



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHRIS TRAYLOR
EXECUTIVE
COMMISSIONER

Memorandum

To: Managed Care Program Oversight
Enrollment Resolution Services
Program Support and Utilization Review
Managed Care Organizations

From: Emily Zalkovsky
Director, Program Management
Medicaid/CHIP Division

Subject: Community First Choice Fair Hearing Processes

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HHSC: 16-02-001

This memorandum applies to Community First Choice (CFC) services in Medicaid managed care programs.

This memorandum provides policy for CFC adverse action notices when a member is denied an institutional level of care (LOC) required for Community First Choice (CFC) eligibility. This memorandum provides policy for the following institutional LOCs and their associated assessment instrument:

- Nursing facility or hospital - Community Medical Necessity/Level of Care (MN/LOC) assessment or Minimum Data Set (MDS) assessment if transitioning from a nursing facility
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) - Intellectual Disability/Related Condition (ID/RC) assessment
- Institution for Mental Disease (IMD) - Child and Adolescent Needs and Strengths (CANS) or Adult Needs and Strengths (ANSA) Assessment

TIERS Data Entry Requirements

When MCO staff enters fair hearing requests in the Texas Integrated Eligibility Redesign System (TIERS), as outlined in below policy, they use the following entries according to the type of LOC being appealed:

- For MN/LOC fair hearing requests:
 - Program: Community Care
 - Type of Assistance (TOA):
 - Issue Code: 57 - Medical Necessity

- For ICF/IID LOC or IMD LOC fair hearing requests:
 - Program: Community Care
 - TOA: CBA
 - Issue Code: 99 - Other

MN/LOC Assessment Denials for Initial or Reassessment Eligibility

As part of the CFC eligibility process, the MCO is responsible for completing and submitting the MN/LOC assessment to the Texas Medicaid and Healthcare Partnership (TMHP) for a medical necessity (MN) determination. Based on TMHP's decision, the following occurs:

- If TMHP approves MN on the initial or reassessment MN/LOC:
 - TMHP notifies the MCO that the member meets medical necessity criteria; and
 - The MCO authorizes 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 notifies the member, following appeal procedures outline in the Uniform Managed Care Manual (UMCM).

- If TMHP denies MN on an initial or reassessment MN/LOC assessment, TMHP notifies the MCO the member does not meet MN. The MCO must follow appeal procedures outlined in the UMCM and take the following action based on the member's situation:
 - For MN denials when the member ***is not requesting or receiving*** HCBS STAR+PLUS Waiver services, the MCO sends the member a denial notice with fair hearing rights. Pages 7-9 of this memorandum contain an example of the required elements the MCO must include in the notice. This information will be incorporated in requirements outlined in the Uniform Managed Care Manual. If the member requests a fair hearing, the MCO must enter the fair hearing in the Texas Integrated Eligibility Redesign System (TIERS) and attend the fair hearing. TMHP staff is also required to attend the fair hearing because TMHP is the entity making the LOC decision.

- For MN denials when the member **is requesting or receiving** CFC and HCBS STAR+PLUS Waiver services, the MCO must post Form H2067-MC, STAR+PLUS Communication, to TexMedCentral within two business days of receiving the notice from TMHP to notify PSU of the denial and that the member requested or is receiving CFC services. The PSU sends the member a denial notice (Form H2065-D, Notification of STAR+PLUS Program Services) for both the HCBS STAR+PLUS Waiver and CFC services with fair hearing rights. The notice instructs the member to contact the PSU to request a fair hearing. If a member makes this request, the PSU:
 - notifies the MCO within five business days of the member's request for a fair hearing by posting Form H2067-MC to TexMedCentral;
 - enters the fair hearing in TIERS within five calendar days; and
 - identifies the MCO as the agency representative.

The MCO attends the fair hearing. TMHP staff is also required to attend the fair hearing to defend their action because TMHP is the entity making the LOC decision. If the member requests a timely fair hearing at reassessment and requests continued benefits, the MCO continues services pending the outcome of the fair hearing.

ID/RC Assessment Denials

As part of the eligibility determination process, the Local Intellectual or Developmental Disability Authority (LIDDA) is responsible for completing Form 8578-CFC, Intellectual Disability/Related Condition Assessment for CFC, and submitting it to the Department of Aging and Disability Services (DADS) for an ICF/IID LOC decision. If DADS denies a member's ICF/IID LOC, the member is not eligible for CFC services. The action the MCO or DADS takes depends on whether it is an assessment for initial eligibility or for an annual reassessment as described below.

ICF/IID LOC Denials for Initial Eligibility

The following policy outlines the steps when DADS denies an initial ICF/IID LOC assessment for CFC eligibility.

- DADS sends the CFC ICF/IID LOC denial notification (see example on page 6) to the member's MCO CFC mailbox via secure email and to the LIDDA via fax.
- When the MCO receives the ICF/IID CFC LOC denial notification, the MCO sends a denial letter to the member explaining the member did not meet the ICF/IID LOC required for CFC eligibility (see template on pages 7-9). The denial letter must include the member's appeal rights and a Fair Hearing Request Form. The MCO must include the CFC ICF/IID LOC denial notification when sending the denial letter to the member. The Fair Hearing Request Form must display the following DADS address and fax number:

Department of Aging and Disability Services
CFC Non-Waiver Eligibility Unit
P.O. Box 149030, Mail Code W-254
Austin, TX 78714-9030
Fax number: (512) 438-5693

- If the member requests a fair hearing, DADS contacts the member and manages the fair hearing process in TIERS, which includes preparing and submitting the evidence packet to the appellant and the Appeals Division. DADS includes the MCO representative as an "Other Participant" when entering the fair hearing information in TIERS so the MCO is aware of the fair hearing. The MCO representative may attend the fair hearing, but is not required to attend for denial of initial level of care assessments.
- DADS notifies the MCO and LIDDA of the fair hearing results, within five business days from the date DADS receives the decision notice, by sending a notice to the MCO CFC mailbox via secure email and to the LIDDA via fax.
 - If the decision is upheld, the MCO continues services or assesses for other available state plan services.
 - If the decision is overturned:
 - DADS updates the CARE system to reflect an approved ICF/IID LOC; and
 - the LIDDA develops the service plan and submits it to the MCO within 10 calendar days from the date the LIDDA receives the notice of the outcome of the fair hearing for members 21 years of age and older; or
 - the MCO completes the service plan and authorizes services for members under 21 years of age.
 - For STAR Health, the MCO develops the service plan for all members.

ICF/IID LOC Denials for Reassessment Eligibility

The following policy outlines the steps when DADS denies an ICF/IID LOC assessment for continued CFC eligibility.

- DADS sends the CFC ICF/IID LOC denial notification to the member's MCO CFC mailbox via secure email and to the LIDDA via fax.
- When the MCO receives the CFC ICF/IID LOC denial notification, the MCO sends a denial letter to the member. The denial letter must include the member's appeal rights and a Fair Hearing Request Form. The MCO must also include the CFC ICF/IID LOC denial notification when sending the denial letter to the member. The Fair Hearing Request Form must include the MCO's return address and fax number.
- If the member requests a fair hearing, the MCO manages the fair hearing process in TIERS, which includes requesting and submitting the evidence packet

to the appellant and the Appeals Division. The MCO must include DADS as an "Other Participant" at the fair hearing, which is the DADS staff person who sent the email with the CFC ICF/IID LOC denial notification. The MCO contacts DADS by email at CfcFairHearing@dads.state.tx.us to request the evidence packet. DADS staff and the MCO must attend the fair hearing.

- If DADS does not contact the MCO within one business day of the request for the evidence packet, the MCO contacts DADS by:
 - Email at CfCLocElig@dads.state.tx.us; or
 - Telephone at (512) 438-2484.
- DADS sends the evidence packet with the CFC Fair Hearing Cover Letter (see example on pages 10-11) and supporting documents in one PDF file to the MCO via secure email within five business days of the request for the evidence packet.
- The Appeals Division notifies the MCO of fair hearing result. The MCO notifies DADS by sending an email to CfcFairHearing@dads.state.tx.us and the LIDDA via fax of the decision within five business days from the date the MCO receives the decision notice.
 - If the decision is upheld, the MCO must notify the provider to end the continued services the latter of:
 - the end of the plan year; or
 - within five business days from the date they receive the decision notice.
 - If the decision is overturned:
 - DADS updates the CARE system within five business days of the MCO notification to reflect an approved ICF/IID LOC; and
 - the LIDDA completes the service plan and submits it to the MCO within 10 calendar days from the date the LIDDA receives the notice of the outcome of the fair hearing for members 21 years of age and older; or
 - the MCO completes the service plan and authorizes services for members under 21 years of age.
 - For STAR Health, the MCO completes the service plan and authorizations for all members.

CANS or ANSA Assessment Denials

For initial or reassessment denials of IMD LOC, the MCO must follow appeal procedures outlined in the Uniform Managed Care Manual and send members a denial letter with fair hearing rights, which includes instructions that members contact the MCO if they want to request a fair hearing and/or continued benefits. If members make this request, the MCO enters the fair hearing in TIERS and attends the fair hearing. The Local Mental Health Authority (LMHA) staff who completed the assessment must also attend the fair hearing, because the LMHA is the entity making the LOC decision.

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If you have any questions regarding this memorandum, you may contact Amanda Dillon at 512-426-6396 or at Amanda.dillon@hhsc.state.tx.us.

ICF/IID LOC DENIAL NOTIFICATION EXAMPLE



CFC Non-Waiver Eligibility Specialist:

[NAME OF REVIEWER], [TITLE]

Office Address:

Department of Aging and Disability Services (DADS)
PO Box 149030 Mail Code W-254
Austin TX 78714-9030

Community First Choice (CFC) Non-Waiver Eligibility

Message Line: 1-512-438-2484

[MCO Name] [Plan Code]
[MCO Email Address]

**LEVEL OF CARE DENIAL NOTIFICATION
[INITIAL or REASSESSMENT]**

Re: [Individual's Full Name] **Medicaid Number:** [_____] **CARE ID:** [_____]

We have reviewed information submitted for a Level of Care (LOC) determination for CFC Non-Waiver Eligibility and found that the aforementioned individual DOES NOT meet the Intermediate Care Facilities for Individuals with Intellectual Disability or Related Conditions (ICF/IID) LOC criteria as defined by Texas Administrative Code (TAC), Title 40, §9.238 and §9.239.

The effective date of this decision is:

MM/DD/YYYY

The decision to deny the aforementioned individual's LOC for CFC Non-Waiver is based on the following criteria:

LOC I

The full scale intelligence quotient (IQ) score is **NOT** 69 or below as required by 40 TAC §9.238(a)(1)(A). The individual's full scale IQ score is [____].

The full scale intelligence quotient (IQ) score is **NOT** 75 or below, for persons' with a primary diagnosis of a related condition, as required by 40 TAC §9.238(a)(1)(B). The individual's full scale IQ score is [____].

The adaptive behavior level (ABL) is **NOT** a "I (1)", "II (2)", "III (3)", or "IV (4)," as required in 40 TAC §9.238(a)(2). The individual's ABL is 0.

LOC VIII

The primary diagnosis is **NOT** a related condition as required in 40 TAC §9.239(1). The individual's primary diagnosis is [____].

The primary diagnosis did **NOT** manifest before the individual's age of 22, as required by 40 TAC §9.239(1) and 40 TAC §9.203(72)(B). The individual's primary diagnosis manifested at age [____].

Substantial functional limitations are **NOT** demonstrated in at least 3 of 4 (for ages under 10 years), **OR** at least 3 of 6 (for ages 10 years and older) major life activity areas as required for a related condition by 40 TAC §9.239(1) and 40 TAC §9.203(72)(D). The individual demonstrated substantial functional limitations in [____] major life activity areas.

The adaptive behavior level (ABL) is **NOT** a "II (2)", "III (3)", or "IV (4)," as required in 40 TAC §9.239(2). The individual's ABL is [____].

LOC I and LOC VIII (No diagnosis of an intellectual disability or a related condition.)

The primary diagnosis is **NOT** found on the Texas Department of Aging and Disability Services' "List of Approved Diagnoses for Persons with Related Conditions," as required by 40 TAC §9.238(a)(1)(B) and §9.239(1). The individual's primary diagnosis is [____].

CFC Non-Waiver Eligibility Specialist (DADS Representative): [REVIEWER'S NAME] /QIDP Date: MM/DD/YYYY

Fax: [LIDDA NAME] [XXX-XXX-XXXX]

Denial of Community First Choice Template

[Date of Mailing]

[Mr./Mrs./Ms. Full Name of Individual or Legally Authorized Representative (LAR)]

[Mailing Address]

[City, State Zip]

Subject: **DENIAL OF COMMUNITY FIRST CHOICE (CFC) ELIGIBILITY**

[Individual's Name] Medicaid Number: [_____] CARE ID: [_____]

Dear Mr./Mrs./ Ms. Full Name of Individual or LAR (if applicable):

[The Department of Aging and Disability Services/Texas Medicaid and Healthcare Partnership/Local Mental Health Authority] reviewed *[you/If sent to LAR, individual's full name]* *[Level of Care (LOC) assessment]* and has said that *[you/If sent to LAR, individual's full name]* **[do/does]** not meet LOC requirements found at 354 TAC, Rule §354.1362. The reason *[you/If sent to LAR, individual's full name]* **[do/does]** not meet LOC requirements is **[(explained in the letter attached) or (because [you/If sent to LAR, individual's full name] do not need the regular services of a licensed nurse) or (insert Institutions for Mental Disease LOC denial reason)].**

This means *[you/If sent to LAR, individual's full name]* **[are/is]** not eligible for CFC services.

If *[you/If sent to LAR, individual's full name]* **[are/is]** applying to get CFC services, **[your/his or her]** request is denied as of the date of this letter.

If *[you/If sent to LAR, individual's full name]* **[are/is]** receiving CFC services, **[your/his or her]** CFC services will end *[MM, DD, YYYY (insert date at least 10 days after mail date of letter)].*

If *[you/If sent to LAR, individual's full name]* **[don't agree/doesn't agree]** with the decision that *[you/If sent to LAR, individual's full name]* **[do not/does not]** qualify for CFC services, *[you/If sent to LAR, individual's full name]* may ask for a fair hearing to appeal this decision in accordance with 1 TAC §357.3(b).

If *[you/If sent to LAR, individual's full name]* **[ask/asks]** for a fair hearing, *[you/If sent to LAR, individual's full name]* may represent **[yourself/himself or herself]** or choose a relative, friend, attorney or someone else to speak for *[you/If sent to LAR, individual's full name]* **[your/his or her]** own cost. Free legal help is available in many communities. Call 2-1-1 to find out where you can get legal help.

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If [you/If sent to LAR, individual's full name] [are/is] applying to receive CFC services and want to appeal, [you/If sent to LAR, individual's full name] may ask for a fair hearing in writing or by telephone. [MCO name/DADS] must get your request **within 90 calendar days after the date of this letter**. That means [you/If sent to LAR, individual's full name] may lose the right to question this decision if the request is not received on or before [Month, DD, YYYY (insert date 90 days from date of letter)]. If [you/If sent to LAR, individual's full name] [are/is] getting services and ask for a fair hearing by [MM, DD, YYYY (insert date at least 10 days after mail date of letter)], [you/If sent to LAR, individual's full name] can ask to continue getting [your/his or her] service(s) until the fair hearing decision has been issued by calling me at [MCO contact number].

[You/If sent to LAR, individual's full name] may ask for a fair hearing by filling out the enclosed Fair Hearing Request Form and mailing or faxing it to the address or fax number listed at the bottom of the Fair Hearing Request Form. [You/If sent to LAR, individual's full name] may also ask for a fair hearing in person or by telephone by calling me.

If [you/If sent to LAR, individual's full name] [have/has] questions or [want/wants] more information, please call me at [MCO contact number].

Sincerely,

MCO signature information

Enclosure

cc: [LIDDA Contact Name] c/o [LIDDA Name]

Fair Hearing Request Form Template

[Mr./Mrs./Ms. Full Name of Individual]

[Mailing Address]

[City, State Zip]

Re: [Individual's Full Name]

Medicaid Number: [_____] CARE ID: [_____]

FAIR HEARING REQUEST FORM

I, [Individual's Full Name or LAR's Full Name], wish to file this form as [my/If filed by LAR, Individual's full name] appeal and request for a fair hearing.

Contact Information: Please complete the following in order to process the appeal in a timely manner and so this information can be provided to the fair hearing officer.

CFC Applicant/Participant:	
Print Name:	Phone # (required):
Address(City, State, ZIP):	
Signature:	Date:
Legally Authorized Representative as per 1 TAC §354.1361: A person authorized by law to act on behalf of an individual with regard to a matter described in the rules regarding CFC.	
Print Name:	Phone # (required):
Address(City, State, ZIP):	
Signature:	Date:
Representative: You are entitled to representation, at your own expense, at any time during the fair hearing process. If you choose to seek representation, please provide your representative's information below.	
Print Name:	Phone # (required):
Address(City, State, ZIP):	
Relationship to Appellant:	
CFC Applicant/Participant Signature Authorizing Representation	Date

Return this form to:

[MCO/DADS Contact Information]

CFC Fair Hearing Cover Letter Example



Department of Aging and Disability Services
CFC Non-Waiver Eligibility Unit
P.O. Box 149030, Mail Code W-254
Austin, TX 78714-9030
(512) 438-2484
(512) 438-5693 Fax

CONFIDENTIAL

To: [Name of Hearing Officer] From: [CFC Reviewer]

Re: [Name of Appellant], Appellant Date: [MM/DD/YYYY]
[Name of LAR], Legally Authorized Rep
Appeal ID: [Number]

HEARING DATE: [MM/DD/YYYY – HH:MM am/pm] CST
Hearing phone number: [1-888-###-####] Code: [#####]

Denial of: Intermediate Care Facilities for Individuals with Intellectual Disability or Related Conditions (ICF/IID) Level of Care (LOC) I and VIII eligibility for Community First Choice (CFC)

Please contact [Name of CFC Reviewer], at (512) 438-[#####] or First.Last@dads.state.tx.us with any questions in regards to the above hearing. [Mr/s. CFC Reviewer] will be participating in this hearing on behalf of DADS via conference call.

The Department of Aging and Disability Services (DADS) has reviewed the individual's request for Community First Choice (CFC) Non-Waiver eligibility and determined that the appellant does not meet ICF/IID LOC I or VIII criteria in accordance with 40 Texas Administrative Code (TAC) §9.238 or §9.239 as required by 1 TAC §354.1362(a)(3). Specifically, the individual [reason(s) for ICF/IID LOC I AND LOC VIII ineligibility].

Attachments:

1. Copy of Level of Care Denial Notification sent to individual's Managed Care Organization. Dated [MM/DD/YYYY] (page 1)
2. Copy of Intellectual Disability/Related Condition (ID/RC) Assessment for CFC Form 8578-CFC. Dated [MM/DD/YYYY] (pages 2-3)
3. Copy of Determination of Intellectual Disability (DID). Evaluation Date [MM/DD/YYYY] (pages [4-#])

4. [IF APPLICABLE] Copy of Adaptive Behavioral Level (ABL) Assessment, [Name of Assessment]. Evaluation Date MM/DD/YYYY (pages [#-#])
5. [IF APPLICABLE] Copy of Related Condition Eligibility Screening Instrument (RCESI) Form 8662. Evaluation Date MM/DD/YYYY (pages [#-#])
6. Excerpt from Texas Administrative Code (TAC) Title 1, Part 15, Chapter 354, 5. Subchapter A, Rule §354.1362, Community First Choice Eligibility (page [#])
7. Excerpt from TAC Title 40, Part 1, Chapter 9, Subchapter E, Rule §9.238, Eligibility, Enrollment and Review ICF/MR Level of Care I criteria (page [#])
8. Excerpt from TAC Title 40, Part 1, Chapter 9, Subchapter E, Rule §9.239, Eligibility, Enrollment and Review ICF/MR Level of Care VIII criteria (page [#])
9. [IF APPLICABLE] Excerpt from TAC Title 40, Part 1, Chapter 9, Subchapter E, Division 1, Rule §9.203(72), Definitions (page [#])
10. [IF APPLICABLE] Copy of Denial Letter. Dated [MM/DD/YYYY] (page [#])
11. [IF APPLICABLE] Copy of Fair Hearing Request submitted by [Name of Requester]. Dated [MM/DD/YYYY] (page [#])
12. Copy of K66 CARE screen: CFC ID/RC Assessment LOC Status. Dated [MM/DD/YYYY] (page [#])

cc: [IF APPLICABLE] [Name of LAR], [Address]

Please note - The attached evidence packet was created by DADS and is being provided to you and the hearing officer with the Health and Human Services Commission in preparation for your pending appeal of adverse action taken by DADS as identified above.

You may want to share information contained in this evidence package with others as you prepare for the hearing. People you may want to share this information with include your case manager or service coordinator, any appellant witnesses or other advocates you plan to have participate in the hearing.

**PLEASE KEEP THIS EVIDENCE PACKET FOR YOUR
FAIR HEARING**