts as income for a particular month, do 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, minus any amount spent or intended to be spent for the Household's bills for burial, health care, or damaged/lost possessions.

Lawsuit Settlement

Count, minus 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, if readilyavailable. Examples include but are not limited to cash, a checking accounts, a savings accounts, a certificates of deposit (CDs), notes, bonds, and stocks.

Loans (Non-Educational)

Exempt these loans from resources.

Consider 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 assistance not considered a loan as unearned income (contribution).

Lump-Sum Payments

Effective January 1, 2013 exempt federal tax refunds permanently as income and resources for 12 months after receipt. Exempt the Earned Income Credit (EIC) for a period of 12 months after receipt through December 31, 2018.

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 contributions, gifts, and prizes as unearned income in the month received regardless of the frequency of receipt.

Personal Possessions

Exempt.

Real Property

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

Reimbursement

Exempt a reimbursement in the month received. 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; and

• 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 FMV of one primary vehicle per household necessary to transport household members, regardless of the purpose of the trip.

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. **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 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 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 sold the vehicle but the buyer has not transferred the title into the buyer's name.
- That the vehicle was repossessed.
- That the vehicle was stolen.
- That he 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,
- Person cannot sell the vehicle, and
- 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 current fair market value of licensed vehicles using the average trade-in or wholesale value listed on a reputable automotive buying resource website (i.e., National Automobile Dealers Association (NADA), Edmunds, or Kelley Blue Book). 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 on an automotive buying resource website 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 an ax assessment or a newspaper advertisement indicating the sale value if similar vehicles.

- Determine the value of new vehicles not listed on an automotive buying resource website 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 or fail to disclose a resource 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 or undisclosed 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 his property, it does not affect the eligibility of the other spouse.

Verifying Resources

Verify all countable resources.

Proof may include but is not limited to:

- Bank account statements and
- Award letters.

Documenting Resources

On HCAP Form 101, 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, unless it is unreasonable to pursue the resource. 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 MCHD MAP 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.

- Income of disqualified and non-household members is excluded, but may be included if processing an application for a sponsored alien.

Adoption Payments

Exempt.

Alien Sponsor's Income

Calculate the total income accessible to the alien sponsor's household according to the same rules and exemptions for income that apply for the sponsored alien applicant. The total countable income for the alien sponsor household will be considered unearned income and added to the total countable income of the sponsored alien applicant.

Please refer to Texas Health and Safety Code, Chapter 61, §61.012.

Sec. 61.012. REIMBURSEMENT FOR SERVICES.
(a) In this section, "sponsored alien" means a person who has been lawfully admitted to the United States for permanent residence under the Immigration and Nationality Act (8 U.S.C. Section 1101 et seq.) and who, as a condition of admission, was sponsored by a person who executed an affidavit of support on behalf of the person.

(b)A public hospital or hospital district that provides health care services to a sponsored alien under this chapter may recover from a person who executed an affidavit of support on behalf of the alien the costs of the health care services provided to the alien.

(c)A public hospital or hospital district described by Subsection (b) must notify a sponsored alien and a person who executed an affidavit of support on behalf of the alien, at the time the alien applies for health care services, that a person who executed an affidavit of support on behalf of a sponsored alien is liable for the cost of health care services provided to the alien.

(b) Section 61.012, Health and Safety Code, as added by this section, applies only to health care services provided by a public hospital or hospital district on or after the effective date of this act.

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.

If a noncertified household member makes additional payments for use by a certified member, it is a contribution.

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 disability payments as unearned income, including Social Security Disability Insurance (SSDI) payments and disability insurance payments issued for non-medical expenses. Exception: Exempt Supplemental Security Income (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.

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 payments made under the Workforce Investment Act (WIA).

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

Exempt on-the-job training (OJT) payments received by a child who is under age 19 and under parental control of another household member

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 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.

Consider retroactive or restored payments to be lump-sum payments and count as a resource. Separate any portion that is ongoing income from a lump-sum amount and count it as income.

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

Effective January 1, 2013 exempt federal tax refunds permanently as income and resources for 12 months after receipt. Exempt the Earned

Income Credit (EIC) for a period of 12 months after receipt through December 31, 2018.

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

Exempt a reimbursement (not to exceed the individual's expense) provided specifically for a past or future expense. If the reimbursement exceeds the individual's expenses, count any excess as unearned income. Do not consider a reimbursement to exceed the individual's expenses unless the individual or provider indicates the amount is excessive. 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 HCAP Form 200: Employer Verification Form).
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.

A person receiving TANF benefits also receives Medicaid and is, therefore, a disqualified household member.

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, pizza 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.

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:

- Americorp,
- Child Nutrition Act of 1966,
- Food Stamp Program – SNAP (Supplemental Nutrition Assistance Program),
- 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:

- Last four (4) consecutive paycheck stubs (for everyone in your household),
- HCAP Form 200, Employment Verification Form, which we provide,
- 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, and
- Statements completed, signed, and dated by the self-employed person.

Documenting Income

On HCAP Form 101, 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, and
    - 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, and
    - 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 Plan (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.

- View at least two pay amounts in the time period beginning 45 days before the interview date or the process date for cases processed without an interview. However, do not require the household to provide verification of any pay amount that is older than two months before the interview date or the process date for cases processed without an interview.

- When determining the amount of self-employment income received, verify four recent pay amounts that accurately represent their pay. Verify one month's pay amount that accurately represent their pay for self-employed income received monthly. Do not require the household to provide verification of self-employment income and expenses for more than two calendar months before the interview date or the case process date if not interviewed, for income received monthly or more often.

- Accept the applicant's statement as proof if there is a reasonable explanation of why documentary evidence or a collateral source is not available and the applicant's statement does not contradict other individual statements or other information received by the entity.

- Use at least three consecutive, current pay periods 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

- Determine countable income.
- Determine how often countable income is received.
- Convert countable income to monthly amounts.
- Convert self-employment allowable costs to monthly amounts.
- Determine if countable income is earned or unearned.
- Subtract converted monthly self-employment allowable costs, if any, from converted monthly self-employment income.
- Subtract earned income deductions, if any.
- Subtract the deduction for Medicaid individuals, of applicable.
- Subtract the deduction for legally obligated child support payments made by a member of the household group, if applicable.
- Compare the monthly gross income to the MCHD MAP 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:
  - 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 monthly if the self-employment income is intended to support the household for at least the next 6 months. The projection period is the last 3 months and the current month.

  - 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, by accepting the deductions listed on the 1040 U.S. Individual Income Tax Return or by allowing the following deductions:

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

Step 3

Convert countable income 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:

- Deduct $120.00 per employed household member for work-related expenses.
- Deduct 1/3 of remaining earned income per employed household member.
- Dependent childcare or adult with disabilities care expenses shall be deducted from the total income when determining eligibility, if paying for the care is necessary for the employment of a member in the CIHCP household. This deduction is allowed even when the child or adult with disabilities is not included in the CIHCP household. Deduct the actual expenses up to:
    - $200 per month for each child under age 2,
    - $175 per month for each child age 2 or older, and
    - $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 MCHD MAP household. Using the Deduction chart on the following page 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 MAP household

Step 9

Subtract the Deduction for Child Support, Alimony, and Other Payments to Dependents Outside the Home, if applicable.

Allow the following deductions from members of the household group, including disqualified members:

- The actual amount of child support and alimony a household member pays to persons outside the home.
- The actual amount of a household member's payments to persons outside the home that a household member can claim as tax dependents or is legally obligated to support.

Consider the remaining income as the monthly net income for the CIHCP household.

Step 10

Compare the household's monthly gross income to the 21- 150% FPIL monthly income standard, using the MCHD MAP Monthly Income Standards chart below.

MONTGOMERY COUNTY HOSPITAL
DISTRICT MEDICAL ASSISTANCE PLAN
INCOME GUIDELINES EFFECTIVE 4/1/2026
21- 150% FPIL

# of Individuals in the MAP Household	Income Standard 21% FPIL	Income Standard 150% FPIL
1	$279	$1,995
2	$379	$2,705
3	$478	$3,415
4	$578	$4,125
5	$677	$4,835
6	$776	$5,545
7	$876	$6,255
8	$975	$6,965
9	$1,075	$7,675
10	$1,174	$8,385
11	$1,273	$9,095
12	$1,373	$9,805

Note: Based on the 2026 Federal Poverty Income Limits (FPIL), which changes March-May of every year.

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

SECTION THREE
CASE
PROCESSING

CASE PROCESSING

General Principles

- Use the MCHD MAP application, documentation, and verification procedures.

- Issue HCAP Form 100 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 HCAP Form 100 if the applicant requests help. Anyone who helps fill out the HCAP Form 100 must sign and date it.

- If the applicant is incompetent, incapacitated, or deceased, someone acting responsibly for the client (a representative) may represent the applicant in the application and the review process, including signing and dating the HCAP Form 100 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, income, and citizenship.

- Allow at least 14 days for requested information to be provided, unless the household agrees to a shorter timeframe, when issuing HCAP Form 12. Note: The requested information is documented on HCAP Form 12 and a copy is given to the household.

- All information required by the "How to Apply for MAP" document 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, income, and citizenship guidelines.

- Issue written notice, namely, HCAP Form 109, Notice of Eligibility and HCAP Form 110, the MAP Identification Card, HCAP Form 120, Notice of Incomplete Application, or HCAP Form 117, Notice of Ineligibility, of the District's decision. 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 or 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 HCAP Form 117 is issued to the household.

- Consult the hospital district's legal counsel to develop procedures regarding disclosure of information.

- Be aware that a person involved in a motor vehicle accident or an assault (before or during MAP benefit period) will not receive benefit coverage for any medical expenses related to that accident or assault, unless proper documentation is provided showing no other liability. The minimum documentation required consists of at least police report or auto insurance information. Other documentation may be necessary.

- Be aware that a person injured on the job (before or during MAP benefit period) who is entitled to Worker's Compensation, must pursue that resource for benefit coverage.

- Remember that MCHD is the payor of last resort. Do not hesitate to explain this to the client.

- The applicant has the right to:

- Have his application considered without regard to race, color, religion, creed, national origin, age, sex, disability, or political belief;

- Request a review of the decision made on his application or re-certification for health care assistance; and

- Request, orally and in writing, a fair hearing about actions affecting receipt or termination of health care assistance.

- The applicant is responsible for:

  - Completing the HCAP Form 100 accurately.

    Application for Montgomery County Hospital District's Medical Assistance Plan (MAP) are available at the Montgomery County Healthcare Assistance Office located at 1400 South Loop 336 West, Conroe, Texas, 77304. Applications may be picked up, Monday through Thursday, except holidays, from 7:30 am to 11:30 am and 1:00 pm to 4:30 pm and on Fridays from 7:30am to 11:30 am. The MAP phone number is 936-523-5100 and the fax number is 936-539-3450. Applications are also available at http://www.mchd-tx.org/.

  - 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 HCAP Form 100 or during the interview.

  - Attending the scheduled interview appointment.

    All appointments will be set automatically by the MAP eligibility office and will be the applicant's responsibility to attend the scheduled appointment. Failure to attend the appointment will result in denial of assistance.

    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 Medical Assistance Plan, since MCHD is a payor of last resort.

- 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.

- The Montgomery County Hospital District has installed a comprehensive video and audio recording system in the Health Care Assistance Program office suite. This system serves many purposes. This system is designed to ensure quality services and to provide a level of security for the staff. It also provides documentation of client interviews which is useful in reducing fraud and abuse of the system. The recordings provide the staff protection against false claims from disgruntled clients, and ensure accuracy in connection with HCAP client interviews. All persons who apply for services, renewal of services, or other issues with the Health Care Assistance Program shall be subject to the video and audio taping equipment of the Montgomery County Hospital District.

PROCESSING AN APPLICATION

Steps for Processing an Application

- **Accept the identifiable application.**
- **Check information.**
- **Request needed information.**
- **Determine if an interview is needed.**
- **Interview.**
- **Determine eligibility.**
- **Issue the appropriate form.**

Step 1

Accept the identifiable application. On the HCAP Form 100 document the date that the identifiable Form 100 is received. This is the application file date.

Step 2

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

Step 3

Request needed information pertaining to the five eligibility criteria, namely, residence, citizenship, household, resources, and income.

Decision Pended. If eligibility cannot be determined because components that pertain to the eligibility criteria are missing, issue HCAP Form 12, 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 HCAP Form 12, 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. In addition, the client is issued HCAP Form G, “How to

contact the eligibility office regarding your SSI status". If the SSI application is denied for eligibility requirements, proceed with Step 3 whether or not the SSI denial is appealed.

Step 4

Determine if an interview is needed. Eligibility may be determined without interviewing the applicant if all questions on HCAP Form 100 are answered and all additional information has been provided.

Step 5

Interview the applicant or his representative face-to-face or by telephone in an interview is necessary.

If an interview appointment is scheduled, provide the applicant with an MAP Appointment Card, HCAP Form 2, 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

Repeat Steps 2 and 3 as necessary.

Step 7

Determine eligibility based on the five eligibility criteria.

Document information in the case record to support the decision.

At this step, all candidates must complete the following forms:

1. Acknowledgment of Receipt of Notice of Privacy Practices, HCAP Form A
2. Background Check Form, HCAP Form B
3. Medical History Form, HCAP Form C
4. Release Form, HCAP Form D
5. Subrogation Form, HCAP Form E
6. Proof of Citizenship, HCAP Form F
7. Representation and Acknowledgement Form, HCAP Form H

If a candidate has a telephone interview or does not require an interview and becomes eligible for MAP benefits, the forms listed above must be filled out at the time the client comes in to get their MAP Identification Card, HCAP Form 110, and the Notice of eligibility, HCAP Form 109.

Additionally at this step in the process, some candidates must complete additional forms as they apply:

1. Statement of Support, HCAP Form 102
2. Request for Domicile Verification, HCAP Form 103
3. Affidavit Regarding Marital Status and Financial Support, HCAP Form 104
4. Employer Verification Form, HCAP Form 200
5. Other Forms as may be developed and approved by Administrator
6. Assignment of Health Insurance Proceeds, HCAP Form I:

Staff Acknowledgement regarding Step 2

All applicants will undergo a background/credit check, as this is a mandatory MAP process. Candidates will be asked to clarify discrepancies. Do not pry or inquire into non-eligibility determination related information. Remember this is confidential material.

Step 8

Issue the appropriate form, namely, HCAP Form 117, Notice of Ineligibility, HCAP Form 120, Notice of Incomplete Application, or HCAP Form 109, Notice of Eligibility along with HCAP Form 110, the MAP Identification Card.

The MAP Identification Card is owned by MCHD and is not transferable. MCHD may revoke or cancel it at any time after notice has been sent out 2 weeks before the termination date explaining the reason for termination.

Incomplete Decision**.** If any of the requested documentation is not provided the application is not complete. Issue HCAP Form 120, Notice of Incomplete Application.

Denial Decision**.** If any one of the eligibility criteria is not met, the applicant is ineligible. Issue HCAP Form 117, 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:

- Not a resident of the county,
- A recipient of Medicaid,
- Resources exceed the resource limit,
- Income exceeds the income limit,
- Failed to keep an appointment,
- Failed to provide information requested,
- Failed to return the review application,
- Failed to comply with requirements to obtain other assistance, or
- 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.

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. (Exception: 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 doesn't 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.)

Issue HCAP Form 109, Notice of Eligibility, including the Eligibility Effective Date along with HCAP Form 110, the MAP Identification Card.

All active cases will be reviewed every 6 months as determined by the Eligibility Supervisor.

Termination of Coverage

Expiration of Coverage:

All active clients are given MAP coverage for a specified length of time and will be notified by mail **two weeks** before their MAP 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 MAP benefits will terminate, along with the explanation for termination. Coverage will terminate on the date listed on HCAP Form 117, 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 hospital 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 HCAP Form 117, Notice of Ineligibility within 30 days from the date of denial.
- District will have 14 days from the date HCAP Form 117 was received in the MAP eligibility office with the appropriate signature to respond to the client to let them know that MCHD received their appeal. At this time, the client will be notified as to the next step in the appeal process either:

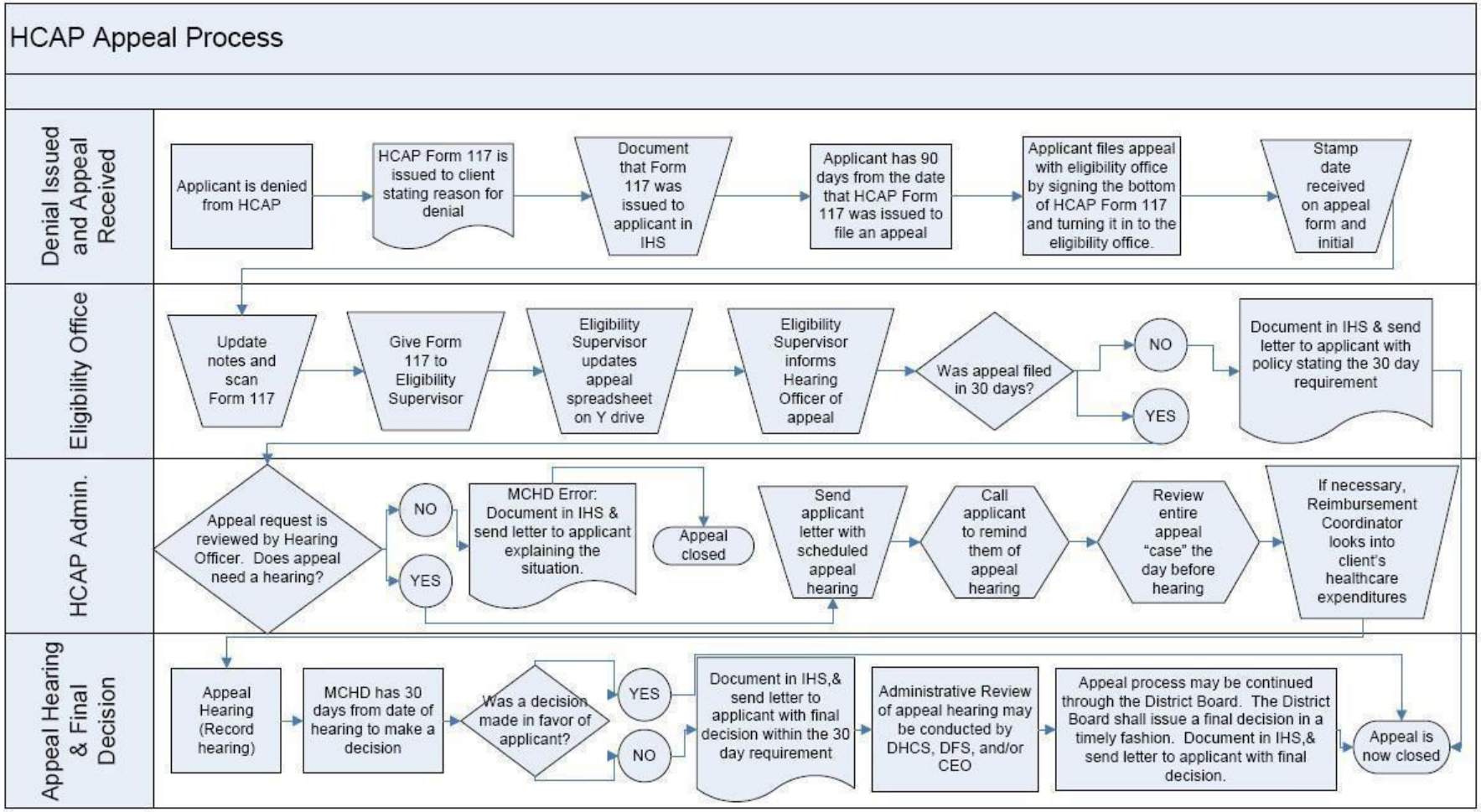
    1. An appeal hearing is not necessary as a mistake has been made on MCHD's behalf. MCHD and the client will take the appropriate steps required to remedy the situation, or
    2. An appeal hearing is necessary and the Hearing Officer or appointee will schedule a date and time for the appeal hearing.

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.

- The District will have 30 days in which to schedule the appeal hearing.
- 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.
- MCHD calls the client to remind the client of appeal hearing.
- 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 Chief Operating Officer, Chief Financial Officer, and/or the Chief Executive Officer.
- The Appeal process may be continued through the District Board.
- The District Board shall issue a final decision in a timely fashion.

MAP Appeal Process Flowchart



Note: At any time it is very important to update IHS with notes regarding the appeal process and to scan in all documents that are important to the appeal "case".

SECTION FOUR
SERVICE DELIVERY

SERVICE DELIVERY

General Principles

- MCHD shall provide or arrange for the basic health care services established by TDSHS or less restrictive health care services.
    - The basic health care services are:
        - Physician services
        - Annual physical examinations
        - Immunizations
        - Medical screening services
            - Blood pressure
            - Blood sugar
            - Cholesterol screening
        - Laboratory and x-ray services
        - Skilled nursing facility services
        - Prescription drugs
        - Rural health clinic services
        - Inpatient hospital services
        - Outpatient hospital services

- In addition to providing basic health care services, MCHD may provide other extended health care services that the hospital district determines to be cost-effective.
    - The extended health care services are:
        - Advanced practice nurse services provided by
            - Nurse practitioner services (ANP)

- Clinical nurse specialist (CNS)
- Certified nurse midwife (CNM)
- Certified registered nurse anesthetist (CRNA)

- Ambulatory surgical center (freestanding) services
- Bi-level Positive Airway Pressure (BIPAP) therapy
- Mental Health - Counseling services provided by:
  - Licensed clinical social worker (LCSW)
  - Licensed marriage family therapist (LMFT)
  - Licensed professional counselor (LPC)
  - Ph.D. psychologist
- Colostomy medical supplies and equipment
- Diabetic medical supplies and equipment
- Durable medical equipment (DME)
- Emergency medical services (EMS)
- Federally qualified health center services (FQHC)
- Home and community health care services (in special circumstances with authorization)
- Occupational Therapy Services
- Physician assistant services (PA)
- Physical Therapy Services

        - Other medically necessary services or supplies that the Montgomery County Hospital District determines to be cost effective.

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

- A hospital 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.

- As prescribed by Chapter 61, Health and Safety Code, a hospital district shall provide health care assistance to each eligible resident in its service area who meets:

    - The basic income and resources requirements established by the department under Sections 61.006 and 61.008 and in effect when the assistance is requested; or

    - A less restrictive income and resources standard by the hospital district serving the area in which the person resides.

- The maximum Hospital District liability for each fiscal year for health care services provided by all assistance providers, including hospital and skilled nursing facility (SNF), to each MAP client is, excluding Oncology clients:

    1. $60,000; or

    2. the payment of 30 days of hospitalization or treatment in a SNF, or both, or $60,000, whichever occurs first.

a. 30 days of hospitalization refers to inpatient hospitalization.

- The maximum Hospital District liability for each fiscal year for Mental Health – Counseling services provided by all assistance providers, including hospital, to each MAP client is:

  1. $20,000;

- The Montgomery County Hospital District is the payor of last resort and shall provide assistance only if other adequate public or private sources of payment are not available. In addition, MCHD is not secondary to any insurance benefits or exhausted benefits.

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

  1. Within 95 days from the approval date for services provided before the household was approved or

  2. 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.

- MCHD MAP mandated providers must provide services and supplies.

- Montgomery County Hospital District's EMS must provide all EMS services.
  - Upon request for EMS the provider must identify the patient as an MAP client to the EMS Dispatch center.

- Any exception requires MCHD MAP approval for each service, supply, or expense.

- 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.

  Households/clients within the 21-150% of the Federal Poverty Income Limit are requested to contribute $5 towards their healthcare.

Services for which co-payments are requested:

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

Basic and Extended Health Care Services do not Include Services and Supplies that:

- Are provided to a patient before or after the time period the patient is eligible for the MCHD Medical Assistance Plan;

- Are payable by or available under any health, accident, or other insurance coverage; by any private or governmental benefit system; by any legally liable third party, or under other contract;

- Are provided by military medical facilities, Veterans Administration facilities, or United States public health service hospitals;

- Are related to any condition covered under the worker's compensation laws or any other payor source.

BASIC HEALTH CARE SERVICES

MCHD-established Basic Health Care Services:

- **Annual Physical Examinations**
- **Immunizations**
- **Inpatient Hospital Services**
- **Laboratory and X-Ray Services**
- **Medical Screening Services**
- **Outpatient Hospital Services**
- **Physician Services**
- **Prescription Drugs**
- **Rural Health Clinic Services**
- **Skilled Nursing Facility Services**

Annual Physical Examinations

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

Associated testing, such as mammograms, can be covered with a physician's referral.

These services may also be provided by an Advanced Practice Nurse (APN) if they are within the scope of practice of the APN in accordance with the standards established by the Board of Nurse Examiners.

Immunizations

These are covered when appropriate. A client must have a current prescription from a physician for the immunization. In the event an immunization is prescribed that MCHD is unable to administer, the immunization must be pre-authorized by MCHD staff.

Inpatient Hospital Services

Inpatient hospital services must be medically necessary and be:

- Provided in an acute care hospital that is JCAHO and TDH compliant,

- 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

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.

In addition, the anesthesia procedures in the chart below may be payable.

CPT Codes and Descriptions only are Copyright 2004 American Medical Association All Rights Reserved

TOS	CPT Code	Description
1	99100	Anesthesia for patient of extreme age, under one year or over 70. (List separately in addition to code for primary anesthesia procedure.)
1	99116	Anesthesia complicated by utilization of total body hypothermia. (List separately in addition to code for primary anesthesia procedure.)
1	99135	Anesthesia complicated by utilization of controlled hypotension. (List separately in addition to code for primary anesthesia procedure.)
1	99140	Anesthesia complicated by emergency conditions (specify). (List separately in addition to code for primary anesthesia procedure.) An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part.

Prescription Drugs

This service includes up to three prescription drugs per month. New and refilled prescriptions count equally toward this three prescription drugs per month total. Drugs must be prescribed from the MCHD HCAP Formulary, 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 MCHD HCAP Formulary may be found in Appendix VII.

The MCICP co-payment for the monthly three covered formulary medications on both generic and brand name drugs, is zero. Co-payment requested on additional medications is $7.50 for each generic drug and $12.50 for each brand name drug.

Over the counter Aspirin will be covered without a co-payment up to a quantity limit of 500 per year.

Asthma Chambers- Active clients with a diagnosis of Asthma or COPD will be allowed under the RX program to have 1 asthma chamber per year per active client with a copay and will not count against the 3 per month prescription limit.

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, an advanced practice nurse (including a nurse practitioner, a clinical nurse specialist, and a certified nurse midwife), or a visiting nurse.

Skilled Nursing Facility Services

Services must be:

- Medically necessary,
- Ordered by a Texas licensed physician in good standing, and
- Provided in a skilled nursing facility that provides daily services on an inpatient basis.

EXTENDED HEALTH CARE SERVICES

- **Advanced Practice Nurse Services**
- **Ambulatory Surgical Center (Freestanding) Services**
- **Bi-level Positive Airway Pressure (BIPAP) Therapy**
- **Colostomy Medical Supplies and Equipment**
- **Mental Health - Counseling services provided by:**
    - **Licensed clinical social worker (LCSW)**
    - **Licensed marriage family therapist (LMFT)**
    - **Licensed professional counselor (LPC)**
    - **Ph.D. psychologist**
- **Diabetic Medical Supplies and Equipment**
- **Durable Medical Equipment**
- **Emergency Medical Services**
- **FQHC (Federally Qualified Health Center) Services**
- **Home Health Care Services**
- **Occupational Therapy Services**
- **Physician Assistant Services**
- **Physical Therapy Services**
- **Other medically necessary services or supplies**

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, a certified nurse midwife (CNM), 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 Surgical Center (ASC) Services

These services must be provided in a freestanding ASC, and are limited to items and services provided in reference to an ambulatory surgical procedure. A freestanding ASC service should be billed as one inclusive charge on a HCFA-1500, using the TOS “F.”

Bi-level Positive Airway Pressure (BIPAP)

Bi-pap therapy must be deemed as medically necessary before treatment is initiated.

Colostomy Medical Supplies and Equipment:

These supplies and equipment must be medically necessary and prescribed by a Texas licensed 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 hospital district requires the supplier to receive prior authorization.

Items covered are:

- Cleansing irrigation kits, colostomy bags/pouches, paste or powder, and skin barriers with flange (wafers).

Colostomy Medical Supplies and Equipment:

Description
Ostomy irrigation supply bag
Ostomy irrigation set
Ostomy closed pouch w att. st. barrier
Ostomy rings
Adhesive for ostomy, liquid, cement, powder, or paste
Skin barrier with flange (solid, flexible, or accordion), any size/Wafer

Mental Health - Counseling Services:

Mental health counseling and inpatient services will be available for International Classification of Diseases, Ninth Revision mental illnesses beginning with 290.0 – 316 for psychoses, neurotic disorders, personality

disorders, and other nonpsychotic mental disorders.

Inpatient services are provided to those who need 24-hour professional monitoring, supervision and assistance in an environment designed to provide safety and security during acute psychiatric crisis.

Inpatient and outpatient psychiatric services: psychotherapy services must be medically necessary; based on a physician referral; and provided by a licensed psychiatrist (MD) or licensed clinical social worker (LCSW , previously know as LMSW -ACP), a licensed marriage family therapist (LMFT), licensed professional counselor (LPC), or a Ph.D. psychologist. These services may also be provided based on an APN referral if the referral is within the scope of their practice.

The hospital district requires prior authorization for all mental health (inpatient and outpatient) counseling services.

- All Inpatient Admissions including Residential Care Inpatient Admissions
- All hospital or facility day treatment admissions
- All multiple (more than one) counseling sessions per week
- All multiple hour counseling sessions

Services provided by a physician or therapist for one counseling session (or less) per week, for medication checks, CSU services, and Lab work do not require pre-certification for payment

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.

The hospital district requires the supplier to receive prior authorization. Items covered are:

- Test strips, alcohol prep pads, lancets, glucometers, insulin syringes, humulin pens, and 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 limiatation. Insulin and humulin pen refills are prescription drugs (not optional services) and count toward the three prescription drugs per month limitation.

Diabetic Medical Supplies and Equipment:

Description
Urine test or reagent strips or tablets, 100 tablets or strips
Blood glucose test or reagent test strips for home blood glucose monitors, 50 strips

Dextrostick or glucose test strips, per box
Protein reagent strips, per box of 50
Glucose tablets, 6 per box
Glucose gel/react gel, 3 dose pack
Home glucose monitor kit
Alcohol wipes, per box
Spring-powered device for lancet, each
Lancets, per box of 100

Durable Medical Equipment:

This equipment must be medically necessary and provided under a written, signed, and dated physician's prescription. 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.

The hospital district requires the supplier to receive prior authorization. Items can be rented or purchased, whichever is the least costly or most efficient.

Items covered with MCHD authorization are:

- Appliances for measuring blood pressure that are reasonable and appropriate, canes, crutches, home oxygen equipment (including masks, oxygen hose, and nebulizers), standard wheelchairs, and walkers that are reasonable and appropriate

Durable Medical Equipment:

Description
Digital blood pressure & pulse monitor

Oxygen, gaseous, per cubic ft
Oxygen contents, liq. Per lb
Oxygen contents, liq. Per 100 lbs
Tubing (oxygen), per foot
Mouth Piece
Variable concentration mask
Disposable kit (pipe style)
Disposable kit (mask style)
Mask w/ headgear
6’ tubing
Filters
Cane with tip [New]
Cane with tip [Monthly Rental]
Cane, quad or 3 prong, with tips [New]
Cane, quad or 3 prong, with tips [Monthly Rental]
Crutches, underarm, wood, pair with pads, tips, handgrips [New]

Crutches, underarm, wood, pair with pads, tips, handgrips [Monthly Rental]
Crutch, underarm, wood, each with pad, tip, handgrip
Crutch, underarm, wood, each with pad, tip, handgrip [Monthly Report]
Walker, folding (pickup) adjustable or fixed height [New]
Walker, folding (pickup) adjustable or fixed height [Monthly Rental]
Walker, folding with wheels
Portable oxygen [Rental] Includes:
regulator, cart and (2) tanks per month
Nebulizer, with compressor [New]
Nebulizer, durable, glass or autoclavable plastic, bottle [New]
Nebulizer, durable, glass or autoclavable plastic, bottle [Monthly Rental]
Wheelchair, standard [New]
Wheelchair, standard [Monthly Rental]
Oxygen Concentrator, Capable of delivering 85% or > Oxygen Concen at Persc Flw Rt [Monthly Rental]
Standard wheelchair
Lightweight wheelchair
Ultra lightweight wheelchair
Elevating leg rests, pair
Continuous positive airway pressure (CPAP) device [monthly rental up to purchase]

Orthopedic braces [monthly rental up to purchase]
Wound care supplies

Emergency Medical Services:

Emergency Medical Services (EMS) services are ground ambulance transport services. When the client's condition is life-threatening and requires the use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate (mandated) facility, ground transport is an emergency service.

The hospital district requires the clients to use MCHD EMS services only. EMS Dispatch must be notified by provider that the patient is a MCHD MAP Client at time of request.

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.

Home Health Care Services

These services must be medically necessary and provided under a written, signed, and dated physician's prescription. A Pa or an APN may also prescribe these services if this is within the scope of their practice in accordance with the standards established by their regulatory authority.

The hospital district requires the provider to receive prior authorization.

Occupational Therapy Services:

These services must be medically necessary and may be covered if provided in a physician's office, a therapist's office, in an outpatient rehabilitation or free-standing rehabilitation facility, or in a licensed hospital.

Services must be within the provider's scope of practice, as defined by Occupations Code, Chapter 454.

The hospital district requires the provider to receive prior authorization.

Physician Assistant (PA) Services:

These services must be medically necessary and provided by a PA under the supervision of a Texas licensed physician and billed by and paid to the supervising physician.

Physical Therapy Services:

These services must be medically necessary and may be covered if provided in a physician's office, a therapist's office, in an outpatient rehabilitation or free-standing rehabilitation facility, or in a licensed hospital. Services must be within the provider's scope of practice, as defined by Occupations Code, Chapter 453.

The hospital district requires the provider to receive prior authorization.

EXCLUSIONS AND LIMITATIONS

The Following Services, Supplies, and Expenses are not MCHD MAP 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 or unless the attending physician certifies in writing that the pregnancy is related to rape or incest;
- Acupuncture or Acupressure
- Air conditioners, humidifiers and purifiers, swimming pools, hot tubs, or waterbeds, whether or not prescribed by a physician;
- Air Medical Transport;
- Ambulation aids unless they are authorized by MCHD;
- Autopsies;
- Charges exceeding the specified limit per client in the Plan;
  - The maximum Hospital District liability for each fiscal year for health care services provided by all assistance providers, including hospital and skilled nursing facility (SNF), to each MAP client is:
    - $60,000; or
    - the payment of 30 days of hospitalization or treatment in a SNF, or both, or $60,000, whichever occurs first.
    - 30 days of hospitalization refers to inpatient hospitalization.
  - The maximum Hospital District liability for each fiscal year for Mental Health – Counseling services provided by all assistance providers, including hospital, to each MCICP client is:
    - $20,000;
- 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;
- Chiropractors;

- 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. All cosmetic surgeries require MCHD authorization;

- Cryotherapy machine for home use;

- Custodial care;

- Dental care; except for reduction of a jaw fracture or treatment of an oral infection when a physician determines that a life-threatening situation exists and refers the patient to a dentist;

- Dentures;

- Drugs, which are:

  - Not approved for sale in the United States, or

  - Over-the-counter drugs (except with MCHD authorization)

  - Outpatient prescription drugs not purchased through the prescription drug program, or

  - Not approved by the Food and Drug Administration (FDA), or

  - Dosages that exceed the FDA approval, or

  - Approved by the FDA but used for conditions other than those indicated by the manufacturer;

- Durable medical equipment supplies unless they are authorized by MCHD;

- Exercising equipment (even if prescribed by a physician), vibratory equipment, swimming or therapy pools, 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 Montgomery County;

- For care or treatment furnished by:

  - Christian Science Practitioner
  - Homeopath
  - Marriage, Family, Child Counselor (MFCC)
  - Naturopath.

- Genetic counseling or testing;
- Hearing aids;
- Hormonal disorders, male or female;
- 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;
- 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;
- Immunizations and vaccines except with MCHD authorization;
  - Pneumovaccine shots for appropriate high risk clients and flu shots once a year may be covered
  - Other immunizations covered are those that can be administered by MCHD staff. A current prescription from a physician is required for immunizations given by MCHD staff.

- Infertility, infertility studies, invitro fertilization or embryo transfer, artificial insemination, or any surgical procedure for the inducement of pregnancy;

- Legal services;

- Marriage counseling, or family counseling when there is not an identified patient;

- Medical services, supplies, or expenses as a result of a motor vehicle accident or assault unless MCHD MAP is the payor last resort ;

- More than one physical exam per year per **active** client;

- Obstetrical Care, except with MCHD Administration authorization;

- Other CPT codes with zero payment or those not allowed by county indigent guidelines;

- Outpatient psychiatric services (Counseling) that exceed 30 visits during a fiscal year unless the hospital district chooses to exceed this limit upon hospital district review of an individual's case record.

- 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;

- 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.

- Prosthetic or orthotic devices, except under MAP Administration authorization;

- Recreational therapy;
- Routine circumcision if the patient is more than three days old unless it is medically necessary. Circumcision is covered during the first three days of his newborn's life;
- 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 or supplies provided in connection with cosmetic surgery unless they are authorized for specific purposes by the hospital 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
- 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);
- Vision Care, including eyeglasses, contacts, and glass eyes;
    - Except, every 12 month's one **diabetic** eye examination only may be covered.
- 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 not cost to patient.

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.

SERVICE DELIVERY DISPUTES

Appeals of Adverse Benefits Determinations

All claims and questions regarding health claims should be directed to the Third Party Administrator. MCHD 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 provisions. Benefits under the Plan will be paid only if MCHD decides in its discretion that the Provider is entitled to them under the applicable Plan rules and regulations in effect at the time services were rendered. The responsibility to process claims in accordance with the Handbook may be delegated to the Third Party Administrator; provided, however, that the Third Party Administrator is not a fiduciary or trustee of the Plan and does not have the authority to make decisions involving the use of discretion.

Each Provider claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as MCHD in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If MCHD 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 Plan, or if the Provider shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

NOTE: PURSUANT TO TEXAS LOCAL GOVERNMENT CODE SECTION 271.154, THE EXHAUSTION OF THE FOLLOWING APPEAL PROCEDURES SHALL BE A PRECONDITION TO THE INSTITUTION OF LITIGATION AGAINST MCHD FOR PAYMENT OF A CLAIM ARISING FROM PROVIDER'S PROVISION OF SERVICES TO A MCHD HCAP 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 Plan afford a Provider with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. Provider 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;

2. Provider the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

3. 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 Plan, 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;

4. 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;

5. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with one or more health care 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;

6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and

7. 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 MCHD or the Third Party Administrator; information regarding any voluntary appeals procedures offered by the Plan; 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 Plan 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 emailed or faxed as follows:

Claims Appeal

HCAPbillpay@mchd-tx.org

Fax Number: 936-523-5137

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 Plan. Any appeal must include the following information:

1. The name of the Client/Provider;
2. The Client's social security number (Billing ID);
3. The Client's HCAP #;
4. 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;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Provider has which indicates that the Provider is entitled to benefits under the Plan.

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 Plan.

For late submission appeals, proof of timely filing must be included for payment reconsideration. Proof of timely filing must indicate original "Bill Date" to HCAP Bill Pay, as well as claim(s) information for cross-reference. Examples of proof of timely filing include: fax confirmations, billing reports, billing records, system screenshots. Please note, the "Signature Date" on paper claim forms will not be considered as proof of timely filing.

Timing of Notification of Benefit Determination on First Appeal
MCHD shall notify the Provider of the Plan'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 Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, with all information necessary to make the determination accompanying the filing.

Manner and Content of Notification of Adverse Benefit Determination on First Appeal.
MCHD may provide a Provider with notification, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Handbook and/ or Provider Agreements on which the denial is based;
3. A description of the Plan's review procedures and the time limits applicable to the procedures for further appeal; and
4. 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 MCHD."

Furnishing Documents in the Event of an Adverse Determination. In the case of an adverse benefit determination on review, MCHD 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

Adverse Decision on First Appeal; Requirements for Second Appeal
Upon receipt of notice of the Plan'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

Timing of Notification of Benefit Determination on Second Appeal
MCHD shall notify the Provider of the Plan'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 Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, with all information necessary to make the determination accompanying the filing.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal
The same information must be included in the Plan'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 Plan'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, MCHD 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 MCHD or other appropriate named fiduciary of the Plan 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 Plan 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 Plan'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 complete a form, which can be obtained from MCHD or the Third Party Administrator. In the event a Provider designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Provider, unless the Provider directs MCHD, in writing, to the contrary.

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 and its MAP Office to assure continuity of care is received by the patients who are on the rolls of the Plan. For this purpose, mandated provider relationships have been established and maintained for the best interest of the patients' health status. The client/patient has the network of mandated providers explained to them and signs a document to this understanding at the time of eligibility processing in the MAP Office. Additionally, they demonstrate understanding in a like fashion that failure to use mandated providers, unless otherwise authorized, will result in them bearing independent financial responsibility for their actions.

Prior Approval:

A non-mandated health care provider must obtain approval from the Hospital District's Medical Assistance Plan (MAP) Office before providing health care services to an active MAP 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.

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 patients 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 MAP rolls of the District for MAP services.

- 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 MAP patient who the provider suspects might be an active client on the MAP rolls with the District, the provider shall notify the District's MAP Office that services have been or will be provided to the patient.

- The notice shall be made:

  (1) 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's MAP rolls; and

  (2) By mail postmarked not 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's MAP Office may authorize health care services to be provided by a non-mandated provider to a MAP 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 patients health in serious jeopardy,
- Serious impairment of bodily functions, or
- Serious dysfunction of any bodily organ or part.

Emergency Medical Services:

MCHD as a provider of EMS for Montgomery County is independently responsible in determining the most appropriate destination by its own policies and procedures for all transported patients, including MAP client patients. MAP client patients are to (as conditions allow) notify EMS about their mandated provider as a preferred destination.

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 MAP 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's MAP Office 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 MAP Office regarding reimbursement and/or payment of a claim for treatment of a person on the rolls of the District's MAP, 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 MAP Office 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.

SECTION FIVE
FORMS

FORMS

Forms may exist online in electronic form through MCHD's Indigent Healthcare Services (I.H.S.) software.

- HCAP Form 100: MONTGOMERY COUNTY HOSPITAL DISTRICT'S HEALTHCARE ASSISTANCE APPLICATION
- HCAP Form 2: HCAP APPOINTMENT CARD
- HCAP Form 3: HCAP BEHAVIORAL GUIDELINES
- HCAP Form A: ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM
- HCAP Form B: ASSET AND BACKGROUND CHECK FORM
- HCAP Form C: MEDICAL HISTORY FORM
- HCAP Form D: RELEASE FORM
- HCAP Form E: SUBROGATION FORM
- HCAP Form F: PROOF OF CITIZENSHIP FOR MCHD HCAP
- HCAP Form G: HOW TO CONTACT THE ELIGIBILITY OFFICE REGARDING YOUR SSI STATUS
- HCAP Form H: REPRESENTATION AND ACKNOWLEDGEMENT FORM
- HCAP Form I: ASSIGNMENT OF HEALTH INSURANCE PROCEEDS
- HCAP Form J: HCAP FRAUD POLICY AND PROCEDURES
- HCAP Form 12: REQUEST FOR INFORMATION
- HCAP Form 101: WORKSHEET (*Electronic Version)*
- HCAP Form 102: STATEMENT OF SUPPORT
- HCAP Form 103: REQUEST FOR DOMICILE VERIFICATION
- HCAP Form 104: AFFIDAVIT REGARDING MARITAL STATUS AND FINANCIAL SUPPORT
- HCAP Form 109: NOTICE OF ELIGIBILITY (*Electronic Version)*
- HCAP Form 110: HCAP IDENTIFICATION CARD
- HCAP Form 117: NOTICE OF INELIGIBILITY (*Electronic Version)*
- HCAP Form 120: NOTICE OF INCOMPLETE APPLICATION
- HCAP Form 200: EMPLOYER VERIFICATION FORM
- HCAP Form 201: SELF-EMPLOYMENT VERIFICATION FORM

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.

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 109, Notice of Eligibility, and HCAP Form 110, MAP 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 MAP benefits who has NEVER been on the Plan before.

Claim – Completed CMS-1500, UB-04, 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 MAP.

Common Law Marriage - Relationship recognized under Texas law 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 man and a woman who want to establish a common-law marriage must sign a form provided by the county clerk. In addition, they must (1) agree to be married, (2) cohabit, and (3) represent to others that they are married.

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 MAP, Form 100) includes validation of these components:

- The applicant's full name and address,

- The applicant's county of residence is Montgomery 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 MCHD MAP household's resources,
- The MCHD MAP household's monthly gross income,
- Information about any health care assistance that household members may receive,
- The applicant's Social Security number,
- All needed information, such as verifications.

The date that Form 100 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 MAP 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 117, Notice of Ineligibility, is issued to the candidate.

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

A disabled person includes:

1. A person approved for SSI, Social Security disability, or blindness.

2. A veteran who receives VA benefits because he/she is rated a 100% service-connected disability or who according to the VA needs regular aid and attendance or is permanently housebound.

3. A surviving spouse of a deceased veteran who meets one of the following criteria according to the VA.

   - Needs regular aid and attendance
   - Permanently housebound
   - Approved for VA benefits because of the veteran's death and could be considered permanently disabled for social security purposes.

4. A surviving child (any age) of a deceased veteran who the VA has determined is:

   - Permanently incapable of self-support, or
   - Approved for benefits because of the veteran's death and could be considered permanently disable for social security purpose.

5. A person receiving disability retirement benefits from any government agency for a disability that could be considered permanent for social security purposes.

6. A person receiving Railroad Retirement Disability, who is also covered by Medicare.

   Note: Permanent disability for Social Security purposes is any of the following conditions that may be obvious by observation or may require a physician's opinion:

   - Permanent loss of use of both hands, both feet, or one hand and one foot;
   - Amputation of leg at hip
   - Amputation of leg or foot because of diabetes mellitus or peripheral vascular diseases;
   - Total deafness, not correctable by surgery or hearing aid;
   - Statutory blindness, unless caused by cataracts or detached retina;
   - IQ 59 or less, established after the person becomes 16 years old;
   - Spinal cord or nerve root lesion resulting in paraplegia or quadriplegia;
   - Multiple sclerosis in which there is damage to the nervous system caused by scattered areas of inflammation. The inflammation recurs and has progressed to varied interferences with the function of the nervous system, including severe muscle weakness, paralysis, and vision and speech defects.
   - Muscular dystrophy with irreversible wasting of the muscles, impairing the ability to use arms or legs;
   - Impaired renal function caused by chronic renal disease, resulting in severely reduced function which may require dialysis or kidney transplant;
   - Amputation of a limb of a person at least 55 years old;
   - Acquired Immune Deficiency Syndrome (AIDS) progressed so that it results in extensive and/or recurring physical or mental impairment.

Disqualified Person – A person receiving or is categorically eligible to receive Medicaid.

The District – Montgomery County 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 Montgomery County Resident - An eligible county resident must reside in Montgomery County, and meets the resource, income, and citizenship 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 Plan eligibility may be hospital district personnel, or persons under contract with the hospital district to determine Plan eligibility.

Emancipated Minor - A person under age 18 who has been married as recognized under Texas law. 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 – MCHD approved, extended health care services that the hospital 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.

Gross Income - Income before deductions.

GRTL - The county's General Revenue Tax Levy (GRTL) is used to determine eligibility for state assistance funds. For information on determining and reporting the GRTL, contact Teri Rodgers, Property Tax Division of the Texas State Comptroller of Public Accounts at 800/252-9121.

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

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 hospital district, who agrees to provide health care services to eligible clients.

Married Minor - An individual, age 14-17, who is married as such is recognized under the laws of the State of Texas. 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.

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

Medicaid - The Texas state-paid insurance program for recipients of Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), and Medical Assistance Plans 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.

Sponsored Alien – a sponsored alien means a person who has been lawfully admitted to the United States for permanent residence under the Immigration and Nationality Act (8 U.S.C. Section 1101 et seq.) and who, as a condition of admission, was sponsored by a person who executed an affidavit of support on behalf of the person.

Status Date – The date when the hospital district make a change to a clients status.

TDSHS – Texas Department of State Health Services

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

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

Third Party Administrator (TPA) – The designated TPA shall be Boon-Chapman Benefit Administrators, Inc.

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
MCHD’S ENABLING LEGISLATION

MONTGOMERY COUNTY HOSPITAL DISTRICT'S ENABLING LEGISLATION

MONTGOMERY COUNTY HOSPITAL DISTRICT [1]

> **An Act relating to the creation, administration, maintenance, operation, powers, duties, and financing of the Montgomery County Hospital District of Montgomery County, Texas, by authority of Article IX, Section 9 of the Texas Constitution.**

***Be it enacted by the Legislature of the State of Texas*:**

Section 1. In accordance with the provisions of Article IX, Section 9, of the Texas Constitution, this Act authorizes the creation, administration, maintenance, operation, and financing of a hospital district within this state with boundaries coextensive with the boundaries of Montgomery County, Texas, to be known as "Montgomery County Hospital District" with such rights, powers, and duties as provided in this Act.

Sec. 2. The district shall take over and there shall be transferred to it title to all land, buildings, improvements, and equipment pertaining to the hospitals or hospital system owned by the county or any city or town within the boundaries of the proposed district and shall provide for the establishment of a health care or hospital system by the purchase, gift, construction, acquisition, repair, or renovation of buildings and equipment and equipping same and the administration of the system for health care or hospital purposes. The district may take over and may accept title to land, buildings, improvements, and equipment of a nonprofit hospital within the district if the governing

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[1] The Montgomery County Hospital District was created in 1977 by the 65th Leg., R.S., Ch. 258. It was amended by the following Acts: Act of 1985, 69th Leg., R.S., Ch. 516; Act of 1991, 72nd Leg., R.S., Ch. 511; Act of 1993, 73rd Leg., R.S., Ch. 267; Act of 1995, Ch. 468; Act of 1999, 76th Leg. R.S., Ch. 747; Act of 2003, 78th Leg. R.S., Ch. 529 (HB 1251); Act of 2005, 79th Leg. R.S.Ch. 690 (SB 264) and Ch. 476 (HB 192).

authority or authorities of the hospital and district agree to the transfer. The district shall assume the outstanding indebtedness incurred by any city or town within the district or by the county for hospital purposes within the boundaries of the district.

Section 3. (a) The district shall not be created nor shall any tax in the district be authorized unless and until the creation and tax are approved by a majority of the electors of the area of the proposed district voting at an election called for that purpose. The election may be called by the commissioners court on presentation of a petition therefor signed by at least 50 electors of the area of the proposed district. The election shall be held not less than 35 nor more than 60 days from the date the election is ordered. The order calling the election shall specify the date, place or places of holding the election, the form of ballot, and the presiding judge and alternate judge for each voting place and shall provide for clerks as in county elections. Notice of election shall be given by publishing a substantial copy of the election order in a newspaper of general circulation in the county once a week for two consecutive weeks, the first publication to appear at least 30 days prior to the date established for the election. The failure of the election shall not operate to prohibit the calling and holding of subsequent elections for the same purposes; provided no district confirmation election shall be held within 12 months of any preceding election for the same purpose. If the district is not confirmed at an election held within 60 months from the effective date of this Act, this Act is repealed.

(b) At the election there shall be submitted to the electors of the area of the proposed district the proposition of whether the hospital district shall be created with authority to levy annual taxes at a rate not to exceed 75 cents on the $100 valuation on all taxable property situated within the hospital district, subject to hospital district taxation, for the purpose of meeting the requirements of the district's bonds, indebtedness assumed

by it, and its maintenance and operating expenses, and a majority of the electors of the area of the proposed district voting at the election in favor of the proposition shall be sufficient for its adoption.

(c) The form of ballot used at the election on the creation of the district shall be in conformity with Section 61, Texas Election Code, as amended (Article 6.05, Vernon's Texas Election Code), so that ballots may be cast on the following proposition: The creation of Montgomery County Hospital District, providing for the levy of a tax not to exceed 75 cents on each $100 of valuation on all taxable property situated within the hospital district, subject to hospital district taxation, and providing for the assumption by the district of all outstanding bonds and indebtedness previously issued or incurred for hospital purposes within the boundaries of the proposed hospital district by the county and any city or town therein.

Sec. 4. (a) The district is governed by a board of seven directors. Three of the directors shall be elected at large from the entire district, and the remaining four directors each shall be elected from a different commissioner's precinct in the district, and each shall be a resident of the precinct he represents. Candidates to represent the district at large shall run by position. A qualified elector is entitled to vote for the directors to be elected at large and for the director to be elected from the precinct in which the elector resides. Directors shall serve for terms of four years expiring on the second Tuesday in June. No person may be appointed or elected as a member of the board of directors of the hospital district unless he is a resident of the district and a qualified elector and unless at the time of such election or appointment he shall be more than 21 years of age. No person may be appointed or elected as a director of the hospital district if he holds another appointed or

elected public office of honor, trust or profit. A person holding another public office of honor, trust or profit who seeks to be appointed or elected a director automatically vacates the first office. Each member of the board of directors shall serve without compensation and shall qualify by executing the constitutional oath of office and shall execute a good and sufficient bond for $1,000 payable to the district conditioned upon the faithful performance of his duties, and the bonds shall be deposited with the depository bank of the district for safekeeping.

(b) The board of directors shall organize by electing from among its membership a chairman, vice-chairman, treasurer and secretary one of their number as president and one of their number as secretary. Any four members of the board of directors shall constitute a quorum, and a concurrence of a majority of the directors present is sufficient in all matters pertaining to the business of the district. A meeting of the board of directors may be called by the chairman or any four directors. All vacancies in the office of director shall be filled for the unexpired term by appointment by the remainder of the board of directors. In the event the number of directors shall be reduced to less than four for any reason, the remaining directors shall immediately call a special election to fill said vacancies, and upon failure to do so a district court may, upon application of any voter or taxpayer of the district, issue a mandate requiring that such election be ordered by the remaining directors.

(c) A regular election of directors shall be held on the first Saturday in May of each even-numbered year, and notice of such election shall be published in a newspaper of general circulation in the county one time at least 10 days prior to the date of election. Any person desiring his name to be printed on the ballot as a candidate for director shall file a

petition, signed by not less than 10 legally qualified electors asking that such name be printed on the ballot, with the secretary of the board of directors of the district. Such petitions shall be filed with such secretary at least 25 days prior to the date of election.

(d) If no candidate for director from a particular commissioner's precinct or no candidate for a district at-large position receives a majority of the votes of the qualified voters voting in that race at the regular election of directors, the board shall order a runoff election between the two candidates from the precinct or from the at-large position who received the highest number of votes in that race at the regular election. The board shall publish notice of the runoff election in a newspaper or newspapers that individually or collectively provide general circulation in the area of the runoff election one time at least seven days before the date of the runoff election. Of the names printed on the ballot at the runoff election, the name of the candidate who received the higher number of votes at the regular election shall be printed first on the ballot. If before the date of the runoff election a candidate who is eligible to participate in the runoff dies or files a written request with the secretary of the board to have his name omitted from the ballot at the runoff election, the other candidate eligible to participate in the runoff election is considered elected and the runoff election shall be cancelled by order of the board.

Sec. 5. (a) The board of directors shall manage, control, and administer the health care or hospital system and all funds and resources of the district, but in no event shall any operating, depreciation, or building reserves be invested in any funds or securities other than those specified in Article 836 or 837, Revised Civil Statutes of Texas, 1925, as amended. The district, through its board of directors, shall have the power and authority to sue and be sued, to promulgate rules governing the operation of the hospital, the health

care or hospital system, its staff, and its employees. The board of directors shall appoint a qualified person to be known as the chief administrative officer of the district to be known as the president of the hospital district or by another title selected by the board. The board may appoint assistants to the chief administrative officer to be known as vice-presidents of the hospital district or by another title selected by the board. The chief administrative officer and any assistant shall serve at the will of the board and shall receive such compensation as may be fixed by the board. The chief administrative officer shall supervise all the work and activities of the district and shall have general direction of the affairs of the district, subject to limitations prescribed by the board. The board of directors shall have the authority to appoint to the staff such doctors as necessary for the efficient operation of the district and may provide for temporary appointments to the staff if warranted by circumstances. The board may delegate to the chief administrative officer the authority to employee technicians, nurses, and employees of the district. The board shall be authorized to contract with any other political subdivision or governmental agency whereby the district will provide investigatory or other services as to the medical, health care, hospital, or welfare needs of the inhabitants of the district and shall be authorized to contract with any county or incorporated municipality located outside its boundaries for the care and treatment of the sick, diseased, or injured persons of any such county or municipality and shall have the authority to contract with the State of Texas or agencies of the federal government for the treatment of sick, diseased, or injured persons.

(b) The district may enter into contracts, and make payments thereunder, relating to or arranging for the provision of health care services as permitted by the Texas Constitution and Chapter 61, Health and Safety Code, and its subsequent amendments, on

terms and conditions as the board of directors determines to be in the best interests of the district. The term of a contract entered into under this subsection may not exceed 15 years.

Sec. 6. The board of directors may provide retirement benefits for employees of the hospital district. The board may provide the benefits by establishing or administering a retirement program or by electing to participate in the Texas County and District Retirement System or in any other statewide retirement system in which the district is eligible to participate.

Sec. 7. The district shall be operated on the basis of a fiscal year as established by the board of directors; provided such fiscal year may not be changed during the time revenue bonds of the district are outstanding or more than once in any 24-month period. The board shall have an audit made of the financial condition of the district, which together with other records of the district shall be open to inspection at the principal office of the district. The chief administrative officer shall prepare an annual budget for approval by the board of directors. The budget shall also contain a complete financial statement of the district showing all outstanding obligations of the district, the cash on hand to the credit of each and every fund of the district, the funds received from all sources during the previous year, the funds available from all sources during the ensuring year, with balances expected at year-end of the year in which the budget is being prepared, and estimated revenues and balances available to cover the proposed budget and the estimated tax rate which will be required. A public hearing on the annual budget shall be held by the board of directors after notice of such hearing has been published one time at least 10 days before the date set therefor. Any person residing in the district shall have the right to be present and participate in the hearing. At the conclusion of the hearing, the budget, as

proposed by the chief administrative officer, shall be acted on by the board of directors. The board of directors shall have authority to make such changes in the budget as in their judgment the law warrants and the interest of the taxpayers demands. No expenditure may be made for any expense not included in the annual budget or an amendment to it. The annual budget may be amended from time to time as the circumstances may require, but the annual budget, and all amendments thereto, shall be approved by the board of directors. As soon as practicable after the close of each fiscal year, the chief administrative officer shall prepare for the board a full sworn statement of all money belonging to the district and a full account of the disbursements of same.

Sec. 8. (a) The board of directors shall have the power and authority to issue and sell its bonds in the name and on the faith and credit of the hospital district for the purchase, construction, acquisition, repair, or renovation of buildings and improvements and equipping the same for health care or hospital purposes, and for any or all such purposes. At the time of the issuance of any bonds by the district, a tax shall be levied by the board sufficient to create an interest and sinking fund to pay the interest and the principal of said bonds as same mature; providing the tax together with any other taxes levied for the district shall not exceed 75 cents on each $100 valuation of all taxable property situated in the district subject to hospital district taxation in any one year. No bonds shall be issued by such hospital district except refunding bonds until authorized by a majority of the electors of the district. The order for bond election shall specify the date of the election, the amount of bonds to be authorized, the maximum maturity of the bonds, the place or places where the election shall be held, the presiding judge and alternate judge for each voting place, and provide for clerks as in county elections. Notice of any bond

election except one held under the provisions of Section 9 of this Act in which instance notice shall be given as provided in Section 3 of this Act, shall be given as provided in Article 704, Revised Civil Statutes of Texas, 1925, as amended, and shall be conducted in accordance with the Texas Election Code, as amended, except as modified by the provisions of this Act.

(b) Refunding bonds of the district may be issued for the purpose of refunding and paying off any outstanding indebtedness it has issued or assumed. Such refunding bonds may be sold and the proceeds thereof applied to the payment of outstanding indebtedness or may be exchanged in whole or in part for not less than a like principal amount of outstanding indebtedness. If the refunding bonds are to be sold and the proceeds hereof applied to the payment of any outstanding indebtedness, the refunding bonds shall be issued and payments made in the manner specified by Chapter 502, Acts of the 54th Legislature, 1955, as amended (Article 717k, Vernon's Texas Civil States).

(c) Bonds of the district shall mature within 40 years of their date, shall be executed in the name of the hospital district and on its behalf by the president of the board and countersigned by the secretary in the manner provided by Chapter 204, Acts of the 57th Legislature, Regular Session, 1961 as amended (Article 717j--1, Vernon's Texas Civil Statutes), shall bear interest at a rate not to exceed that prescribed by Chapter 3, Acts of the 61st Legislature, Regular Session, 1969, as amended (Article 717k--2, Vernon's Texas Civil Statutes), and shall be subject to the same requirements in the manner of approval by the Attorney General of Texas and registration by the Comptroller of Public Accounts of the State of Texas as are by law provided for approval and registration of bonds issued by

counties. On the approval of bonds by the attorney general and registration by the comptroller, the same shall be incontestable for any cause.

(d) The district shall have the same power and authority as cities and counties under The Certificate of Obligation Act of 1971 (Article 2368a.1, Vernon's Texas Civil Statutes) to issue and sell certificates of obligation for permitted purposes under this Act in accordance with the provisions of The Certificate of Obligation Act. Certificates of Obligation shall be issued in conformity with and in the manner specified in The Certificate of Obligation Act, as it may be amended from time to time.

Sec. 9. A petition for an election to create a hospital district, as provided in Section 3 of this Act, may incorporate a request that a separate proposition be submitted at such election as to whether the board of directors of the district, in the event same is created, shall be authorized to issue bonds for the purposes specified in Section 8 of this Act. Such petition shall specify the maximum amount of bonds to be issued and their maximum maturity, and same shall be included in the proposition submitted at the election.

Sec. 9A. The district may issue revenue bonds or certificates of obligation or may incur or assume any other debt only if authorized by a majority of the voters of the district voting in an election held for that purpose. This section does not apply to refunding bonds or other debt incurred solely to refinance an outstanding debt.

Sec. 10. In addition to the power to issue bonds payable from taxes levied by the district, as contemplated by Section 8 of this Act, the board of directors is further authorized to issue and to refund any previously issued revenue bonds for purchasing, constructing, acquiring, repairing, equipping, or renovating buildings and improvements for health care or hospital purposes and for acquiring sites for health care or hospital

purposes, the bonds to be payable from and secured by a pledge of all or any part of the revenues of the district to be derived from the operation of its hospital or health care facilities. The bonds may be additionally secured by a mortgage or deed of trust lien on any part or all of its properties. The bonds shall be issued in the manner and in accordance with the procedures and requirements specified for the issuance of revenue bonds by county hospital authorities in Sections 8 and 10 through 13 of Chapter 122, Acts of the 58th Legislature, 1963 (Article 4494r, Vernon's Texas Civil Statutes).

Sec. 11. (a) The board of directors is hereby given complete discretion as to the type of buildings, both as to number and location, required to establish and maintain an adequate health care or hospital system. The health care or hospital system may include domiciliary care and treatment of the sick, wounded, and injured, hospitals, outpatient clinic or clinics, dispensaries, geriatric domiciliary care and treatment, convalescent home facilities, necessary nurses, domicilaries and training centers, blood banks, community mental health centers and research centers or laboratories, ambulance services, and any other facilities deemed necessary for health or hospital care by the directors. The district, through its board of directors, is further authorized to enter into an operating or management contract with regard to its facilities or a part thereof or may lease all or part of its buildings and facilities on terms and conditions considered to be to the best interest of its inhabitants. Except as provided by Subsection (c) of Section 15 of this Act, the term of a lease may not exceed 25 years from the date entered. The district shall be empowered to sell or otherwise dispose of any property, real or personal, or equipment of any nature on terms and conditions found by the board to be in the best interest of its inhabitants.

(b) The district may sell or exchange a hospital, including real property necessary or convenient for the operation of the hospital and real property that the board of directors finds may be useful in connection with future expansions of the hospital, on terms and conditions the board determines to be in the best interests of the district, by complying with the procedures prescribed by Sections 285.052, Health and Safety Code, and any subsequent amendments.

(c) The board of directors of the district shall have the power to prescribe the method and manner of making purchases and expenditures by and for the hospital district and shall also be authorized to prescribe all accounting and control procedures. All contracts for construction involving the expenditure of more than $10,000 may be made only after advertising in the manner provided by Chapter 163, Acts of the 42nd Legislature, Regular Session, 1931, as amended (Article 2368a, Vernon's Texas Civil Statutes). The provisions of Article 5160, Revised Civil Statutes of Texas, 1925, as amended, relating to performance and payment bonds shall apply to construction contracts let by the district. The district may acquire equipment for use in its health care or hospital system and

mortgage or pledge the property so acquired as security for the payment of the purchase price, but any such contract shall provide for the entire obligation of the district to be retired within five years from the date of the contract. Except as permitted in the preceding sentence and as permitted by Sections 5, 8, 9 and 10 of this Act, the district may incur no obligation payable from any revenues of the district, except those on hand or to be on hand within the then current and following fiscal year of the district.

(d) The board may declare an emergency in the matter of funds not being available to pay principal of and interest on any bonds of the district payable in whole or in part

from taxes or to meet any other needs of the district and may issue negotiable tax anticipation notes to borrow the money needed by the district. Tax anticipation notes may bear interest at any rate or rates authorized by general law and must mature within one year of their date. Tax anticipation notes may be issued for any purpose for which the district is authorized to levy taxes, and tax anticipation notes shall be secured with the proceeds of taxes to be levied by the district in the succeeding 12-month period. The board may covenant with the purchasers of the notes that the board will levy a sufficient tax in the following fiscal year to pay principal of and interest on the notes and pay the costs of collecting the taxes.

Section 12. (a) The board of directors of the district shall name one or more banks within its boundaries to serve as depository for the funds of the district. All funds of the district, except those invested as provided in Section 5 of this Act and those transmitted to a bank or banks of payment for bonds or obligations issued or assumed by the district shall be deposited as received with the depository bank and shall remain on deposit; provided that nothing in this Act shall limit the power of the board to place a portion of such funds on time deposit or purchase certificates of deposit.

(b) Before the district deposits in any bank funds of the district in an amount which exceeds the maximum amount secured by the Federal Deposit Insurance Corporation, the bank shall be required to execute a bond or other security in an amount sufficient to secure from loss the district funds which exceed the amount secured by the Federal Deposit Insurance Corporation.

Sec. 13. (a) The board of directors shall annually levy a tax not to exceed the amount hereinabove permitted for the purpose of paying:

(1) the indebtedness assumed or issued by the district, but no tax shall be levied to pay principal of or interest on revenue bonds issued under the provisions of Section 9 of this Act; and

(2) the maintenance and operating expenses of the district.

(b) In setting the tax rate the board shall take into consideration the income of the district from sources other than taxation. On determination of the amount of tax required to be levied, the board shall make the levy and certify the same to the tax assessor-collector.

Sec. 13A. (a) Notwithstanding Section 26.07(b)(3), Tax Code, a petition to require an election under Section 26.07, Tax Code, on reducing the district's tax rate to the rollback tax rate shall be submitted to the county election administrator of Montgomery County instead of to the board of directors of the district.

(b) Notwithstanding Section 26.07(c), Tax Code, not later than the 20th day after the day a petition is submitted under Subsection (a) of this section, the county elections administrator shall:

(1) determine whether the petition is valid under Section 26.07, Tax Code; and

(2) certify the determination of the petition's validity to the board of directors of the district.

(c) If the county elections administrator fails to act within the time allowed, the petition is treated as if it had been found valid.

(d) Notwithstanding Section 26.07(d), Tax Code, if the county elections administrator certifies to the board of directors that the petition is valid or fails to act within the time allowed, the board of directors shall order that an election under Section

26.07, Tax Code, to determine whether to reduce the district's tax rate to the rollback rate be held in the district in the manner prescribed by Section 26.07(d) of that code.

(e) The district shall reimburse the county elections administrator for reasonable costs incurred in performing the duties required by this section.

Sec. 14. All bonds issued and indebtedness assumed by the district shall be and are hereby declared to be legal and authorized investments of banks, savings banks, trust companies, building and loan associations, savings and loan associations, insurance companies, trustees, and sinking funds of cities, towns, villages, counties, school districts, or other political subdivisions of the State of Texas, and for all public funds of the State of Texas or its agencies including the Permanent School Fund. Such bonds and indebtedness shall be eligible to secure deposit of public funds of the State of Texas and public funds of cities, towns, villages, counties, school districts, or other political subdivisions or corporations of the State of Texas and shall be lawful and sufficient security for said deposits to the extent of their value when accompanied by all unmatured coupons appurtenant thereto.

Sec. 15. (a) The district shall have the right and power of eminent domain for the purpose of acquiring by condemnation any and all property of any kind and character in fee simple, or any lesser interest therein, within the boundaries of the district necessary or convenient to the powers, rights, and privileges conferred by this Act, in the manner provided by the general law with respect to condemnation by counties; provided that the district shall not be required to make deposits in the registry of the trial court of the sum required by Paragraph 2 of Article 3268, Revised Civil Statutes of Texas, 1925, as amended, or to make bond as therein provided. In condemnation proceedings being

prosecuted by the district, the district shall not be required to pay in advance or give bond or other security for costs in the trial court, nor to give any bond otherwise required for the issuance of a temporary restraining order or a temporary injunction, nor to give bond for costs or for supersedeas on any appeal or writ of error.

(b) If the board requires the relocation, raising, lowering, rerouting, or change in grade or alteration in the construction of any railroad, electric transmission, telegraph or telephone lines, conduits, poles, or facilities or pipelines in the exercise of the power of eminent domain, all of the relocation, raising, lowering, rerouting, or changes in grade or alteration of construction due to the exercise of the power of eminent domain shall be the sole expense of the board. The term "sole expense" means the actual cost of relocation, raising, lowering, rerouting, or change in grade or alteration of construction to provide comparable replacement without enhancement of facilities, after deducting the net salvage value derived from the old facility.

(c) Land owned by the district may not be leased for a period greater than 25 years unless the board of directors:

(1) funds that the land is not necessary for health care or hospital purposes;

(2) complies with any indenture securing the payment of bonds issued by the district; and

(3) receives on behalf of the district not less than the current market value for the lease.

(d) Land of the district, other than land that the district is authorized to sell or exchange under Subsection (b) of Section 11 of this Act, may not be sold unless the board of directors complies with Section 272.002, Local Government Code.

Sec. 16. (a) The directors shall have the authority to levy taxes for the entire year in which the district is created as the result of the election herein provided. All taxes of the district shall be assessed and collected on county tax values as provided in Subsection (b) of this section unless the directors, by majority vote, elect to have taxes assessed and collected by its own tax assessor-collector under Subsection (c) of this section. Any such election may be made prior to December 1 annually and shall govern the manner in which taxes are subsequently assessed and collected until changed by a similar resolution. Hospital tax shall be levied upon all taxable property within the district subject to hospital district taxation.

(b) Under this subsection, district taxes shall be assessed and collected on county tax values in the same manner as provided by law with relation to county taxes. The tax assessor-collector of the county in which the district is situated shall be charged and required to accomplish the assessment and collection of all taxes levied by and on behalf of the district. The assessor-collector of taxes shall charge and deduct from payments to the hospital districts an amount as fees for assessing and collecting the taxes at a rate of one percent of the taxes assessed and one percent of the taxes collected but in no event shall the amount paid exceed $5000 in any one calendar year. Such fees shall be deposited in the officers salary funds of the county and reported as fees of office of the county tax assessor- collector. Interest and penalties on taxes paid to the hospital district shall be the same as in the case of county taxes. Discounts shall be the same as allowed by the county. The residue of tax collections after deduction of discounts and fees for assessing and collecting shall be deposited in the district's depository. The bond of the county tax assessor-collector shall stand as security for the proper performance of his duties as assessor-collector of the

district, or if in the judgment of the district board of directors it is necessary, additional bond payable to the district may be required. In all matters pertaining to the assessment, collection, and enforcement of taxes for the district, the county tax assessor-collector shall be authorized to act in all respects according to the laws of the State of Texas relating to state and county taxes.

(c) Under this subsection, taxes shall be assessed and collected by a tax assessor-collector appointed by the directors, who shall also fix the term of his employment, compensation, and requirement for bond to assure the faithful performance of his duties, but in no event shall such bond be for less than $5,000, or the district may contract for the assessment and collection of taxes as provided by the Tax Code.

Sec. 17. The district may employ fiscal agents, accountants, architects, and attorneys as the board may consider proper.

Sec. 18. Whenever a patient residing within the district has been admitted to the facilities of the district, the chief administrative officer may cause inquiry to be made as to his circumstances and those of the relatives of the patient legally liable for his support. If he finds that the patient or his relatives are able to pay for his care and treatment in whole or in part, an order shall be made directing the patient or his relatives to pay to the hospital district for the care and support of the patient a specified sum per week in proportion to their financial ability. The chief administrative officer shall have the power and authority to collect these sums from the estate of the patient or his relatives legally liable for his support in the manner provided by law for collection of expenses in the last illness of a deceased person. If the chief administrative officer finds that the patient or his relatives are not able to pay either in whole or in part for his care and treatment in the

facilities of the district, same shall become a charge on the hospital district as to the amount of the inability to pay. Should there be any dispute as to the ability to pay or doubt in the mind of the chief administrative officer, the board of directors shall hear and determine same after calling witnesses and shall make such order or orders as may be proper. Appeals from a final order of the board shall lie to the district court. The substantial evidence rule shall apply.

Sec. 19. (a) The district may sponsor and create a nonstock, nonmember corporation under the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes) and its subsequent amendments and may contribute or cause to be contributed available funds to the corporations.

(b) The funds of the corporations, other than funds paid by the corporation to the district, may be used by the corporation only to provide, to pay the costs of providing, or to pay the costs related to providing indigent health care or other services that the district is required or permitted to provide under the constitution or laws of this state. The board of directors of the hospital district shall establish adequate controls to ensure that the corporation uses its funds as required by this subsection.

(c) The board of directors of the corporation shall be composed of seven residents of the district appointed by the board of directors of the district. The board of directors of the district may remove any director of the corporation at any time with or without cause.

(d) The corporation may invest funds in any investment in which the district is authorized to invest funds of the district, including investments authorized by the Public Funds Investment Act of 1987 (Article 842a-2, Vernon's Texas Civil Statutes) and its subsequent amendments.

Sec. 20. After creation of the hospital district, no county, municipality, or political subdivision wholly or partly within the boundaries of the district shall have the power to levy taxes or issue bonds or other obligations for hospital or health care purposes or for providing medical care for the residents of the district. The hospital district shall assume full responsibility for the furnishing of medical and hospital care for its needy inhabitants. When the district is created and established, the county and all towns and cities located wholly or partly therein shall convey and transfer to the district title to all land, buildings, improvements, and equipment in anywise pertaining to a hospital or hospital system located wholly within the district which may be jointly or separately owned by the county or any city or town within the district. Operating funds and reserves for operating expenses which are on hand and funds which have been budgeted for hospital purposes by the county or any city or town therein for the remainder of the fiscal year in which the district is created shall likewise be transferred to the district, as shall taxes previously levied for hospital purposes for the current year, and all sinking funds established for payment of indebtedness assumed by the district.

Sec. 21. The support and maintenance of the hospital district shall never become a charge against or obligation of the State of Texas nor shall any direct appropriation be made by the legislature for the construction, maintenance, or improvement of any of the facilities of the district.

Sec. 22. In carrying out the purposes of this act, the district will be performing an essential public function, and any bonds issued by it and their transfer and the issuance therefrom, including any profits made in the sale thereof, shall at all times be free from taxation by the state or any municipality or political subdivision thereof.

Sec. 23. The legislature hereby recognizes there is some confusion as to the proper qualification of electors in the light of recent court decisions. It is the intention of this Act to provide a procedure for the creation of the hospital district and to allow the district, when created, to issue bonds payable from taxation, but that in each instance the authority shall be predicated on the expression of the will of the majority of those who cast valid ballots at an election called for the purpose. Should the body calling an election determine that all qualified electors, including those who own taxable property which has been duly rendered for taxation, should be permitted to vote at an election by reason of the aforesaid court decisions nothing herein shall be construed as a limitation on the power to call and hold an election; provided provision is made for the voting, tabulating, and counting of the ballots of the resident qualified property taxpaying electors separately from those who are qualified electors, and in any election so called a majority vote of the resident qualified property taxpaying voters and a majority vote of the qualified electors, including those who own taxable property which has been duly rendered for taxation, shall be required to sustain the proposition.

23A. (a) The board of directors may order an election on the question of dissolving the district and disposing of the districts assets and obligations.

(b) The election shall be held on the earlier of the following dates that occurs at least 90 days after the date on which the election is ordered:

(1) the first Saturday in May; or

(2) the date of the general election for state and county officers.

(c) The ballot for the election shall be printed to permit voting for or against the proposition: "The dissolution of the Montgomery County Hospital District." The election shall be held in accordance with the applicable provisions of the Election Code.

(d) If a majority of the votes in the election favor dissolution, the board of directors shall find that the district is dissolved. If a majority of the votes in the election do not favor dissolution, the board of directors shall continue to administer the district and another election on the question of dissolution may not be held before the fourth anniversary of the most recent election to dissolve the district.

(e) If a majority of the votes in the election favor dissolution, the board of directors shall:

(1) transfer the ambulance service and related equipment, any vehicles, and any mobile clinics and related equipment that belong to the district to Montgomery County not later than the 45th day after the date on which the election is held; and

(2) transfer the land, buildings, improvements, equipment not described by Subdivision (1) of this subsection, and other assets that belong to the district to Montgomery County or administer the property, assets, and debts in accordance with Subsections (g)-(k) of this section.

(f) The county assumes all debts and obligations of the district relating to the ambulance service and related equipment, any vehicles, and any mobile clinics and related equipment at the

time of the transfer. If the district also transfers the land, buildings, improvements, equipment, and other assets to Montgomery County under Subsection (e)(2) of this section, the county assumes

all debts and obligations of the district relating to those assets at the time of the transfer and the district is dissolved. The county shall use all transferred assets to:

(1) pay the outstanding debts and obligations of the district relating to the assets at the time of the transfer; or

(2) furnish medical and hospital care for the needy residents of the county.

(g) If the board of directors finds that the district is dissolved but does not transfer the land, buildings, improvements, equipment, and other assets to Montgomery County under Subsection (e)(2) of this section, the board of directors shall continue to control and administer that property and those assets and the related debts of the district until all funds have been disposed of and all district debts have been paid or settled.

(h) After the board of directors finds that the district is dissolved, the board of directors shall:

(1) determine the debt owed by the district; and

(2) impose on the property included in the district's tax rolls a tax that is in proportion of the debt to the property value.

(i) The board of directors may institute a suit to enforce payment of taxes and to foreclose liens to secure the payment of taxes due the district.

(j) When all outstanding debts and obligations of the district are paid, the board of directors shall order the secretary to return the pro rata share of all unused tax money to each district taxpayer and all unused district money from any other source to Montgomery County. A taxpayer may request that the taxpayer's share of surplus tax money be credited to the taxpayer's county taxes. If a taxpayer requests the credit, the board of directors shall direct the secretary to transmit the funds to the county tax

assessor-collector. Montgomery County shall use unused district money received under this section to furnish medical and hospital care for the needy residents of the county.

(k) After the district has paid all its debts and has disposed of all its assets and funds as prescribed by this section, the board of directors shall file a written report with the Commissioners Court of Montgomery County setting forth a summary of the board of directors' actions in dissolving the district. Not later than the 10th day after it receives the report and determines that the requirements of this section have been fulfilled, the commissioners court shall enter an order dissolving the district.

Sec. 23B. (a) The residents of the district by petition may request the board of directors to order an election on the question of dissolving the district and disposing of the district's assets and obligations. A petition must:

(1) state that it is intended to request an election in the district on the question of dissolving the district and disposing of the district's assets and obligations;

(2) be signed by a number of residents of the district equal to at least 15 percent of the total vote received by all candidates for governor in the most recent gubernatorial general election in the district that occurs more than 30 days before the date the petition is submitted; and

(3) be submitted to the county elections administrator of Montgomery County.

(a-1) Not later than the 30th day after the date a petition requesting the dissolution of the district is submitted under Subsection (a) of this section, the county elections administrator shall:

(1) determine whether the petition is valid; and

(2) certify the determination of the petition's validity to the board of directors of the district.

(a-2) If the county elections administrator fails to act within the time allowed, the petition is treated as if it had been found valid;

(a-3) If the county elections administrator certifies to the board of directors that the petition is valid or fails to act within the time allowed, the board of directors shall order that a dissolution election be held in the district in the manner prescribed by this section.

(a-4) If a petition submitted under Subsection (a) of this section does not contain the necessary number of valid signatures, the residents of the district may not submit another petition under Subsection (a) of this section before the third anniversary o fthe date the invalid petition was submitted.

(a-5) The district shall reimburse the county elections administrator for reasonable costs incurred in performing the duties required by this section.

(b) The election shall be held on the earlier of the following dates that occurs at least 90 days after the date on which the election is ordered:

(1) the first Saturday in May; or

(2) the date of the general election for state and county officers.

(c) The ballot for the election shall be printed to permit voting for or against the proposition: "The dissolution of the Montgomery County Hospital District." The election shall be held in accordance with the applicable provisions of the Election Code.

(d) If a majority of the votes in the election favor dissolution, the board of directors shall find that the district is dissolved. If less than a majority of the votes in the election

favor dissolution, the board of directors shall continue to administer the district and

another election on the question of dissolution may not be held before the <u>third</u> anniversary

of the most recent election to dissolve the district.

(e) If a majority of the votes in the election favor dissolution, the board of directors shall transfer the land, buildings, improvements, equipment, and other assets that belong to the district to Montgomery County not later than the 45th day after the date on which the election is held. The county assumes all debts and obligations of the district at the time of the transfer and the district is dissolved. The county should use all transferred assets in a manner that benefits residents of the county residing in territory formerly constituting the district. The county shall use all transferred assets to:

(1) pay the outstanding debts and obligations of the district relating to the assets at the time of the transfer; or

(2) furnish medical and hospital care for the needy residents of the county.

Sec. 24. If a hospital district has not been created under this Act by January 1, 1982, then the Act will no longer be in effect.

Sec. 25. Proof of provisions of the notice required in the enactment hereof under the provisions of Article IX, Section 9, of the Texas Constitution, has been made in the manner and form provided by law pertaining to the enactment of local and special laws, and the notice is hereby found and declared proper and sufficient to satisfy the requirement.

Sec. 26. The importance of this legislation and the crowded condition of the

calendars in both houses create an emergency and an imperative public necessity that the constitutional rule requiring bills to be read on three several days in each house be suspended, and this rule is hereby suspended, and that this Act take effect and be in force from and after its passage, and it is so enacted.

APPENDIX III
CHAPTER 61

Chapter 61 of the Health and Safety Code is a law passed by the First Called Special Session of the 69th Legislature in 1985 that:

- Defines who is indigent,
- Assigns responsibilities for indigent health care,
- Identifies health care services eligible people can receive, and
- Establishes a state assistance fund to match expenditures for counties that exceed certain spending levels and meet state requirements.

Chapter 61, Health and Safety Code, is intended to ensure that needy Texas residents, who do not qualify for other state or federal health care assistance programs, receive health care services.

Chapter 61, Health and Safety Code, may be accessed at:

http://www.dshs.state.tx.us/cihcp/cihcp_info.shtm

APPENDIX IV
TEXAS
ADMINISTRATIVE
CODE SUBCHAPTERS

The Texas Administrative Code (TAC) is the compilation of all state agency rules in Texas.

The County Indigent Health Care Program (CIHCP) rules are in: TAC, Title 25 (Health Services), Part 1 (TDSHS), Chapter 14 (CIHCP), and the following Subchapters:

A - Program Administration
B - Determining Eligibility
C - Providing Services

The CIHCP rules may be accessed at:

http://www.dshs.state.tx.us/cihcp/cihcp_info.shtm

APPENDIX V
FEDERAL POVERTY GUIDELINES

MONTGOMERY COUNTY HOSPITAL DISTRICT
MEDICAL ASSISTANCE PLAN
INCOME GUIDELINES EFFECTIVE
04/01/2026
21- 150% FPIL

# of Individuals in the MAP Household	Income Standard 21% FPIL	Income Standard 150% FPIL
1	$279	$1,995
2	$379	$2,705
3	$478	$3,415
4	$578	$4,125
5	$677	$4,835
6	$776	$5,545
7	$876	$6,255
8	$975	$6,965
9	$1,075	$7,675
10	$1,174	$8,385
11	$1,273	$9,095
12	$1,373	$9,805

* Effective April 1, 2026

APPENDIX VI

AGREEMENT FOR ENROLLMENT OF COUNTY INMATES INTO MONTGOMERY COUNTY HOSPITAL DISTRICT'S HEALTHCARE ASSISTANCE PROGRAM

State of Texas §
§
County of Montgomery §

AGREEMENT FOR ENROLLMENT OF COUNTY INMATES INTO MONTGOMERY COUNTY HOSPITAL DISTRICT'S HEALTHCARE ASSISTANCE PROGRAM

This Agreement is made and entered into this the day of March, 2014, by and between the County of Montgomery, a governmental subdivision of the State of Texas, (hereinafter "the County") and the Montgomery County Hospital District, a governmental subdivision of the State of Texas created pursuant to Acts of the 65th Legislature, Regular Session, 1977, Chapter 258, as amended (hereinafter "the MCHD").

WITNESSETH:

WHEREAS, the County operates a county jail and provides law enforcement services; and

WHEREAS, County jail inmates and detainees have the need for occasional medical treatment beyond that which jail personnel are qualified to administer; and

WHEREAS, many County inmates and detainees at the County jail qualify under the financial and other criteria of the Montgomery County Hospital District Public Assistance Program (hereinafter "Hospital District Public Assistance Program" or sometimes "Program") as indigent persons; and

WHEREAS; the MCHD was created and enacted for the purpose of providing healthcare services to the needy or indigent residents of Montgomery County; and

WHEREAS, the MCHD is the only local governmental entity with the power to levy taxes, issue bonds or other obligations for hospital or health care purposes or for providing medical care for the residents of Montgomery County; and

WHEREAS, providing for the healthcare needs of the citizens in Montgomery County is MCHD's primary mission; and

WHEREAS, the County is authorized to provide minor medical treatment for inmates and the MCHD is authorized to provide the indigent healthcare services for certain inmates as is contemplated by this Agreement; and

WHEREAS, both the County and the MCHD have budgeted and appropriated sufficient funds which are currently available to carry out their respective obligations contemplated herein.

NOW, THEREFORE, for and in consideration of the mutual covenants, considerations and undertakings herein set forth, it is agreed as follows:

I.
ENROLLMENT INTO HOSPITAL DISTRICT PUBLIC ASSISTANCE PROGRAM

A. *The* County will assist inmates in seeking coverage under the Hospital District Public Assistance Program. County staff shall make available to County inmates such application forms and instructions necessary to seek enrollment in *the* Hospital District Public Assistance Program. Upon completion of such enrollment materials the County will promptly forward such enrollment materials to MCHD for evaluation. Alternatively, County staff may assist potentially eligible inmates with MCHD's online application process for determining eligibility into the Program.

B. Upon receipt of an inmate's enrollment materials from the County, MCHD shall promptly review such materials for purposes of qualifying the inmate for the Hospital District Public Assistance Program. In this regard, MCHD agrees to deem Montgomery County, Texas as the place of residence for any County inmate housed in the Montgomery County jail, regardless of whether the inmate has declared or maintained a residence outside the boundaries of MCHD. Upon obtaining satisfactory proof that the inmate qualifies under the Hospital District Public Assistance Program, MCHD shall enroll such inmate into such

program and place such inmate on its rolls as eligible for healthcare services under such program. MCHD agrees to abide by its criteria and policies regarding eligibility for the Hospital District Public Assistance Program and to not unreasonably withhold approval of an indigent irunate eligible under the program. If MCHD determines that the inmate is covered under another federal, state or local program which affords medical benefits to covered individuals and such benefits are accessible to the inmate, MCHD will promptly advise the County of such fact. As requested by County, MCHD enrollment and eligibility personnel shall reasonably assist County personnel with the application and enrollment materials for inmates seeking enrollment into the Program, including providing periodic training to County staff on matters pertinent to the Program, including the Program policies and rules. However, MCHD shall not be required to assign Program staff member to the jail for purposes of fulfilling its assistance responsibilities.

C. MCHD agrees to provide for the health care and medical treatment of Montgomery County jail inmates that are enrolled in the Hospital District's Public Assistance Program, subject to the terms and conditions of such Program except as noted herein. The parties agree that the effective date of coverage under the Hospital District Public Assistance Program for such services is the actual date of enrollment into the program; however, certain health care expenses incurred by an eligible inmate up to ninety (90) days prior to the inmate's enrollment into the Program may be covered under the Program as is set out in the Program rules and guidelines. MCHD and County agree to cooperate in arranging for the provision of the health care services covered by the Program to jail inmates who qualify for such services, including use of MCHD's physician network and contracted healthcare providers as well as MCHD's patient care management protocols administered by MCHD's third-party claims

and benefits manager. The Parties understand and agree that eligible inmates enrolled in the Program will not receive prescription medications or similar prescription services from the Program as the County dispenses such medications at the jail.

E. If treatment at an out of network provider is medically necessary, the County shall notify MCHD of such need as soon as reasonably possible, not later than the close of business the first day following the incident giving rise to the medical necessity. If treatment is sought at a local healthcare provider within MCHD's patient care network, and the local healthcare provider determines additional treatment is necessary by an out of network provider, then any notice requirements set forth herein shall be the responsibility of the in-network healthcare provider and/or primary care physician, as per existing Hospital District Public Assistance Program guidelines and policies. MCHD shall honor and abide by all of the provisions of its Program and its in-network provider agreements as well as the Indigent Care and Treatment Act, Chapter 61 Texas Health & Safety Code.

F. The County shall remain responsible for medical care and treatment of county inmates who do not qualify for the Hospital District Public Assistance Program. MCHD shall not be responsible for treatment or payment for healthcare services provided to County inmates who are not eligible to participate in Program, or to State or Federal inmates (including INS detainees) incarcerated in the County jail. For purposes of this Agreement, a State or Federal inmate (including INS detainees) is a person incarcerated in the county jail through a contract or other agreement with a state or federal governmental agency, but shall not include a County inmate who is in the County jail, or who has been returned to the County jail while awaiting criminal proceedings on local, state or federal

charges, or a combination thereof.

G. The County and MCHD agree that MCHD may deny an inmate's application for enrollment in the Program in the event MCHD determines the inmate's health care needs resulted from conduct or conditions for which the County or its employees would be responsible in a civil action at law, exclusive of any affirmative defenses of governmental and/or official immunity. In such event, County shall remain responsible for the inmate's health care needs. In addition, County agrees to reimburse MCHD for any medical expenses that MCHD incurred or expended on behalf of an indigent inmate or detainee housed at the County jail that resulted from conduct or conditions for which the County or its employees would be responsible in a civil action at law, exclusive of any affirmative defenses of governmental and/or official immunity. Should the County deny responsibility for any such claims, the County Judge, the County Sheriffand the Chief Executive Officer of MCHD shall meet to discuss the facts of such claims and the underlying responsibi1ity therefor. Any agreement(s) reached at such meeting shall be reduced to writing and recommended by such persons to their respective governing boards for approval as necessary. Should the parties be unable to reach agreement as to financial responsibility, the dispute will be submitted to binding arbitration. The prevailing party in such arbitration shall be entitled to recover its reasonable attorneys' fees.

H. The County shall provide prompt written notification to MCHD in the event an enrolled inmate is transferred to another detention facility, or is released from the County jail, so that MCHD may revise its records to delete such inmate from its Program rolls. As used in this paragraph and the following paragraph "prompt written notification" shall be notification as soon as is practicable but in no event after the end of the calendar month in which the inmate is released from jail or transferred to another detention facility.

I. The County and MCHD agree that County will reimburse MCHD for health care expenses incurred by an enrolled inmate after such inmate has been released from jail or transferred to another detention facility if County fails to provide prompt written notification to MCHD ofthe inmate's release or transfer from the County jail.

J. In the event any portion of this agreement conflicts with the Texas Health and Safety Code, or the Montgomery County Hospital District enabling legislation, or any other applicable statutory provision, then said statutory provisions shall prevail to the extent of such conflict.

K. Any provision of this Agreement which is prohibited or unenforceable shall be ineffective to the extent of such prohibition or unenforceability without invalidating the remaining provisions hereof.

L. No provision herein nor any obligation created hereunder should be construed to impose any obligation or confer any liability on either party for claims of any non-signatory party. Further, it is expressly agreed by the parties hereto that other than those covenants contained in section I(F), no provision herein is intended to affect any waiver of liability or immunity from liability to which either party may be entitled by laws affecting governmental entities.

II.
LIABILITY

To the extent allowed by law, it is agreed that the MCHD agrees to indemnify and hold harmless the County for any acts or omissions associated with any medical treatment that the MCHD provides to eligible inmates through its Health .Care Assistance Program in accordance with the terms and conditions of this Agreement. The foregoing indemnity

obligation is limited and does not extend to negligent, grossly negligent, reckless or intentional conduct of an enrolled inmate that result in injuries or property damages to the County or to third-parties.

III.
NOTICES

The parties designate the following persons as contact persons for all notices contemplated by this Agreement:

MCHD: Donna Daniel, Records Manager
P.O. Box478
Conroe, Texas 77305
(936) 523-5241
(936) 539-3450

COUNTY: Tommy Gage, Sheriff
#I Criminal Justice Drive
Conroe, Texas 77301
(936) 760-5871
(936) 5387721 (fax)

IV.
TERM

This Agreement shall take effect on the 11th day of March 2014 ("Effective Date") regardless of when executed by the Parties, and shall continue through the 10th day of March, 2015. Thereafter, contingent on the Parties' budgeting and appropriating funds for the continuation of their obligations hereunder, this Agreement shall automatically renew for successive terms of one-year unless terminated by either party in the manner set forth herein. Notwithstanding the foregoing, this Agreement shall be renewed automatically for not more than ten (10) successive terms.

V.
TERMINATION

This Agreement may be terminated at any time by either party upon thirty (30) days written notice delivered by hand, facsimile or U.S. Certified Mail to the other party of its intention to withdraw. In addition, this Agreement shall automatically terminate should either party fail to appropriate revenues sufficient to perform its obligations hereunder, such termination effective on the first date of the fiscal year of such non-appropriation.

VI.

APPROPRIATIONS AND CURRENT REVENUES

The Parties represent that they have each budgeted and appropriated funds necessary to carry out their respective duties and obligations hereunder for the current fiscal year. For any renewal terms of this Agreement, the Parties sha11 seek to budget and allocate appropriations in amounts sufficient to continue to carry out their respective obligations as set forth herein.

VII.

AMENDMENT

This Agreement may be amended only in writing approved by the Parties' respective governing boards.

IN WITNESS WHEREOF, Montgomery County, Texas and the Montgomery County Hospital District have hereunto caused their respective corporate names and seals to be subscribed and affixed by their respective officers, duly authorized.

PASSED AND APPROVED to become effective on the Effective Date.

MONTGOMERY COUNTY HOSPITAL DISTRICT

By: Randy Johnson, Chief Executive Officer

Date: March 25, 2014

MONTGOMERY COUNTY, TEXAS

By; Alan B. Sadler, County Judge

Date;_____

Attest:

Mark Turnbull, County Clerk

MONTGOMERY COUNTY HOSPITAL DISTRICf

_____

By: Randy Johnson, ChiefExecutive Officer

Date:_____

MONTGOMERY COUNTY, TEXAS

By: Ala B. Sadler, County Judge

Date: ---l!M AR 2 4-=20.:.....:.14..:.....

Attest:

Mark Turnbull, County Clerk

APPENDIX VII
MCHD
HCAP FORMULARY

MCHD HCAP Preferred Drug List

This is a condensed version of the IPM-MCHD Formulary. Changes may occur and plan exclusions apply. Benefit designs vary with respect to drug coverage, quantity limits, step therapy, days supply, and prior authorization.

*** For questions contact HCAP pharmacy benefit personnel @ 936-523-5108**

ANTI-INFECTIVE

ANTIFUNGALS
clotrimazole
fluconazole
clotrimazole/betamethasone
econazole
ketoconazole
nystatin
terbinafine
nystatin/triamcinolone
ciclopirox cream/shampoo

CEPHALOSPORINS
cefaclor
cefadroxil
cefdinir
cefpodoxime
cefprozil
cefuroxime
cephalexin

FLUOROQUINOLONES
ciprofloxacin
ofloxacin
levofloxacin

MACROLIDE ANTIBIOTICS
azithromycin
clarithromycin
erythromycin

PENICILLINS
amoxicillin
amoxicillin- clavulanate
ampicillin
dicloxacillin
penicillin

MISC. ANTI-INFECTIVES
clindamycin
doxycycline
metronidazole
minocycline
nitrofurantoin
tetracycline
trimethoprim
trimethoprim/ sulfamethoxazole
vancomycin

ANTIVIRALS
acyclovir
valacyclovir

CARDIOVASCULAR

ACE INHIBITORS
benazepril
captopril
enalapril
fosinopril
lisinopril
quinapril
ramipril capsules

ANGIOTENSIN II BLOCKERS
losartan
olmesartan
valsartan

ANTIADRENERGICS
clonidine
doxazosin
terazosin

ANTIDYSRHYTHMICS
amiodarone
digoxin
sotalol

ANTIHYPERLIPIDEMICS
cholestyramine
fenofibrate
gemfibrozil
lovastatin
atorvastatin
pravastatin
rosuvastatin
simvastatin
ezetimibe
niacin

ANTIHYPERTENSIVE COMBOS
amlodipine/ benazepril
atenolol/ chlorthalidone
benazepril/ HCTZ
bisoprolol /HCTZ
captopril/ HCTZ
enalapril/ HCTZ
fosinopril/ HCTZ
losartan/ HCTZ
methyldopa/ HCTZ
metoprolol/ HCTZ
trimaterene/ HCTZ
quinapril/HCTZ Tabs
valsartan/HCTZ

ANTIPLATELET AGENT
clopidogrel
cilostazol

BETA BLOCKERS
atenolol
carvedilol
labetalol
metoprolol
nadolol
propranolol
sotalol
bisoprolol

CALCIUM CHANNEL BLOCKERS
amlodipine
diltiazem
felodipine
nifedipine
verapamil

CENTRAL NERVOUS SYSTEM

ALZHEIMER AGENTS
donepezil Tabs
memantine Tabs
rivastigmine Caps

ANTICONVULSANTS
carbamazepine- ER Tabs
divalproex- ER Tabs
lamotrigine Tabs
levetiracetam Tabs
oxcarbazepine
phenytoin
topiramate
valproic Acid
zonisamide

ANTIDEPRESSANTS
amitriptyline
citalopram
escitalopram
desvenlafaxine
doxepin
duloxetine
fluoxetine
imipramine
mirtazapine
nortriptyline
paroxetine
sertraline
trazodone
venlafaxine

ANTIPARKINSON
carbidopa & levodopa tabs
ropinirole

CENTRAL NERVOUS SYSTEM (continued)

NEUROPATHIC - PAIN
gabapentin

MIGRAINE
(Quantity Limits -Tabs only)
Fioricet (generic)
Fioricet/codeine (generic) prior authorization required
Fiorinal (generic)
Fiorinal/codeine (generic) prior authorization required
sumatriptan
rizatriptan

ENDOCRINE/METABOLIC

ANTIDIABETICS
glimepiride
glipizide/ extended-release
glipizide/ metformin
glyburide
glyburide/ metformin
metformin/ extended-release
arcobose
pioglitazone

INSULINS vials only-(requires PA)
Humulin - generic
Levemir-generic
Lantus-generic
Novolin-generic
Novolog-generic

OTHER ENDOCRINE DRUGS
alendronate
risedronate Tabs

ESTROGENS
estradiol

THYROID
euthyrox
liothyronine
levothyroxine
armour thyroid

GASTRO-INTESTINAL

H-2 ANTAGONISTS
famotidine
ranitidine

PROTON PUMP INHIBITORS
esomeprazole
lansoprazole
omeprazole
pantoprazole

MISC. ULCER
dicyclomine
misoprostol
sucralfate

MUSKULOSKELETAL

NSAIDS
celecoxib caps
diclofenac
etodolac
ibuprofen
indomethacin
ketorolac
meloxicam
nabumetone
naproxen
piroxicam
sulindac

OTHER MUSCLE RELAXANTS
baclofen
cyclobenzaprine
methocarbamol
tizanidine

RESPIRATORY

ALLERGY - nasal
flunisolide
fluticasone

ANTIASTHMATICS
albuterol nebulization
albuterol/ ipratropium neb
ipratroprium nebulization

INHALERS
albuterol
Wixela-pa req
fluticasone/salmeterol

UROLOGICAL

ANTICHOLINERGICS/ ANTISPASMODICS
hyoscyamine subl
oxybutynin

BENIGN PROSTATIC HYPERTROPHY
doxazosin
finasteride
tamsulosin
terazosin