

Medicaid Coverage of Generators

The purpose of this notice is to provide clarification to Medicaid managed care organizations (MCOs) on when and how generators¹ can be covered in Texas Medicaid. Generators help MCOs and their members plan for emergencies that impact members using life-sustaining medical equipment. MCOs must follow all applicable contract requirements and state and federal regulations when considering coverage of items such as generators. A generator may be covered under a home and community-based services waiver for eligible members or provided as a case-by-case service for non-waiver members or members who are in a waiver that does not cover generators. MCOs may cover costs or partial costs above the cost limits in waiver programs through case-by-case as well.

Generators requested through the Medically Dependent Children Program (MDCP) or STAR+PLUS home and community-based services (HCBS) must be purchased from a Medicaid-enrolled provider. The exception is if the generator is requested through the consumer-directed services option under a waiver, the member can receive it from a non-Medicaid enrolled generator supplier. The financial management services agency is still required to be Medicaid-enrolled and meet other program requirements. For the Community Living Assistance and Support Services (CLASS) and Deaf Blind with Multiple Disabilities (DBMD) waiver programs, the waiver provider must be Medicaid-enrolled, but not the generator supplier they may contract with. If providing through case-by-case, the generator provider does not have to be Medicaid-enrolled.

Medicaid State Plan:

Generators are not coverable under Texas Medicaid through the Texas Health Steps Comprehensive Care Program /Early Periodic Screening, Diagnosis, and Treatment or the Home Health Durable Medical Equipment and Supplies Exceptional Circumstances provision. Therefore, a request for a generator is considered to have exhausted Medicaid coverage through each of these benefits.

Case-by-Case Services:

The MCO may offer additional benefits that are outside the scope of covered services to individual members on a case-by-case basis. Case-by-case services may be based on medical necessity, cost-effectiveness, the wishes of the member or the member's legally authorized representative (LAR), the potential for improved health status of the member, and for STAR+PLUS members based on functional necessity.

¹ The terms "generator" and "back-up generator" are used interchangeably in different handbooks and the Texas Medicaid Provider Procedures Manual (TMPPM). In this guidance, HHSC has opted to use the terminology used in each waiver or program in the corresponding sections of this guidance. HHSC considers the two terms to mean the same thing.

The MCO does not have to receive HHSC approval for case-by-case services and does not have to provide such services to all MCO members. The MCO has the discretion to offer case-by-case services, which are not included in the capitation rate. The MCO must maintain documentation of each authorized case-by-case service provided to each member. At a minimum, this documentation must include the reason for providing the service. Please see the following resources for additional program-specific information:

- Uniform Managed Care Contract, Section 8.1.2.2
- STAR Kids Contract, Section 8.1.2.4
- STAR+PLUS MRSA Contract, Section 8.1.2.2
- STAR Health Contract, Section 8.1.2.2
- Medicare-Medicaid Dual Demonstration Contract, Section 2.4.1.6
- STAR+PLUS Expansion Contract, Section 8.1.2.2.
- Uniform Managed Care Manual, Section 16.1.2.22.3
- 1 Texas Administrative Code § 353.409(f)

Home and Community-based Services Waivers

The information below outlines relevant coverage policies in the home and community-based services waivers. If a generator is not a benefit of a specific home and community-based waiver or if a member has exhausted the lifetime cap for minor home modifications or annual cap for adaptive aids in the waivers below, MCOs may consider covering the cost or partial cost of a generator as a case-by-case service.

STAR+PLUS Home and Community-Based Services (HCBS):

Back-up generators are available for individuals in the STAR+PLUS HCBS program as an adaptive aid.

Adaptive aids and medical supplies are covered by the STAR+PLUS HCBS program only after the member has exhausted state plan benefits and any third-party resources, including product warranties or Medicare benefits.

The annual cost limit of adaptive aids and medical supplies is \$10,000 per individual service plan year. The MCO may exceed the \$10,000 cost limit; however, the MCO must not include any costs over the \$10,000 on any cost reports, claims, encounters or financial statistical reports.

Adaptive aids and medical supplies are limited to the most cost-effective items that:

- meet the member's needs; and
- directly aid the member to avoid premature nursing facility (NF) placement or provide NF residents an opportunity to return to the community.

[See STAR+PLUS Handbook Section 6400 Adaptive Aids and Medical Supplies and Section 6410 – List of Adaptive Aids and Medical Supplies](#) for additional information.

1915(c) Waiver Programs

Medically Dependent Children Program (MDCP):

Back-up generators are not explicitly listed as an example of an allowable item for individuals receiving MDCP services; however, HHSC sent a clarification to all MCOs on February 18, 2021 regarding the MDCP adaptive aids list.

This clarification advised MCOs that the examples provided in the Uniform Managed Care Manual Chapter 16.2, STAR Health MDCP Policy, and STAR Kids Handbook are not an exhaustive list of the adaptive aids available to members.

Per the [STAR Kids Handbook section 4810 List of Adaptive Aids](#), adaptive aids are devices necessary to treat, rehabilitate, prevent or compensate for conditions resulting in disability or loss of function and enable members to: perform activities of daily living; or control the environment in which they live. When the above criteria are met, and all third party and other sources have been exhausted, a back-up generator may be approved.

The service limit on all adaptive aids combined is \$4,000 per annual individual service plan period. If the cost of a requested adaptive aid exceeds the service limit, the MCO may approve the request only if the member agrees to pay any costs that are in excess of the service limit. The MCO must document the member's agreement to pay these costs in the member's case file. MCOs can also choose to pay the excess costs on a case-by-case basis with MCO funds.

Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waivers:

HCS and TxHmL waivers do not allow for purchase of generators or back-up generators.

Community Living Assistance & Support Services (CLASS):

Emergency back-up gas-powered generators (limited to critical medical equipment) may be covered as a minor home modification in CLASS when need is assessed by an occupational therapist, physical therapist, or physician. A list of minor home modifications that are purchasable by a CLASS direct service agency are found in the [CLASS Provider Manual, Appendix II - Minor Home Modification Services](#). Minor

home modifications in CLASS include the installation, maintenance and repair of approved items not covered by warranty. Additional information on requirements around minor home modifications in CLASS can be found in the [CLASS Provider Manual, Appendix II](#). There is a lifetime limit of \$10,000 for minor home modifications. After reaching the lifetime limit of \$10,000, an additional \$300 is available per individual plan of care period for repair and maintenance of minor home modifications purchased through the CLASS Program after one year has passed from the date the modification was completed. MCOs can also choose to pay excess costs on a case-by-case basis with MCO funds.

Deaf Blind with Multiple Disabilities (DBMD):

Emergency gas-powered generators (limited to critical medical equipment) may be covered in DBMD when recommended by an appropriate licensed professional. A list of minor home modifications that are purchasable by a DBMD program provider with appropriate licensed professionals are found in the [DBMD Program Manual, Section 2000 Minor Home Modification Services](#). Additional information on requirements around minor home modifications in CLASS can be found in [40 TAC Chapter 42 Subchapter F Division 2, Minor Home Modifications](#). Minor home modifications in DBMD include the installation, maintenance and repair of approved items not covered by warranty. There is a lifetime limit of \$10,000 for minor home modifications. After reaching the lifetime limit of \$10,000, an additional \$300 is available per individual plan of care period for repair and maintenance of minor home modifications purchased through the DBMD Program after one year has passed from the date the modification was completed. MCOs can also choose to pay excess costs on a case-by-case basis with MCO funds.