



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHARLES SMITH
EXECUTIVE COMMISSIONER

Memorandum

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

From: Michelle Erwin
Director, Policy and Program Management
Medicaid/CHIP Division

Subject: Policy and Procedures for Reassessment of Community First Choice Services

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This memorandum applies to managed care organization (MCOs) providing Medicaid state plan services including STAR+PLUS, STAR Health, and Medicare-Medicaid Plans (MMPs).

These procedures do not apply to 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 through their waiver providers rather than through managed care.

Level of Care Reassessment Process

Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition (ICF/IID)

Monthly, Local Intellectual and Developmental Disability Authority (LIDDA) staff will provide the MCO a list of members who are due for a level of care assessment for an intermediate care facility (ICF) level of care no later than 90 prior to the expiration of a member's level of care assessment. The LIDDA notifies the MCO by adding the identified members' names and

pertinent information to the "Renewals" tab of the spreadsheet shared by the MCO and LIDDA on the Secure File Transfer Protocol (SFTP) site. The MCO will respond within 10 calendar days confirming the member requires a new intellectual disability or related condition assessment (ID/RC) for continued CFC eligibility. If the member does not require a new ID/RC because they declined services or moved into another program with a different level of care assessment, the MCO updates the renewal tab of the spreadsheet indicating "no".

The LIDDA schedules reassessments only for those members receiving CFC services who require an ID/RC assessment for continued CFC eligibility. Every year, a new tab will be created for tracking CFC level of care renewals for MCO members for June 1 through May 31. The LIDDA completes Form 8578-CFC to determine if the member continues to meet the ICF-IID level of care. Once the LIDDA completes the Form 8578-CFC, they submit the assessment information to DADS using the CARE system for a level of care determination. If the member is 21 years of age and older, the LIDDA must complete the ID/RC and CFC assessment 45 days prior to the expiration of the level of care.

DADS' staff is responsible for determining whether the member continues to meet an ICF-IID LOC based on the assessment information the LIDDA submits.

- If the member continues to meet the criteria for an ICF-IID LOC, DADS updates CARE.
- If the member does not meet the criteria for an ICF-IID LOC, DADS notifies the LIDDA and the MCO.
 - The MCO notifies the member regarding the denial and the member's right to appeal, outlined in HHSC 16-02-001, Community First Choice Fair Hearing Processes. MCO must notify the LIDDA and DADS if the member appeals.
- The member may also request a Fair Hearing through HHSC.

If the member continues to meet the criteria for an ICF-IID LOC, 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 STAR+PLUS and Dual Demonstration **members 21 years of age and older**, the following activities occur:
 - If DADS approves the ICF-IID LOC, The LIDDA schedules the member for a renewal CFC Assessment. The LIDDA completes Form H6516 with the member, which is conducted face-to-face and occurs at a time and location convenient to the member.
 - The LIDDA also completes Form 1581, Consumer Directed Services Option Overview and Form H2060-B, Needs Assessment Addendum.
 - Once the LIDDA completes the recommended service plan as identified on Form H6516, they transmit this information to the MCOs at least 30 days prior to the end date of the ICF-IID LOC using a SFTP site. The LIDDA must also complete and send Form 1040, Contact Information Sheet and CFC Packet Checklist. The LIDDA

- schedules the joint meeting approximately 3 weeks in advance and notifies the MCO of the date of the meeting on Form 1040.
- o If the member has a new determination of intellectual disability (DID) or adaptive behavior level (ABL), the updated information is provided to the MCO, as well. When the MCO receives the Form H6516 from the LIDDA, 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. The MCO updates the SFTP site indicating the member is not receiving CFC services.
 - 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 LIDDA to discuss the service plan and to reach an agreement about what service plan will be presented to the member.
 - If the member would like to change providers, the LIDDA requests a list of providers for the services on the H6516. The MCO must provide the list within 3 business days of the request. The MCO must update the SFTP site to note the selected provider.
 - For **members under 21 years of age** or enrolled in STAR Health, the MCO meets with the member and completes the appropriate Personal Care Assessment Form (PCAF) and CFC addendum (according to whether the member is age 0-3 or 4-20) to redetermine 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. The MCO updates the SFTP site to indicate the member does not receive CFC services.
 - o If there are services on the service plan, the MCO authorizes services and notifies the member of his or her continued eligibility. The MCO updates the SFTP site with the name of the provider selected by the member (or their legally authorized representative) and the start of care date.

Institution for Mental Disease (IMD)

Members who meet an IMD LOC must be reassessed by a comprehensive provider of mental health rehabilitative services or a Local Mental Health Authority (LMHA) annually for continued eligibility for CFC services. For the purposes of CFC, an IMD LOC is approved for 12 months following a licensed practitioner approving an IMD LOC. 45 days prior to the expiration the member's LOC, the MCO must assist the member in obtaining an appointment with the provider for a reassessment using the Child and Adolescent Needs and Strengths (CANS) or Adult Needs and Strengths assessment (ANSA). Following the assessment, the provider notifies the MCO of the member's LOC. If the member continues to meet IMD LOC, the MCO meets

with the member to conduct a reassessment of CFC needs using Form H6516, Community First Choice Assessment, and authorizes the services identified by the assessment for another 12 months.

Hospital or Nursing Facility Level of Care

Members who meet a nursing facility LOC must be reassessed by a registered nurse for continued eligibility for CFC services. 90 days prior to the expiration of the member's LOC, the MCO must reassess the member using the Medical Necessity and Level of Care assessment and submit the assessment to Texas Medicaid & Healthcare Partnership (TMHP) for a determination of continued eligibility for CFC. The MCO must reassess the member no later than 45 days before the end of the member's current assessment using Form H6516, Community First Choice Assessment and authorize services identified by the assessment for another 12 months.

If you have any questions regarding this memorandum, you may contact Amanda Dillon, at 512-462-6396 or at Amanda.dillon@hhsc.state.tx.us.