



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

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EXECUTIVE
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Memorandum

To: Managed Care Organizations
Program Management
Operations Coordination
Program Support Unit

From: Emily Zalkovsky
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Subject: STAR+PLUS Policy and Procedures for Community First Choice Services

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This memorandum applies to the STAR+PLUS Program.

The purpose of this memorandum is to detail policy and procedures used for administering the Community First Choice (CFC) services in the STAR+PLUS managed care program.

These procedures do not apply to STAR+PLUS members enrolled in Risk Groups 122 or 123. These risk groups indicate the member is enrolled in a Department of Aging and Disability Services (DADS) 1915(c) waiver. Members in these risk groups receive their CFC services from DADS rather than through STAR+PLUS.

These procedures do not include the process when a member is being assessed for an Institution for Mental Disease level of care. This process is being finalized and will be addressed in a separate memorandum.

Program Overview

Senate Bill 7, 83rd Texas Legislature, Regular Session, 2013, directs the Health and Human Services Commission (HHSC) to implement a cost-effective option for attendant and habilitation services for members with disabilities. A federal state plan option, called Community First Choice, allows states to provide home and community-based attendant services and supports to Medicaid recipients with disabilities. This option provides states with a six percent increase in federal matching funds for these services.

Service Introduction

The CFC service array is designed to offer home and community-based services as cost-effective options for eligible members who receive services according to their specific needs, as defined by a person-centered assessment process.

Agencies contracted with managed care organizations (MCOs) provide services to members living in their own homes or family's home. The services provided are identified on a service plan and are authorized by the MCOs.

Eligibility for Community First Choice Services

To be eligible for the CFC program, a member must:

- be a child or an adult who is financially eligible for Medicaid*;
- require an institutional level of care for:
 - a nursing facility;
 - a hospital;
 - an institution for mental disease (IMD - under age 21 or 65 or older¹); or
 - an intermediate care facility for individuals with an intellectual disability or related condition (ICF-IID); and
- need CFC services.

*Members eligible for Medicaid as part of the HCBS STAR+PLUS waiver Medical Assistance Only group are not eligible to receive CFC services.

CFC Services

Services provided are tailored to meet the member's goals and needs based upon his or her physical impairments, cognitive and behavioral impairments, and functional limitations,

¹ Social Security Act, Section 1905(a)(B) prohibits federal financial participation for inpatient stays for adults between 21 and 64 in an Institution of Mental Disease.

including consideration for the member's ability to self-manage, and availability of family and other support.

The MCO must assure the member's informed choice and convenience is incorporated into the planning and provision of the member's care. Members must be encouraged and allowed to play an active role in determining their ongoing plan of care.

While providing care under the standards of professional practice, MCOs must recognize and support the member's right to a dignified existence, privacy and self-determination.

The following services are available in the CFC program:

Personal Assistance Services - This service provides assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) through hands-on assistance, supervision, and/or cueing. Such assistance is provided to a member in performing ADLs and IADLs based on a person-centered service plan. CFC personal assistance services include:

- Non-skilled assistance with the performance of ADLs and IADLs;
- Household chores necessary to maintain the home in a clean, sanitary, and safe environment;
- Escort services, which consist of accompanying, but not transporting, and assisting a member to access services or activities in the community; and
- Assistance with health-related tasks. Health-related tasks, in accordance with state law, include tasks delegated by a registered nurse, health maintenance activities, and extension of therapy. An extension of therapy is an activity that a speech therapist, physical therapist or occupational therapist instructs the member to do as follow-up to therapy sessions. If appropriate, the member's attendant can assist the member in accomplishing such activities with supervision, cueing and hands-on assistance.

In the consumer-directed services model, the member or legally-authorized representative, determines health-related tasks without a nurse assessment, in accordance with state law (§531.051(e), Texas Government Code and 22 Texas Administrative Code, §225.4.).

Habilitation - This service assists members with acquisition, maintenance, and enhancement of skills necessary for the member to accomplish ADLs, IADLs, and health-related tasks. This service is provided to allow a member to reside successfully in a community setting by assisting the member to acquire, retain, and improve self-help, socialization, and daily living skills or assisting with and training the member on ADLs and IADLs. Personal assistance may be a component of CFC habilitation for some members. CFC habilitation services include training, which is interacting face-to-face with a member to train the member in activities, such as:

- self-care;
- personal hygiene;
- household tasks;
- mobility;

- money management;
- community integration, including how to get around in the community;
- use of adaptive equipment;
- personal decision-making;
- reduction of challenging behaviors to allow members to accomplish ADLs, IADLs, and health-related tasks; and
- self-administration of medication.

Emergency Response Service - This service provides backup systems and supports to ensure continuity of services and supports. Reimbursement for backup systems and supports is limited to electronic devices to ensure continuity of services and supports and are available for members who live alone, who are alone for significant parts of the day, or have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Support Management - This service provides voluntary training on how to select, manage, and dismiss attendants.

CFC Service Locations

All CFC services are provided in a home or community-based setting, which include member homes, apartment buildings, and non-residential settings. Community-based settings do not include provider-owned or controlled residential settings, and exclude:

- nursing facilities;
- hospitals providing long-term care services;
- IMDs;
- ICF-IIDs; or
- a setting with the characteristics of an institution.

Assessment Used to Determine Institutional Levels of Care

To be eligible for CFC services, a member must meet an institutional level of care. The assessments used to make this determination are as follows:

- Nursing facility and hospital levels of care are determined using the Medical Necessity and Level of Care (MN/LOC) assessment.
- ICF-IID levels of care are determined by the Local Authority using Form 8578-CFC, Community First Choice Intellectual Disability/Related Condition Assessment
- Institution for Mental Disease (IMD) levels of care are determined using the Adults Needs and Strength Assessment (ANSA), or the Child Needs and Strength Assessment (CANS).

Assessment Process

For CFC eligibility, members must meet an institutional level of care; therefore, the member's physical or cognitive status determines how the member will be assessed in order to meet this eligibility criterion. The following policy outlines the assessment process used to determine eligibility for CFC services.

All assessments and service plans developed must follow the person-centered planning process described later in this memorandum.

Attached to this memorandum are flowcharts and a responsibility chart depicting the assessment and reassessment processes described below for ease of reference.

Screening for Intellectual or Developmental Disabilities

For STAR+PLUS members of all ages who may have an intellectual disability or developmental disability (also known as a related condition) who may meet an ICF-IID level of care, the MCO must make a referral to a Local Intellectual and Developmental Disabilities Authority (Local Authority or LA) to complete the necessary assessments used to determine whether the member meets the ICF-IID level of care.

During the initial contact with the member, the MCO must decide if the member appears to have an intellectual or developmental disability to determine if a referral to the LA is appropriate. In order to make this decision, the MCO may use the screening tool below to assist the MCO in determining if a referral to the LA should be made. If there is at least one indicator of disability under either question 1 or question 2 present, the member should be referred to the LA.

1. Is there an indicator the member has an intellectual disability?

Indicators:

- Member received special education services for an intellectual disability.
- Member was tested and determined eligible for services by a Community Center (MHMR Center) based on a diagnosis of intellectual disability.
- Member was tested and determined to have an intellectual disability (as evidenced by test records or school records).
- Member did not attend school (all or some grades) due to family belief the member would not benefit from educational services.
- Member or other indicated that prior to age 22, the member was limited in his or her functional skills in at least three of the following areas:
 - self-care
 - understanding and use of language

- o learning
- o mobility
- o self-direction
- o capacity for independent living

2. Is there an indicator the member has a developmental disability (also known as a related condition) other than an intellectual disability? *(Examples of Developmental Disabilities include Autism, Cerebral Palsy, and Spina Bifida.)*

Indicators:

- Member received special education services for a health condition, autism, or developmental disability.
- Member was tested and determined eligible for services by a Community Center (MHMR Center) based on a diagnosis of Pervasive Developmental Disorder, Autism Spectrum Disorder, or a developmental disability.
- Member was tested by a physician or licensed psychologist and determined to have a developmental disability.
- Prior to age 22, the member experienced a serious illness, accident, or surgery that resulted in a severe and chronic disability that limited his or her functional skills in at least three of the following areas:
 - o self-care
 - o understanding and use of language
 - o learning
 - o mobility
 - o self-direction
 - o capacity for independent living

To know when to apply this screening instrument, the MCO or MCO-contracted service coordinator may recognize someone has difficulty learning, self-directing activities, and doing things necessary to live independently as expected of someone in the member's age group.

For example, the member may not easily grasp new concepts, understand consequences of behavior or not be able to generalize information and skills from one situation to another. The MCO service coordinator may recognize a lack of maturity or skills expected of someone in the member's age group, such as a lack of social skills when interacting with others, inability to initiate routine medical care or manage personal finances, inability to travel within the community, comprehend rules, and follow multi-step instructions for completing basic life activities. If the MCO service coordinator recognizes these difficulties, the screening tool may be used to assist the MCO service coordinator in determining if a referral to the LA should be made.

The screening tool uses some terms defined below and is in relation to what is expected of someone in the member's age group:

Self-Care: The member often needs the help of another person or a mechanical device, or takes a long time to take care of:

- o Personal hygiene – toileting, washing and bathing, tooth brushing;
- o Grooming – dressing, undressing, hair and nail care, overall appearance;
- o Feeding – eating/drinking, using utensils, chewing and swallowing; or
- o Needs to be prompted to take care of personal hygiene, grooming or feeding.

Receptive and Expressive Language: The member needs daily assistance from another person, or a person with special skill (such as sign language), or a mechanical device to communicate (verbally or non-verbally).

Expressive:

- o Has difficulty speaking intelligibly
- o Has difficulty sharing information or communicating wants or needs

Receptive:

- o Has difficulty hearing (without a hearing aid)
- o Has difficulty understanding an ordinary conversation

Learning: The member needs special assistance to aid learning. The person may be unable or have very limited ability, even with special intervention, to acquire knowledge or to transfer knowledge or skills to new situations. The person may have difficulties with:

- o Cognition – recognition of persons, places, events or objects;
- o Retention – short and/or long-term memory;
- o Reasoning – ability to grasp concepts, to perceive “cause and effect”; relationships, ability to generalize information and skills from one situation to another; or
- o Academic skills – reading and/or writing, numerical concepts (arithmetic, money and value of objects).

Mobility: The member needs the assistance of another person or a mechanical device, takes a long time or requires a barrier-free environment in moving from place to place in his or her home or community. Note: This does not refer to the ability to operate motor vehicles or use public transportation.

- o Member needs or uses crutches, walker or wheelchair.
- o Member walks independently, but takes a long time due to gait or coordination difficulties.
- o Member requires assistance in performing activities requiring manual dexterity, fine motor control or eye-hand coordination, such as using locks, appliances or light switches.

The following major life activities (self-direction and capacity for independent living) must be considered in relation to age appropriateness and would generally not apply to members below the age of 10.

Self-direction: The member needs help in making judgments and decisions concerning personal or social life. He or she may also need someone to help protect his or her interests or rights (such as property, civil, or voting rights).

- Emotional development – The member is unable to routinely cope with fears, anxieties or frustrations; emotionally unstable; exhibits low self-esteem.
- Interpersonal/family relations – The member has difficulties in establishing and maintaining relationships with family or peers; lacks social maturity and awareness; is unable to protect self from exploitation.
- Initiative – The member is unable to make independent decisions regarding daily schedules or time management; unable to manage personal finances or initiate routine medical care.
- Personal independence – The member is unable to make major life decisions concerning work, marriage, voting, or where to live.

Capacity for Independent Living: The member is unable to live independently or to maintain normal societal roles, and may present a danger to him or herself without the assistance or supervision of another person. The member:

- cannot perform simple household tasks such as bed-making, sweeping and washing dishes;
- cannot manage multiple step activities such as meal planning and preparation, house cleaning, laundry (care and selection of clothing), home repair and maintenance, and household and personal safety;
- cannot travel around neighborhood independently without presenting significant risk of harm to self or others;
- has difficulty using the telephone, using public transportation or going shopping;
- does not comprehend rules, restrictions, laws or contracts; or
- has physical impairments that prevent him/her from living independently unless support services (such as attendant care or homemaker services), special equipment, accessible environments and/or skills training are provided.

STAR+PLUS Members with Physical Disabilities or Who Are Older

For STAR+PLUS members of all ages being assessed for CFC services who do not appear to have an intellectual disability but who have a physical disability or who are older and may meet nursing facility or hospital level of care, the MCO contacts the member to schedule a face-to-face visit at a time and location convenient to the member to develop a person-centered service plan and conduct the MN/LOC assessment. A registered nurse employed by the MCO completes a MN/LOC assessment to determine whether the member meets a nursing facility or hospital level of care. When submitting the assessment in the Texas Medicaid and Healthcare

Partnership (TMHP) Long Term Care (LTC) portal, the MCO submits it according to the age of the member as follows:

- For members 21 years of age and older, the MCO submits the MN using Service Group 19.
- For members under 21 years of age, the MCO submits the MN using Service Group 23.

The MCO completes Form 6516, Community First Choice Assessment, to determine the member's service needs in order to develop an appropriate service plan.

- If the member is denied MN, TMHP notifies the member of the denial and the member is not eligible for CFC services.
- If the member who requests CFC services receives an approved MN but the MCO does not identify a need for CFC services, the MCO denies the request for services and sends the member an adverse determination letter.
- If the member receives an approved MN and the member has a need for services, the MCO authorizes services and notifies the member.

STAR+PLUS Members Who Appear to Have Intellectual or Developmental Disabilities

For STAR+PLUS members of all ages who appear to have intellectual or developmental disabilities who may meet an ICF-IID level of care, the MCO must make a referral to the LA for assessment purposes.

The LA is responsible for completing all assessments needed to make a decision on whether the member meets an ICF-IID level of care. This includes completing the Determination of Intellectual Disability (DID) and Form 8578-CFC, Community First Choice Intellectual Disability/Related Condition Assessment, when appropriate. It is possible the member may have an existing DID when he or she is referred to the LA, in which case the LA only completes the Form 8578-CFC. Once the LA completes the appropriate assessments, they submit the assessment information to DADS using the CARE system for a level of care determination. The MCOs also have access to screens in the CARE system specific to CFC ICF-IID level of care determinations in order for them to view the status of referrals and DADS' level of care decisions.

DADS' staff is responsible for determining whether the member meets an ICF-IID level of care based on the assessment information the LA submits.

- If the member meets the criteria for an ICF-IID level of care, DADS notifies the LA and the MCO of the decision.
- If the member does not meet the criteria for an ICF-IID level of care, DADS staff sends a denial notice to the member, and copy to the LA and the MCO. The member can appeal the denial through DADS by following procedures explained on the denial notice. DADS notifies the LA and the MCO if the member appeals their decision and the outcome of the appeal.
- The member may also request a Fair Hearing through HHSC.

If the member meets the criteria for an ICF-IID level of care, the member is assessed to determine what services he or she needs. This is accomplished as follows by using a CFC assessment form according to the age of the member:

- For **members 21 years of age and older**, the following activities occur:
 - o If DADS approves the ICF-IID level of care, the LA contacts the member to schedule a time to complete the Form 6516, which is conducted face-to-face and occurs at a time and location convenient to the member. This form is used to determine the services the member needs. Once the LA completes the recommended service plan as identified on Form 6516, they transmit this information to the MCOs using a secure File Transfer Protocol (FTP) site established by DADS for the LAs and the MCOs to communicate assessment information.
 - o When the MCO receives the Form 6516 from the LA, the MCO determines if the member has a need for CFC services.
 - If there are no services on the recommended service plan, the MCO denies the request for services and sends the member an adverse determination letter.
 - If there are services on the recommended service plan, the MCO reviews the service plan to ensure agreement with the recommended services. If the MCO does not agree with the services being recommended, he or she contacts the LA to discuss the service plan and to reach an agreement about what service plan will be presented to the member.
 - Once the LA and the MCO agree with the service plan, the MCO schedules a face-to-face visit with the member and LA to jointly review the services for which the member will be authorized. The MCO then authorizes services and notifies the member.
- For **members under 21 years of age**, the MCO completes the appropriate Personal Care Assessment Form (PCAF) (according to whether the member is age 0-3 or 4-20) to determine the member's service plan.
 - o If there are no services on the service plan, the MCO denies the request for services and sends the member an adverse determination letter.
 - o If there are services on the service plan, the MCO authorizes services and notifies the member.

Reassessment Process

The person-centered service plan is reviewed and revised at least annually, when the member's circumstances or needs change significantly, and at the request of the member or legally authorized representative through contact with the member's MCO. The person-centered service plan is reviewed by the service planning team, which consists of the member, the member's Legally Authorized Representative (LAR), the MCO, the LA assessing the member, when

applicable, and any other individuals designated by the member or the member's legally authorized representative. The provider may be a participant on the service planning team.

Institutional levels of care for purposes of CFC eligibility are effective for one year. Each year, a member's level of care must be redetermined, as well as the Form 6516 or the appropriate PCAF completed as described above. When the member is due for an annual reassessment, the process used depends on whether the MCO or the LA will conduct the level of care assessment as follows.

Annual Reassessments for STAR+PLUS Members with a Physical Disability or Who Are Older

For STAR+PLUS members of all ages being reassessed for CFC services who meet the MN/LOC level of care criteria the MCO contacts the member to schedule a face-to-face visit at a time and location convenient to the member to develop a person-centered service plan and conduct the MN/LOC assessment. The MCO registered nurse completes a MN/LOC assessment to determine whether the member continues to meet a nursing facility or hospital level of care. When submitting the assessment in the Texas Medicaid and Healthcare Partnership (TMHP) LTC portal, the MCO submits it according to the age of the member as follows:

- For members 21 years of age and older, the MCO submits the MN/LOC using Service Group 19.
- For members under 21 years of age, the MCO submits the MN/LOC using Service Group 23.

The MCO completes Form 6516 to determine the member's service needs in order to develop an appropriate service plan.

- If the member is denied MN/LOC, TMHP notifies the member of the denial and the member is not eligible for CFC services.
- If the member who requests CFC services receives an approved MN/LOC but the MCO does not identify a need for CFC services, the MCO denies the request for services and sends the member an adverse determination letter.
- If the member receives an approved MN/LOC and the member continues to have a need for services, the MCO authorizes services and notifies the member.

Annual Reassessments for STAR+PLUS Members Who Meet an ICF-IID Level of Care

For STAR+PLUS members of all ages who have intellectual or developmental disabilities and who meet an ICF-IID level of care, the MCO must notify the LA at least 90 days prior to the end date of the ICF-IID level of care to complete the Form 8578-CFC to determine if the member continues to meet the ICF-IID level of care.

Once the LA completes the Form 8578-CFC, they submit the assessment information to DADS using the CARE system for a level of care determination. The MCOs also have access to screens

in the CARE system specific to CFC ICF-IID level of care determinations in order for them to view the status of reassessments and DADS' level of care decisions.

DADS' staff is responsible for determining whether the member continues to meet an ICF-IID level of care based on the assessment information the LA submits.

- If the member continues to meet the criteria for an ICF-IID level of care, DADS notifies the LA and the MCO of the decision.
- If the member does not meet the criteria for an ICF-IID level of care, DADS staff sends a denial notice to the member, and copy to the LA and the MCO. The member can appeal the denial through DADS following procedures explained on the denial notice. DADS notifies the LA and the MCO if the member appeals their decision and the outcome of the appeal. If the member appeals, the MCO must continue services as described in the appeals section of this memorandum.
- The member may also request a Fair Hearing through HHSC.

If the member continues to meet the criteria for an ICF-IID level of care, the member is reassessed to determine what services he or she needs. This is accomplished as follows by using a CFC assessment form according to the age of the member:

- For **members 21 years of age and older**, the following activities occur:
 - o If DADS approves the ICF-IID level of care, the LA contacts the member to schedule a time to complete the Form 6516, which is conducted face-to-face and occurs at a time and location convenient to the member. This form is used to redetermine the services the member needs. Once the LA completes the recommended service plan as identified on Form 6516, they transmit this information to the MCOs at least 45 days prior to the end date of the ICF-IID level of care using a secure FTP site established by DADS for the LAs and MCOs to communicate assessment information.
 - o When the MCO receives the Form 6516 from the LA, the MCO determines if the member continues to have a need for CFC services.
 - If there are no services on the recommended service plan, the MCO denies the request for services and sends the member an adverse determination letter.
 - If there are services on the recommended service plan, the MCO reviews the service plan to ensure agreement with the recommended services. If the MCO does not agree with the services being recommended, he or she contacts the LA to discuss the service plan and to reach an agreement about what service plan will be presented to the member.
 - Once the LA and MCO agree with the service plan, the MCO schedules a visit with the member and LA to jointly review the services for which the member will be authorized. The MCO then authorizes services and notifies the member.

- For **members under 21 years of age**, the MCO meets with the member and completes the appropriate Personal Care Assessment Form (PCAF) (according to whether the member is age 0-3 or 4-20) to redetermine the member's service plan.
 - If there are no services on the service plan, the MCO denies the request for services and sends the member an adverse determination letter.
 - If there are services on the service plan, the MCO authorizes services and notifies the member of his or her continued eligibility.

Service Delivery Options

The service delivery options described in Section 8000, Service Delivery Options, of the STAR+PLUS handbook are also available for CFC Personal Assistance Service and habilitation services. MCO or MCO-contracted service coordinators must present these options to the member and determine the member's preference following policy in Section 8000. Service delivery options include the following:

- Agency Option
- Consumer Directed Services Option
- Service Responsibility Option

Person-Centered Service Plan

The person-centered service plan is created simultaneously and in conjunction with the functional needs assessment by qualified LA staff and the MCO. Texas partners with the Institute for Person-Centered Practices for development of a person-centered thinking and person-centered plan facilitation training, which is tailored to teach individuals developing CFC service plans to meet the person-centered planning requirements contained in the CFC and the HCBS settings federal requirements.

Every LA staff person and the MCO service coordinator who develops a CFC service plan is required to complete the Institute for Person-Centered Practices training or an HHSC-approved training developed and delivered as stipulated in the managed care contracts.

The LA staff person or the MCO service coordinator works with the member to identify the member's goals, needs, and preferences. The member or legally authorized representative may choose who is included in the person-centered plan development process. The member and people who know and care about the member are considered the content experts that provide the information to the LA staff person or the MCO service coordinator.

Throughout development of the person-centered service plan, the LA staff person or the MCO service coordinator ensures consideration of information from the member or legally authorized representative to determine any risks that might exist to health and welfare of the member as a result of living in the community. The discovery process utilized by the LA staff person or the

MCO service coordinator conducting the assessment is designed to address all areas of a member's life: social inclusion/relationships, health and safety, work/school, self-determination, financial security, living environment, physical/emotional/behavioral, rights/legal status, and daily living skills. Following the discovery process, the LA staff person or the MCO service coordinator identifies and documents those services critical to the health and welfare of the member for which a backup plan must be developed.

Appeal Process

Access to Fair Hearings

The MCO must follow procedures in the STAR+PLUS handbook, Section 4100, Managed Care Organization Procedures, and requirements detailed in the UMCC related to fair hearing, complaint and appeal processes.

Members receiving CFC are entitled to appeal the following actions:

- an action to reduce, suspend, terminate, or deny benefits or eligibility;
- a failure to act with reasonable promptness on a member's claim for benefits or services;
- the denial of a prior authorization request; and
- the failure to reach a service authorization decision within the time period specified by federal law.

In accordance with 42 C.F.R. §438.410, the MCO must establish and maintain an expedited review process for appeals.

In accordance with 42 C.F.R. § 438.406, the MCO's policies and procedures must require that individuals who make decisions on appeals are not involved in any previous level of review or decision-making, and are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease.

In accordance with 42 C.F.R. §438.420, the MCO must continue the member's benefits currently being received by the member, including the benefit that is the subject of the appeal, if all criteria are met. During the appeal process, the MCO must provide the member a reasonable opportunity to present evidence and any allegations of fact or law in person as well as in writing. The MCO must provide the member and his or her representative opportunity, before and during the appeal process, to examine the member's case file, including medical records and any other documents considered during the appeal process.

In accordance with 42 C.F.R. § 438.408, the MCO must provide written notice of resolution of appeals, including expedited appeals, as expeditiously as the member's health condition requires, but the notice must not exceed the timeframes for standard appeals or expedited appeals. The written resolution notice must include the results and date of the appeal resolution.

Appeals for Member with Physical Disabilities or Who Are Older

For STAR+PLUS members with physical disabilities or who are older, the MCO completes a MN/LOC assessment to determine whether the member meets a nursing facility or hospital level of care and submits it to TMHP.

- If the member is denied MN, TMHP notifies the member of the denial and the member is not eligible for CFC services.
 - The member may initiate the appeal process when notified that MN has been denied by the TMHP physician.
- If the member who requests CFC services receives an approved MN but the MCO does not identify a need for CFC services, the MCO denies the request for services and sends the member an adverse determination letter.

Appeals for Members with Intellectual or Developmental Disabilities

For STAR+PLUS members with an intellectual or developmental disability, the local authority completes the level of care assessment instrument and submits the information to DADS. DADS determines whether the member meets the criteria for an institutional level of care for ICF-IID.

- If a member does not demonstrate a need for services but has an approved level of care, the MCO sends an adverse determination letter to the member, who has the opportunity to appeal through the MCO's established procedures. The LA must also participate in the fair hearing because they are the entity that recommended the service plan.
- If DADS denies the level of care, DADS sends a denial notice to the member, who can then appeal the decision through the DADS appeal process. Members may also request a Fair Hearing through HHSC.

CFC Provider Information

Provider Base

CFC services are delivered by providers determined to be qualified by Texas for a program already approved by the Centers for Medicare & Medicaid Services. Providers delivering CFC services include licensed home and community support services agencies (HCSSAs), certified Home and Community-based Service and Texas Home Living providers, licensed personal emergency response services agencies, qualified financial management services agencies, and providers hired by individuals using the CDS option who meet qualifications.

General Provider Requirements for Participation

CFC providers must:

- provide the array of services through its own employees, subcontractors or personal service agreements with qualified members;
- provide trained and competent staff for member care;
- maintain documentation of the assessment and provision of services; and
- provide for the delegation and supervision of nursing tasks and personal care tasks.

Agencies may subcontract with an individual or a group in order to provide the necessary services, as long as the group designates at least one signature authority for the contract. A document showing signature authority for the person signing is required.

If a provider is not delivering services as authorized or meeting their contract requirements, the member or member's LAR may choose a change to another contracted provider.

Qualifications for PAS Supervisors

Supervision of PAS attendants is provided by the contracted agencies' registered nurses (RNs) or an individual who has completed two years of full-time study at an accredited college or university. An individual with a high school diploma or general equivalence diploma may substitute one year of full-time employment in a supervisory capacity in a health care facility, agency or community-based agency for each required year of college.

RNs must:

- have proof of a current license from the Board of Nurse Examiners for the state of Texas; and
- practice in compliance with the Nurse Practice Act according to the rules and regulations of the Board of Nurse Examiners.

Proof of licensure can be validated by viewing the nurse's original current license and recording in a log the nurse's name, license number, date of expiration and initials of the individual who verified the license is current. If necessary, licenses can be verified with the Board of Nurse Examiners at <https://www.bon.texas.gov/forms/rninq.asp>.

Specific Qualification Requirements for Community First Choice Providers

Specific qualification requirements for all CFC providers will be outlined in the managed care contract by June 1, 2015.

Complaints Related to Licensed and Certified CFC Providers Contracted with a MCO

DADS handles complaints related to licensed HCSSAs according to the Texas Administrative Code, Chapter 97, Licensing Standards for Home and Community Support Services Agencies.

For certified providers contracting with MCOs to deliver CFC services, DADS handles complaints the MCO submits in relation to services delivered by these providers according to the following:

- If a complaint is regarding abuse, neglect or exploitation (ANE), the MCO follows established procedures for reporting the complaint to the Department of Family and Protective Services by calling 1-800-252-5400 or submitting the complaint online in non-emergency situations at www.txabusehotline.org.
- If the complaint is not ANE related, the MCO securely emails a referral form to DADS Consumer Rights and Services (CRS) at CRScomplaints@dads.state.tx.us to submit a complaint about a certified HCS or TxHmL provider contracted with an MCO to deliver CFC services. If the referral form cannot be faxed, the MCO calls CRS at 1-800-458-9858 to submit the complaint.
- CRS staff logs the complaint.
- DADS investigates the complaint.
- DADS sends a summary outlining the results of the complaint investigation to the MCO.
- DADS investigations, based on complaints received by an MCO, will focus on the member who is the subject of the complaint. It is unlikely DADS will identify a systemic issue given the narrow focus of the inquiry. If the investigation of a complaint results in a systemic issue, DADS can do any of the following activities:
 - Request an on-site review of the HCS or TxHmL waiver contract. During this on-site review, DADS may review a focused sample of individuals receiving waiver services.
 - If any items of non-compliance are identified, the team may open up an intermittent review and expand the sample of individuals. An intermittent review is more extensive and results in a written report similar to the reports generated from an annual certification review.
 - Based on the outcome of the review, DADS may take action on the provider's contract, up to and including contract termination.
 - If the intermittent review results in contract termination, the MCO is notified of the termination of certification for the contract once due process afforded the waiver contractor is complete.
- DADS Waiver, Survey and Certification staff will not take contract action against an MCO-contracted provider.
- The MCO is responsible for any contract action taken against an MCO-contracted provider based on the results of an investigation.

If you have any questions regarding this memorandum, you may contact **Chris Welch**, at 512-428-1946 or at Chris.Welch@hhsc.state.tx.us.