



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

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EXECUTIVE COMMISSIONER

**Memorandum**

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

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Subject: Introduction to the Electronic ISP

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This memorandum applies to the Home and Community Based Services (HCBS) STAR+PLUS Waiver (SPW) program delivered by managed care organizations (MCOs) through STAR+PLUS or delivered by a Medicare-Medicaid Plan (MMP) in the Dual Demonstration.

The policy contained in this memorandum provides guidance to all STAR+PLUS MCOs, MMPs and Program Support Unit (PSU) processing electronic individual service plans (ISPs). Section 9000, Service Authorization System Help File, only applies to the PSU. MCOs may submit electronic ISPs individually or in batches. This memorandum revises Appendix IV, SPW Closure Reasons Code and also introduces Appendix XXVI, MCO Long Term Care (LTC) Portal ISP User Guide and Appendix XXVII, PSU LTC Portal ISP User Guide.

Throughout this memorandum, applicable policy in the *STAR+PLUS Handbook* is restated. All policy *changes* are *italicized and underlined to highlight when the process is different for electronic ISPs.*

The LTC Portal matches approved Medical Necessity and Level of Care (MN/LOC) assessments records to individual service plans (ISPs) based on Medicaid Number and Social Security Number (SSN). If an MCO submits an MN/LOC without both member-identifying elements, the ISP cannot be matched and will return an error. In the event an

MCO submits an MN/LOC without both the Medicaid number and the SSN, the MCO must inactivate the MN/LOC, use it as a template, enter the SSN (and/or Medicaid Number), and resubmit the MN/LOC for processing.

For ISPs with a start date of May 1, 2016 or later that have not been submitted through TexMedCentral as of the effective date of this memorandum, MCOs must submit eligible ISPs through the LTC portal. Eligible ISPs are:

- Upgrades for members in the community with Supplemental Security Income (SSI) and SSI-related Medicaid eligibility (including those ISPs over the cost ceiling), and
- All annual reassessment ISPs.

ISPs ineligible for the electronic process must be processed manually, through existing processes outlined in Section 3000 of the STAR+PLUS Handbook. ISPs ineligible for the electronic process are ISPs developed for:

- Members/applicants discharging from a nursing facility;
- Members/applicants aging out of children's programs; and
- Applicants released from the HCBS SPW interest list.

The PSU will review and process electronic ISPs and generate HCBS SPW program notifications, as applicable.

This memorandum revises the following sections of the STAR+PLUS Handbook:

- Section 3000, Waiver Eligibility and Services;
- Section 5000, Automation and Payment Issues in STAR+PLUS; and
- Section 9000, Service Authorization System Help File.

The following information provides a description of the LTC portal edits, the benefits, and limitations of the electronic ISP (Form H1700-1) submission and HCBS SPW notifications:

- An edit prevents an ISP 'from date' that is not the first of a month.
- An edit prevents ISP submission for an individual who is not a member.
- An edit prevents submission of ISPs with total waiver costs equal to \$0.00.
- The ISP 'effective date', equal to the submission date (similar to the TxMedCentral posting date), is system-generated and cannot be altered.
- The ISP 'from date' is system-generated and defaults according to existing Handbook requirements. This is an editable field, restricted to the first of a month.
- The ISP 'to date' is system-generated equal to one year from the 'from date', and cannot be altered, unless an ISP is terminated by the PSU.
- Reassessment ISPs with a 'from date' greater than 120 days from the expired ISP 'to date' are defaulted to an initial ISP.
- Transfers between plan codes (including the same MCO, but a different service delivery area (SDA)) are processed by the portal as follows:

- There is a daily, automated process to check for members with plan code changes on a current or future ISP in a 'processed/complete' status.
- When the system identifies these members, a batch update process creates a 'child' ISP (a duplicate of the original) from the 'parent' ISP (the original ISP) with a new effective date equal to the date the plan conversion process is run, and new 'from date' equal to the new plan code effective date. The 'to date' remains unchanged on the 'child' ISP.
- The generation of a 'child' ISP, even on initial assessments, does not generate a new H2065-D. This notification letter is created only once, directly from an initial ISP, when the ISP is in 'pending notification' status.
- The MCO that submitted the original (or 'parent') ISP will see the ISP in 'transferred status' with a system-generated history note added, stating the member was transferred due to a member plan code change.
- The 'parent' ISP will reflect a 'to date' equal to the end date of the initial MCO plan code enrollment.
- The gaining MCO, or same MCO in a different SDA, will have access to view the new 'child' ISP with an automated history note providing an audit trail on the plan code change.
- SAS authorizing agent, service plan, and service authorization records for the 'parent' (transferred) ISP are automatically ended with the prior plan code enrollment end date.
- SAS authorizing agent, service plan, and service authorization records are system-generated on the 'child' ISP with a begin date equal to the new plan code effective date.
- The 'services identified on ISP effective date' on the H2065-D is populated with the ISP 'from date', which is an editable field.
- The notification letter 'eligibility date' is populated with the ISP 'from date', which is an editable field.
- PSU creates an H2065-D only once from the initial ISP, but PSU may use the "Letters" tab to generate additional notifications, if needed, for ISPs which have processed through the LTC portal.
- ISPs successfully processed through the LTC portal generate service plan and service authorization records in SAS. Authorizing agent records are also generated in SAS for initial ISPs (to include 'child' ISPs, as mentioned above).

Further information on system use and requirements is available in Appendix XXVI MCO LTC Portal ISP User Guide and Appendix XXVII PSU LTC Portal ISP User Guide. Until the STAR+PLUS Handbook updates, this information is available in the HHSC Updates section of the Handbook.

The following subsections of Section 3000, Waiver Eligibility and Services, contain revisions to existing *STAR+PLUS Handbook* Sections explaining how existing processes change for ISPs processed electronically through the LTC Portal.

The following subsections of Section 3000 are contained in this memorandum:

- 3314, MCO Changes
- 3316, Requests for STAR+PLUS Waiver Services from Participants in Other Medicaid Home and Community Based Services Programs
- 3330, STAR+PLUS Members Requesting an Upgrade to the Home and Community Based Services STAR+PLUS Waiver
- 3411, SPW Member Transferring to Another SPW Service Delivery Area with Prior Knowledge
- 3412, SPW Member Transferring to Another SPW Service Delivery Area Without Prior Knowledge
- 3413, SPW Member Transferring from One MCO to Another Within the Same SPW Service Delivery Area
- 3621, Reassessment Procedures
- 3622, Notification Requirements
- 3632, Program Support Unit (PSU) Initiated Denials/Terminations
- 3633, Denial/Termination Initiated by the Managed Care Organization
- 3623.1, Upgrades and Interest List Releases
- 3633.4, Denial as a Result of Exceeding the Cost Limit

The following subsections of Section 5000 are contained in this memorandum:

- 5110, TxMedCentral Naming Convention and File Maintenance
- 5210, Managed Care Data in SAS
- 5310, Using the Long Term Care Portal

The following subsections of Section 9000 are contained in this memorandum:

- 9110, Authorizing Agent
- 9130, Service Plan
- 9140, Service Authorization
- 9230, Service Plan – Reassessment
- 9240, Service Authorization – Reassessment
- 9310, Transfers from One STAR+PLUS Area to Another STAR+PLUS Area
- 9320, Transfers from One MCO to Another MCO in the Same Service Area
- 9480, Money Follows the Person (MFP) Demonstration for an SPW Applicant
- 9700, Terminations
- 9710, Terminating All Services

### **Section 3314, MCO Changes**

Members may change managed care organization (MCO) at any time by contacting the enrollment broker at 1-800-964-2777; Members in a Nursing Facility may call 1-877-782-6440. The enrollment broker makes plan changes based on the monthly cutoff periods, which occur around the middle of the month. Depending on which day of the

month (before or after the enrollment broker cutoff), the plan change will either occur the first day of the next month or the month after. The change will show up on the 834 daily enrollment file notifying the MCO of the new member. The Program Support Unit (PSU), when notified by the member, state or an MCO that a member has elected to change MCOs, will update the Service Authorization System (SAS) to change the previous MCO to the new MCO.

- When notified of an MCO change, PSU reviews records in SAS to confirm the Long Term Care portal generated the correct records for electronic ISPs or updates appropriate SAS records for ISPs posted to TxMedCentral. When PSU confirms the automated ISP registration in SAS, PSU takes a screenshot, and posts the screenshot to HHS Enterprise Administrative Report and Tracking System (HEART).

### **Section 3316, Requests for STAR+PLUS Waiver Services from Participants in Other Medicaid Home and Community Based Services Programs**

Other Medicaid Home and Community Based Services Programs include the following:

- Community Living Assistance and Support Services (CLASS);
- Deaf Blind with Multiple Disabilities (DBMD);
- Home and Community-based Services (HCS);
- Texas Home Living (TxHmL); and
- Home and Community Based Services-Adult Mental Health (HCBS-AMH).

Participants in other Medicaid Home and Community Based Services programs may request an assessment for HCBS STAR+PLUS Waiver (SPW) services at any time if they:

- have Supplemental Security Income (SSI) Medicaid or another full Medicaid program; or
- are Medical Assistance Only.

When a participant in a Medicaid Home and Community Based Services program requests SPW services, a referral is made to the Program Support Unit (PSU). PSU specialists are responsible for completing the following activities within 14 days of the initial request for an SPW assessment. All attempted contacts with the member or encountered delays must be documented. The PSU:

- moves the individual to the top of the SPW interest list with an "assessment requested" notation; and
- contacts the participant interested in SPW and explains SPW services.

For non-members, within two business days of notification of the MCO selection by the applicant individual, PSU completes Section A of [Form H3676](#), Managed Care Pre-Enrollment Assessment Authorization, and posts it in the MCO's XXXSPW folder on TxMedCentral, using the appropriate naming convention.

For members, PSU posts Form H2067-MC, STAR+PLUS Communication to TxMedCentral, to notify the MCO of the referral when a referral comes from a party other than the MCO.

The MCO completes:

- [Form H2060](#), Needs Assessment Questionnaire and Task/Hour Guide or Form H6516, Community First Choice Assessment;
- [Form H2060-A](#), Addendum to Form H2060;
- [Form H2060-B](#), Needs Assessment Addendum, as applicable;
- medical necessity and level of care (MN/LOC);
- Section B of Form H3676; and
- [Form H1700-1](#), Individual Service Plan — SPW (Pg. 1), and [Form H1700-2](#), Individual Service Plan — SPW (Pg. 2), and attachments.

*The MCO completes and submits the electronic Form H1700-1 through the Long Term Care portal for members in a Medicaid HCBS program. The MCO completes the manual process outlined above for dual eligible individuals.*

If the packet from the MCO is not received within 45 days after the assessment is authorized, PSU emails the assigned health plan management (HPM) team as notification the time frame for completing the individual service plan (ISP) was not met. The HPM team notifies the MCO of the delay and requests that action be taken immediately.

Within two business days of receipt of all required waiver eligibility documentation, PSU determines waiver eligibility based upon medical necessity, and an ISP cost within the Resource Utilization Group cost limit.

If eligibility for SPW is denied or the waiver individual decides not to accept SPW services, PSU completes [Form H2065-D](#), Notification of STAR+PLUS Program Services.

*If the ISP is electronic, PSU generates Form H2065-D through the LTC portal.*

PSU then:

- mails the original [Form H2065-D](#) to the HCBS program participant, with the explanation that this finding does not affect eligibility for the service the individual is currently receiving; and
- notifies the MCO by posting a copy of [Form H2065-D](#) to TxMedCentral.

*If the ISP is electronic, MCOs must check the LTC portal to check the status of the member's ISP and to retrieve Form H2065-D.*

If eligibility is approved and the individual chooses to accept SPW services, the individual is enrolled in SPW.

Within two days of the MCO, PSU, and the waiver case manager/service coordinator determining the start of care date for SPW services, PSU completes Form H2065-D and:

- mails the original H2065-D to the Medicaid HCBS participant;
- notifies the MCO by posting a copy to TxMedCentral; and
- for non-members, notifies Enrollment Resolution Services by emailing [HPO\\_Star\\_Plus@hhsc.state.tx.us](mailto:HPO_Star_Plus@hhsc.state.tx.us).

*If the ISP is electronic, MCOs must check the LTC portal to check the status of their member's ISP and to retrieve Form H2065-D.*

PSU staff must coordinate with MCO and waiver staff, as appropriate, to ensure the current Medicaid HCBS program end the day before enrollment in SPW.

### **Section 3330, STAR+PLUS Members Requesting an Upgrade to the Home and Community Based Services STAR+PLUS Waiver**

Medicaid recipients enrolled in STAR+PLUS qualify for Medicaid eligibility through various program types. Some members who request services through the HCBS SPW may be Medicaid eligible through one of the following Supplemental Security Income (SSI)-related Medicaid program types:

- Pickle (Type Program (TP)-03);
- Disabled Adult Child (TP-18);
- Disabled Widow(er) (TP-21); or
- Early Aged Widow(er) (TP-22).

Although these Medicaid programs represent full Medicaid eligibility, they do not consider transfer of assets and substantial home equity reviews required to establish financial eligibility for HCBS SPW services. Therefore, these Medicaid types are not eligible for an upgrade and enrollment in HCBS SPW until Medicaid for the Elderly and People with Disabilities (MEPD) staff test for these additional criteria.

Managed care organizations (MCOs) must notify the Program Support Unit (PSU) by posting [Form H2067-MC](#), STAR+PLUS Communication, to TxMedCentral within three business days of an upgrade request for a member who has one of these Medicaid program types. PSU staff must contact the member within three business days of the posting date of Form H2067-MC to advise the member [Form H1200](#), Application for Assistance - Your Texas Benefits, must be completed and returned to the PSU. Once the member returns Form H1200, PSU sends the signed and completed application form within two business days of receipt to MEPD staff, along with [Form H1746-A](#), MEPD Referral Cover Sheet, identifying the action to be taken.

The MCO service coordinator must, within 45 calendar days of a STAR+PLUS member's request or identified need for HCBS SPW services:

- complete an assessment to prepare the individual service plan (ISP);

- complete the Medical Necessity/Level of Care assessment and submit it to Texas Medicaid & Healthcare Partnership (TMHP) to request a determination of medical necessity; and
- Submit [Form H1700-1, Individual Service Plan — SPW \(Pg. 1\) through the Long Term Care \(LTC\) portal for members who are not discharging from a nursing facility \(NF\).](#)

MCOs are required to check the "ME-Waiver" box in the LTC Portal when developing an initial ISP for members with SSI-related Medicaid eligibility, which suspends the ISP from processing to allow PSU to review and collaborate with MEPD staff.

PSU staff reviews the LTC portal daily to search for ISPs for members referred for HCBS SPW services. ISPs requiring PSU action may be notated by one of the following status codes:

- Pending PSU Review;
- PSU Action Required; and
- Pending Notification, which applies only to initial ISPs.

MCOs must review the LTC portal to search for the status of their member's ISP and to retrieve Form H2065-D, Notification of STAR+PLUS Program Services when applicable.

Within three business days of an ISP pending PSU action, PSU staff takes appropriate action to process the SPW eligibility determination.

If medical necessity is denied for a pending upgrade, the MCO must inform the PSU within three business days by posting Form H2067-MC to TxMedCentral. When this occurs, PSU staff must send Form 1746-A to MEPD notifying MEPD of the denial within three business days after receiving it from the MCO.

PSU staff must apply *STAR+PLUS Handbook* policy regarding upgrades to determine if the member meets the eligibility criteria for SPW services. This will include not only review of the functional criteria evaluated by the MCO, but also a determination that the member's Medicaid type is eligible for SPW. For SSI-denied Medicaid program types referenced in this section, the Medicaid program type verification includes the MEPD certification that the additional required financial criteria have been met.

**If not eligible**, PSU staff:

- follow actions in [Section 3632](#), Program Support Unit (PSU)-Initiated Denials/Terminations, to deny the request;
- generate [Form H2065-D, Notification of STAR+PLUS Program Services in the LTC portal, if available;](#)
- send H2065-D, within three business days to the member; and
- post Form H2065-D to TxMedCentral to the MCO's SPWXXX folder.

If the ISP is electronic, MCOs must check the LTC portal to check the status of their member's ISP and to retrieve Form H2065-D.

**If the member is eligible**, PSU staff will process the member upgrade by:

- generating Form H2065-D through the LTC portal if the ISP is electronic;
- completing Form H2065-D and sending H 2065-D to the member and (if applicable) the Medicaid for the Elderly and People with Disabilities specialist;
- posting Form H2065-D in TxMedCentral to the MCO's SPWXXX folder;
- completing Service Authorization System entries to authorize eligibility for SPW; and
- confirming ISP registration in SAS, taking a screenshot of the ISP, H2065-D, and other records, and posting the screenshots to HHS Enterprise Administrative Report and Tracking System (HEART), if the ISP is electronic).

MCOs must check the LTC portal to check the status of their member's ISP and to retrieve Form H2065-D, if generated through the LTC portal.

### **Section 3411, SPW Member Transferring to Another SPW Service Delivery Area with Prior Knowledge**

When the Program Support Unit (PSU) is notified of a transfer from one STAR+PLUS service delivery area (SDA) to another SDA and a different managed care organization (MCO), within two business days, the losing PSU:

- notifies the gaining PSU a member is transferring to its service area and provides the member's:
  - name;
  - Social Security number;
  - Medicaid number;
  - current and future contact information; and
  - date of the move or anticipated move;
- notifies Medicaid for the Elderly and People with Disabilities (MEPD) using [Form H1746-A](#), MEPD Referral Cover Sheet, for Medical Assistance Only individuals;
- reminds Supplemental Security Income members to contact the Social Security Administration to change the address; and
- posts Form H2067-MC, STAR+PLUS Communication, to the MCO XXXSPW folder in TxMedCentral using the appropriate naming convention, and requests Form H1700-1 and all forms listed below from the losing MCO:
  - [Form H1700-2](#), Individual Service Plan — SPW (Pg. 2);
  - [Form H1700-A](#), Rationale for HCBS STAR+PLUS Waiver Items/Services;
  - [Form H1700-A1](#), Certification of Completion/Delivery of HCBS STAR+PLUS Waiver Items/Services;
  - [Form H1700-B](#), Non-HCBS STAR+PLUS Waiver Services;
  - [Form 8604](#), Transition Assistance Services (TAS) Assessment and Authorization;
  - the medical necessity/level of care (MN/LOC);

- [Form H2060](#), Needs Assessment Questionnaire and Task/Hour Guide or Form H6516, Community First Choice Assessment;
- [Form H2060-A](#), Addendum to Form H2060; and
- [Form H2060-B](#), Needs Assessment Addendum, as applicable.
- sends [Form H1700-1](#), Individual Service Plan — SPW (Pg. 1), to the gaining PSU;
- if the current ISP is electronic and the member's MCO change processed in the Texas Integrated Eligibility Registration System (TIERS), staff does not take action for Form H1700-1. The Long Term Care (LTC) portal generates a new ISP (called a child) with a new 'From Date' and the new plan code. PSU requests all relevant forms from the losing MCO using Form H2067-MC;
- if the current ISP is electronic and the member's MCO change processed in TIERS, the losing PSU does not send Form H1700-1 as the (LTC) portal generates a new 'child' ISP) and updates SAS;
- Staff confirms ISP registration in SAS, takes a screenshot of the records and the ISP, and posts the screenshots to HHS Enterprise Administrative Report and Tracking System (HEART).

Once the gaining PSU receives Form H1700-1, PSU follows the usual intake procedures. The process is abbreviated since the member already has a:

- medical necessity;
- Resource Utilization Group; and
- financial eligibility determination by MEPD, if applicable.

The gaining PSU coordinates all appropriate activities between the losing PSU, MCOs, member, Eligibility Resolution Services (ERS) and other key parties to help ensure a successful transition. For the PSU, this includes tracking each step of the process through the start of the new SPW services in the gaining area.

The gaining PSU maintains contact with the member until the move is complete. Within five business days after the move, PSU:

- sends an email to the ERS mailbox notifying ERS the member has moved;
- manually closes all Service Authorization System (SAS) records for the losing MCO effective the end of the month the member moves;
- updates SAS with the gaining MCO's information;
- generates Form H2065-D through the LTC portal "LETTERS" tab. If the current and future, 'child' ISPs are electronic, SAS records are updated automatically consistent with the adjusted 'to date' on the current ISP and new 'from date' on the future ISP. The 'child' ISP will have an "effective" date equal to the plan conversion date and a "from" date equal to the new plan begin date. The "to" date on the new ISP remains unaltered.
- sends [Form H2065-D](#), Notification of STAR+PLUS Program Services, to the member and includes the begin and end dates in the Comments section; and
- posts a copy of Form H2065-D to the appropriate MCO's XXXSPW folder in TxMedCentral, using the appropriate naming convention.

- if the ISP is electronic, PSU posts Form H2067-MC to TxMedCentral to alert the gaining MCO of their new member and the availability of the new Forms H1700-1 and H2065-D in the portal within two business days.

Within five business days of notification of the move, Enrollment Resolution Services (ERS) disenrolls the member effective the end of the month in which the member moved and re-enrolls the member to the gaining MCO.

### **Section 3412, SPW Member Transferring to Another SPW Service Delivery Area Without Prior Knowledge**

If the member's existing individual service plan (ISP) was not submitted through the Long Term Care (LTC) portal or the existing ISP is electronic but MCO selection is delayed until after the move and the gaining MCO is not identified, the losing and gaining MCO and PSU must follow the manual process.

When the Program Support Unit (PSU) is notified a transfer from one STAR+PLUS service area and/or MCO to another STAR+PLUS area and/or MCO has already occurred, within one business day the losing PSU:

- notifies the gaining PSU a member has transferred to its service area and provides the member's:
  - name;
  - Social Security number;
  - Medicaid number;
  - current and future contact information; and
  - date of the move or anticipated move;
- posts [Form H2067-MC](#), STAR+PLUS Communication, to the managed care organization (MCO) XXXSPW folder in TxMedCentral, using the appropriate naming convention, and requests [Form H1700-1](#), Individual Service Plan — SPW (Pg. 1), and all the forms listed below from the losing MCO:
- if the current ISP is electronic and the MCO change updates in the Texas Integrated Eligibility Registration System (TIERS), PSU does not take action for Form H1700-1. The LTC portal generates a new ISP with a new 'From Date' and the new plan code. If the MCO change did not process in TIERS, PSU requests the following forms from the losing MCO using Form H2067-MC:
  - [Form H1700-2](#), Individual Service Plan — SPW (Pg. 2)
  - [Form H1700-A](#), Rationale for HCBS STAR+PLUS Waiver Items/Services;
  - [Form H1700-A1](#), Certification of Completion/Delivery of HCBS STAR+PLUS Waiver Items/Services;
  - [Form H1700-B](#), Non-HCBS STAR+PLUS Waiver Services;
  - [Form 8604](#), Transition Assistance Services (TAS) Assessment and Authorization;
  - the medical necessity/level of care (MN/LOC);
  - [Form H2060](#), Needs Assessment Questionnaire and Task/Hour Guide or [H6516](#), Community First Choice Assessment and

- [Form H2060-A](#), Addendum to Form H2060; and
- [Form H2060-B](#), Needs Assessment Addendum, as applicable.
- checks the individual's address information in the Texas Integrated Eligibility Redesign System (TIERS) to determine if the new residential address has been updated to this system. If this has not occurred and the individual is Medical Assistance Only, PSU notifies Medicaid for the Elderly and People with Disabilities (MEPD) using [Form H1746-A](#), MEPD Referral Cover Sheet, for Medical Assistance Only individuals; and
- checks the individual's address information in the Texas Integrated Eligibility Redesign System (TIERS) to determine if the new address has been updated to this system. If this has not occurred and the member is Supplemental Security Income (SSI) eligible, PSU reminds the members to contact the Social Security Administration to change their residential address.

Within two business days of notification from the losing PSU, the gaining PSU:

- contacts the member to select an MCO from the gaining area;
- sends the packet containing the MCO comparison chart; and
- posts Form H2067-MC to TxMedCentral in the MCO's XXXSPW folder, using the appropriate naming convention, requesting the MCO to inform the gaining health plan of the move.

Upon receipt of Form H2067-MC, the gaining MCO must contact the member within one business day and begin services within two business days.

Once the gaining PSU receives Form H1700-1, staff follow the usual intake procedures. The process is abbreviated since the member already has a:

- MN/LOC;
- Resource Utilization Group; and
- financial eligibility determination by MEPD, if applicable.

The gaining PSU coordinates all appropriate activities between the losing PSU, MCOs, the member, Enrollment Resolution Services (ERS) and other key parties to help ensure a successful transition. For PSU, this includes tracking each step of the process through the start of the new SPW services in the gaining area.

Within two business days after completing the steps above, the gaining PSU:

- sends an email to the ERS mailbox notifying ERS the member has moved;
- manually closes all service authorization records effective the end of the month the member moves;
- updates the Service Authorization System (SAS) with the gaining MCO's information;
- *if the current and future, 'child' ISPs are electronic, SAS records are updated automatically consistent with the adjusted 'to date' on the current ISP and new 'from date' on the future ISP. The 'child' ISP will have an "effective" date equal to the plan conversion date and a "from" date equal to the new plan begin date. The "to" date on the new ISP remains unaltered. PSU generates Form H2065-D through the LTC portal "LETTERS" tab;*

- takes a screenshot, and posts the screenshot to HHS Enterprise Administrative Report and Tracking System (HEART);
- sends Form H2065-D, Notification of STAR+PLUS Program Services, to the member and includes the begin and end dates in the Comments section; and
- posts a copy of Form H2065-D to the appropriate MCO's XXXSPW folder in TxMedCentral, using the appropriate naming convention.
- if the member's ISP is electronic, , PSU posts Form H2067-MC to TxMedCentral to alert the gaining MCO of their new member, if applicable, and the availability of the new Forms H1700-1 and H2065-D in the portal within two business days.

Within five business days of notification of the move, ERS manually updates the plan code to reflect the current MCO.

### **Section 3413, SPW Member Transferring from One MCO to Another Within the Same SPW Service Delivery Area**

Once the initial enrollment period of one calendar month is passed, a member is eligible to change managed care organization (MCO) plans. When a member chooses to change from one MCO to another MCO in the same delivery area, the member or responsible party must contact the state-contracted enrollment broker via phone call to 1-800-964-2777, or via written correspondence. The enrollment broker will ask if the member is in a hospital or residing in a nursing facility. If so, the member cannot change plans until the member has been discharged. The member can change MCOs as many times as the member wants, but not more than once per month.

If the member calls to change the MCO on or before the 15th day of the month, the change will take place on the first day of the next month. If the member calls after the 15th day of the month, the change will take place the first day of the second month following the change request.

#### **Examples**

- If the member calls on or before April 15, the change will take place on May 1.
- If the member calls after April 15, the change will take place on June 1.

For more details, see the [Uniform Managed Care Manual](#), Chapter 3.4, Attachment C to the Medicaid Managed Care Member Handbook Required Critical Elements.

#### **Monthly Plan Changes Report**

Health and Human Services Commission – Managed Care Operations prepares and sends the Monthly Plan Changes report to the Program Support Unit (PSU) and Health Plan Management (HPM) shares the information with the gaining MCO. PSU receives a full list; the MCO receives a member-specific report. The report gives a list of HCBS STAR+PLUS Waiver (SPW) members who have changed MCOs from the previous month. PSU must correct the contract number in the Service Authorization System to reflect all MCO changes. See [Appendix I-E](#), Monthly Plan Changes.

Within five business days of receiving the list, the gaining MCO must request [Form H1700-1](#), Individual Service Plan — SPW (Pg. 1), and Medical Necessity and Level of Care from the losing MCO. Within five business days of receiving the request, the losing MCO must provide the requested documents to the gaining MCO.

The gaining MCO is responsible for service delivery from the first day of enrollment. Within 14 calendar days of notification of the new member, the gaining MCO must contact the member to discuss services needed by the member. Within 30 calendar days of notification of the new member, the gaining MCO must conduct a home visit to assess the member's needs.

*If the ISP is electronic, and the member's MCO change registers in the Texas Integrated Eligibility Registration System (TIERS), the Long Term Care (LTC) portal updates the Service Authorization System (SAS) records for current and future individual service plans (ISPs) that are in a "processed/ complete" status. PSU takes a screenshot of the H2065-D, Notification of STAR+PLUS Program Services ISP, and other records, and posts the screenshots to HHS Enterprise Administrative Report and Tracking System (HEART). PSU notifies the gaining MCO of their new member, if applicable, and the availability of the system generated Forms H1700-1 for ISPs submitted through the LTC portal using Form H2067-MC, STAR+PLUS Communication within one business day.*

## **Section 3621, Reassessment Procedures**

The Program Support Unit (PSU) must ensure the member's individual service plan (ISP) is entered into the Service Authorization System (SAS) annually. The PSU:

- checks TxMedCentral to determine if the managed care organization (MCO) has submitted [Form H1700-1](#), Individual Service Plan — SPW (Pg. 1), before the ISP end date;
- *if the ISP is electronic, checks the Long Term Care (LTC) portal to determine if the MCO submitted Form H1700-1 before the ISP end date;*
- verifies the case has an approved medical necessity and level of service ;
- confirms ongoing Medicaid eligibility;
- verifies continuing enrollment in SAS reflects any plan change;
- verifies the ISP is within the cost limit;
- determines if the ISP was submitted on time and if:
  - on time, enters service group (SG) 19 service code (SC) 12;
  - not on time, enters SG 19 SC 13 for the month(s) for which the ISP was late and SG 19 SC 12 for the remaining ISP period; and
- *if the ISP is electronic, verifies the SAS ISP records have been accurately generated based on whether the submission was timely or late. PSU takes a screenshot, and posts the screenshot to HHS Enterprise Administrative Report and Tracking System (HEART)*
  - *Timely ISPs reflect a SG 19 SC 12 record; and*
  - *Late ISPs reflect a record for SG 19 SC 13 for the month(s) for which the ISP was late and an SG 19 SC 12 record for the remaining ISP period.*

- If the ISP is not electronic, PSU enters the ongoing ISP in SAS within five business days of receipt, not to exceed the ISP end date.

The Supplemental Security Income (SSI)-denied Medicaid program types referenced in [Section 3330](#), STAR+PLUS Members Requesting an Upgrade to the Home and Community-based Services STAR+PLUS Waiver, do not change in the Texas Integrated Eligibility Redesign System (TIERS) either during the initial or annual review by Medicaid for the Elderly and People with Disabilities (MEPD) staff. As part of reassessment procedures, PSU staff will remain responsible for confirming ongoing Medicaid eligibility, but is not required to request MEPD test an individual for the additional criteria, or request a change in the Medicaid program type.

If the reassessment ISP is being submitted due to the participant's timely appeal of a STAR+PLUS Waiver denial, PSU extends the end date an additional four calendar months. Services continue using the existing ISP until a decision is received from the hearing officer. At that time PSU and the MCO coordinate the submission of a reassessment ISP to ensure SAS records are correct and the reassessment ISP processes correctly.

*If a member is reassessed and the Medical Necessity and Level of Care is denied, the MCO must send PSU staff using [Form H2067-MC](#), STAR+PLUS Communication, as notification to manually generate [Form H2065-D](#), Notification of STAR+PLUS Program Services. PSU sends Form H2065-D to the member and posts a copy to the appropriate MCO folder in TxMedCentral.*

### **3622 Notification Requirements**

If the member continues to meet waiver requirements, it is not necessary to send [Form H2065-D](#), Notification of STAR+PLUS Program Services, at the reassessment as notification of continuing services. If the member does not meet waiver requirements, the Program Support Unit (PSU) must, within two business days of notification:

- send Form H2065-D to the member indicating why the case is being terminated;
- post a copy of Form H2065-D in TxMedCentral to the XXXSPW folder using the appropriate naming convention;
- *if the ISP is electronic, terminate the ISP through the Long Term Care (LTC) Portal and generates Form H2065-D through the portal, if available. PSU posts [Form H2067-MC](#), STAR+PLUS Communication, to TxMedCentral to alert the MCO the denial notice is available in the LTC portal; and*
- sends a copy of Form H2065-D to Enrollment Resolution Services for medical assistance only (MAO) members ([HPO\\_STAR\\_PLUS@hhsc.state.tx.us](mailto:HPO_STAR_PLUS@hhsc.state.tx.us)).

The MCO notifies the member's providers of the last day the member is eligible to receive services.

If no appeal is filed, Eligibility Resolution Services (ERS) disenrolls the MAO member from STAR+PLUS effective the date of the action on Form H2065-D.

If the member files an appeal timely, the PSU, within two business days of notification:

- sends [Form H1746-A](#), MEPD Referral Cover Sheet, for cases in the Centralized Representation Unit, which forwards the information to the appropriate MEPD specialist;
- posts [Form H2067-MC](#) in TxMedCentral to the XXXSPW folder, using the appropriate naming convention, informing the MCO to continue services due to the timely appeal (if services have already ended, the MCO reinitiates services immediately);
- extends the end date of the current ISP an additional four calendar months; and
- sends an email to ERS on Medical Assistance Only cases as notification that a timely appeal was submitted and enrollment should remain open.

ERS, within 10 calendar days of receiving the fair hearings officer's decision, carries out the decision. See [Section 4234](#), Hearing Decision.

### **Section 3623.1, Upgrades and Interest List Releases**

Individual service plans (ISPs) developed for upgrades are submitted through the Long Term Care (LTC) portal. The LTC portal populates the ISP 'from date', also referred to as 'start of care' date, which is based on the logic outlined in the following examples:

- An individual has a Medicaid Eligibility Determination (MED) of 07-01-16, an approved MN/LOC submittal date of 10-15-16, and an ISP posted 11-01-16. The eligibility effective date on Form H2065-D is 11-01-16.
- An individual has an MED of 07-01-16, an approved MN/LOC submittal date of 10-15-16, and an ISP posted 10-20-16. The eligibility effective date on Form H2065-D is 11-01-16.

Program Support Unit (PSU) staff generates Form H2065-D in the LTC portal. The LTC portal generates the 'start of care' date for the H2065-D automatically. Should there be a delay in the start of care date, if the ISP is not in a 'processed/complete' status, MCOs can inactivate the ISP.

For example, an MCO submits an initial ISP assessment for a member with SSI-related Medicaid eligibility and checked the "ME-Waiver" box in the LTC Portal to suspend the case for PSU review and MEPD staff experience a delay in determining Medicaid eligibility. In this scenario, the Medicaid certification date is later than the ISP 'from date'.

The following actions must be taken:

- PSU adds a note to the ISP in the LTC portal to indicate the revised 'from date' with instructions for the MCO to inactivate the form and resubmit the ISP with new dates.
- PSU activates the "MCO Action Required" button to alert the MCO of the date revision request.

- The MCO inactivates the ISP, presses the "Use as Template" button to copy previous data, revises the 'from date', and submits the form for processing.

ISPs developed for interest list releases continue to be processed manually and posted to TxMedCentral because these applicants are not members at the time the ISP is submitted. For ISPs developed for interest list releases, the start of care (SOC) date for an HCBS STAR+PLUS Waiver (SPW) applicant being released from the interest list is based on the:

- Medicaid eligibility effective date (MED);
- date the approved Medical Necessity/Level of Care (MN/LOC) was submitted through the Long Term Care (LTC) portal; and
- date the member's individual service plan (ISP) was posted to TxMedCentral.

PSU staff determines the effective date based on the later of the above dates. If the date falls on the first day of the month, the effective date on [Form H2065-D](#), Notification of STAR+PLUS Program Services, is the first day of that month. If the date falls between the second and the last day of the month, the effective date is the first date of the following month.

- An individual has an MED of 07-01-16, an approved MN/LOC submittal date of 6-15-16, and an ISP posted 7-01-16. The eligibility effective date on Form H2065-D is 7-01-16
- An individual has an MED of 07-01-16, an approved MN/LOC submittal date of 6-15-16, and an ISP posted 7-20-16. The eligibility effective date on Form H2065-D is 8-01-16.

### **3632 Program Support Unit (PSU) Initiated Denials/Terminations**

If an individual service plan (ISP) is in "processed/complete" or "PSU processed/complete" status in Long Term Care (LTC) portal, only PSU staff may terminate the ISP. PSU selects the "Terminate ISP" option, the "to date" field and "ISP Termination Reason" fields are activated. PSU terminates the ISP, when needed.

PSU generates [Form H2065-D](#), Notification of STAR+PLUS Program Services, through the LTC portal. PSU may refer to tables in the memorandum attachment, 10-Day Adverse Action Notification Tables to determine the appropriate dates for Form H2065-D, Notification of STAR+PLUS Program Services. PSU notifies the member's MCO of the termination and the availability of the H2065-D in the LTC portal by posting Form H2067-MC, STAR+PLUS Communication, to TxMedCentral to alert the MCO the denial notice is available in the LTC portal.

If the member timely appeals and requests continued benefits, PSU must notify the MCO using Form H2067-MC, STAR+PLUS Communication. PSU then follows existing manual policies and procedures.

If the member appeals a loss in Medicaid eligibility, PSU sends [Form H1746-A](#), MEPD Referral Cover Sheet, for cases in the Centralized Representation Unit (CRU), which forwards the information to the appropriate MEPD specialist.

### **3633 Denial/Termination Initiated by the Managed Care Organization**

MCOs may initiate a Home and Community Based Services STAR +PLUS Waiver denial for the reasons outlined in Sections 3633.1 through 3633.7. The electronic individual service plan (ISP) process does not affect these policies.

If the MCO needs to terminate a member's ISP, the MCO must notify Program Support Unit (PSU) staff by sending [Form H2067-MC](#), STAR+PLUS Communication, requesting PSU terminate the ISP through the Long Term Care (LTC) portal. The MCO must include the reason for termination.

PSU selects the "Terminate ISP" option, the "to date" field and "ISP Termination Reason" fields are activated. PSU terminates the ISP, when needed.

PSU generates [Form H2065-D](#), Notification of STAR+PLUS Program Services, through the Long Term Care (LTC) portal. PSU may refer to tables in the memorandum attachment, 10-Day Adverse Action Notification Tables to determine the appropriate dates for Form H2065-D. PSU notifies the member's MCO of the termination and the availability of the H2065-D in the LTC portal using PSU posts Form H2067-MC, STAR+PLUS Communication, to TxMedCentral to alert the MCO the denial notice is available in the LTC portal.

If the member timely appeals and requests continued benefits, the PSU must notify MCO using Form H2067-MC, STAR+PLUS Communication. PSU then follows existing manual policies and procedures.

If the member appeals a loss in Medicaid eligibility, PSU sends [Form H1746-A](#), MEPD Referral Cover Sheet, for cases in the Centralized Representation Unit, which forwards the information to the appropriate MEPD specialist. PSU also sends an email to ERS for Medical Assistance Only cases as notification that a timely appeal was submitted and enrollment should remain open.

### **Section 3633.4, Denial as a Result of Exceeding the Cost Limit**

The managed care organization (MCO) must consider all available support systems in determining if the waiver is a feasible alternative that ensures the needs of the applicant are adequately met.

The MCO must notify the HHSC Transition/High Needs Coordinator of all ISPs over the cost limit before submitting the ISP.

If an MCO submits an initial individual service plan (ISP) through the Long Term Care (LTC) portal with a total estimated waiver cost exceeding the annual cost limit, a checkbox titled 'Over Annual Cost Limit override with GR approval' will appear. When this box is present, the MCO must select this checkbox to submit the ISP. Checking the box automatically generates a 'pending PSU review' status for the ISP. PSU immediately notifies, by email, the HHSC Transition/High Needs Coordinator of all ISPs over the cost limit. The email must contain the following elements:

- Name of applicant/member; and
- Medicaid ID

Within five business days, the HHSC Transition/High Needs Coordinator will notify PSU if the applicant/member meets the general revenue determination process criteria.

Within two business days, PSU manually creates [Form H2065-D, Notification of STAR+PLUS Program Services](#), sends the H2065-D denial notification to the member, and posts a copy of the H2065-D to TxMedCentral.

Denial notices, which afford the member the right to appeal, are sent prior to a final determination for use of general revenue (GR) funding. Therefore, PSU leaves the electronic ISP in a pending status until the HHSC Transition/High Needs Coordinator communicates the decision on the request for use of GR to PSU.

If the GR approval request is granted, PSU clicks the "submit to SAS" button for processing. Once the processing successfully completes, initial ISPs are placed in a 'pending notification' status. PSU generates Form H2065-D directly from the ISP to notify the member of Home and Community Based Services STAR+PLUS Waiver eligibility, and sends this notice to the member.

If the GR approval request is denied for the initial ISP, PSU selects the "PSU Invalid/Complete" button in the LTC portal to deny the ISP. PSU adds a note to the ISP communicating the denial. Because a manually developed denial notice has already been sent to the member, no further action is needed.

## **Section 5110, TxMedCentral Naming Convention and File Maintenance**

TxMedCentral is a secure Internet bulletin board that the state and managed care organizations (MCOs) use to share information. TxMedCentral uses specific naming conventions **only** for documents listed below. Staff must follow these conventions any time one of the following documents is filed in TxMedCentral.

### **Form H1700-1, Individual Service Plan — SPW (Pg 1)**

The following forms may be used, if appropriate, in development of the individual service plan (ISP). Only Form H1700-1 and Form H1700-2 are posted to MCO's ISPXXX folder in TxMedCentral and should not be posted in any other folder:

- [Form H1700-1](#), Individual Service Plan — SPW (Pg. 1) and [Form H1700-2](#), Individual Service Plan — SPW (Pg. 2);
- [Form H1700-A](#), Rationale for HCBS STAR+PLUS Waiver Items/Services;
- [Form H1700-A1](#), Certification of Completion/Delivery of HCBS STAR+PLUS Waiver Items/Services;
- [Form H1700-B](#), Non-HCBS STAR+PLUS Waiver Services;
- [Form H2060](#), Needs Assessment Questionnaire and Task/Hour Guide;
- Form H2060-A, Addendum to Form H2060; and
- Form H2060-B, Needs Assessment Addendum, as applicable.

Two-Digit Plan Identification (ID)	Form Number (#)	Member ID, Medicaid # or Social Security Number (SSN)	Member Last Name (first four letters)	Page Number of Form H1700	Sequence Number of Form
##	1700	123456789	ABCD	1	2

This file would be named ##\_1700\_123456789\_ABCD\_1\_2.doc.

Form H1700-1, completed for non-members, age-outs, and nursing facility residents transitioning to Home and Community Based (HCBS) STAR+PLUS Waiver (SPW) program, continues to be posted to TxMedCentral.

Form H1700-1, completed for members in the community, is submitted to the Long Term Care (LTC) portal.

### Form H3676, Managed Care Pre-Enrollment Assessment Authorization

This form is posted to the STAR+PLUS Waiver (SPW) folder and should **not** be posted in any other folder.

Two-Digit Plan ID	Form #	Member ID, Medicaid # or SSN	Member Last Name (first four letters)	Section Number	Sequence Number of Form
##	3676	123456789	ABCD	A	2

This file would be named ##\_3676\_123456789\_ABCD\_A\_2.doc.

### Form H2065-D, Notification of STAR+PLUS Program Services

This form is posted to the SPW folder and should **not** be posted in any other folder.

Two-Digit Plan ID	Form #	Member ID, Medicaid # or SSN	Member Last Name (first four letters)	Form Suffix Character	Sequence Number of Form
##	2065	123456789	ABCD	D	2D or 2A

- Denials will be coded with a “D” (denial) immediately following the form’s sequence number. This denial file would be named  
##\_2065\_123456789\_ABCD\_D\_2D.doc.
- Approvals will be coded with an “A” immediately following the sequence number. This approval file would be named ##\_2065\_123456789\_ABCD\_D\_2A.doc.

If a member has ISP which is electronically generated, Form H2065-D is available in the "LETTERS" tab of the LTC portal when the member's ISP is selected. Form H2065-D is posted to TxMedCentral only for individuals without electronic ISPs.

MCOs must check the LTC portal to check for updates and notifications electronically generated by PSU.

### Form H2067-MC, STAR+PLUS Communication

This form is posted to the SPW folder and should **not** be posted in any other folder. An "M" or "S" is added to the sequence number to indicate whether the MCO or Program Support Unit (PSU) posted the form.

Two-Digit Plan ID	Form #	Member ID, Medicaid # or SSN	Member Last Name (first four letters)	Sequence Number of Form
##	2067	123456789	ABCD	2M

This file would be named ##\_2067\_123456789\_ABCD\_2M.doc.

Additional to the standardized naming convention for [Form H2067-MC](#) a separate naming convention has been developed to address use of Form H2067-MC for nursing facility residents who request transition to the community under the HCBS SPW program. These individuals are considered expedited cases for application to HCBS SPW services. For this reason, staff from both the MCO and Program Support Unit (PSU) must be able to readily identify communications specific to these cases.

An "M" or "S" continues to be added to the sequence number to denote, respectively, whether the MCO or PSU has posted the form. The new naming convention for posting Form 2067, on both member and non-member cases in a nursing facility, is expanded as follows:

Two-Digit Plan ID	Form #	Member ID, Medicaid # or SSN	Member Last Name (first four letters)	Sequence Number of Form	Status Suffix
##	2067	123456789	ABCD	1M or 1S	MFP

This form file posted by the MCO would be named  
##\_2067\_123456789\_ABCD\_1M\_MFP.doc.

### TxMedCentral Folders

The STAR+PLUS MCOs use the following folders for all SPW related postings. Each MCO has two folders with three-letter identifiers:

- ISP — Individual Service Plan, which contains Form H1700-1 and Form H1700-2; and
- SPW — STAR+PLUS Waiver, which contains:
  - [Form H2065-D](#), Notification of STAR+PLUS Program Services;
  - [Form H3676](#), Managed Care Pre-Enrollment Assessment Authorization; and
  - [Form H2067-MC](#), STAR+PLUS Communication.

<b>Primary Folder: MCO Three-Letter Identifiers</b>	<b>Secondary Folder: TxMedCentral Folders by Plan</b>
AMC — Amerigroup MCO	AMCISP AMCSPW
EVR — United Healthcare Community Plan MCO	EVRISP EVRSPW
MOL — Molina MCO	MOLISP MOLSPW
SUP — Superior MCO	SUPISP SUPSPW
BRV — Cigna-HealthSpring MCO	BRVISP BRVSPW

### **File Maintenance**

Due to the volume of forms being posted to TxMedCentral, it is mandatory to purge older documents from time to time. The PSU must electronically back up documents from the XXXISP and XXXSPW on a daily basis to prevent loss of form history. Documents must be easily accessible to staff whenever needed. The state requires these backup documents be maintained for five years.

### **Section 5210, Managed Care Data in SAS**

STAR+PLUS Waiver (SPW) services are authorized by the managed care organization and registered by Program Support Unit (PSU) staff in the Service Authorization System (SAS) with Service Group (SG) 19 and a service code (SC). *If the member's individual service plan (ISP) is electronic, the Long Term Care (LTC) portal registers the appropriate SG/SC combination, which is verified by the PSU.* Service codes are based on the following:

- **Service Code 12:** Use this service code when registering initial service authorizations or annual re-determination service authorizations received up to 90 days prior to the end date of the current individual service plan (ISP).
- **Service Code 13:** Use this service code if an ISP is received after the end date of the most recent ISP. Register one service authorization using Service Code 13 effective the day after the end date of the most recent ISP and with an end date that is the end of the month in which the new ISP was received. Register a second service authorization using Service Code 12 with an effective date one day after the Service Code 13 service authorization ends and an end date of one year minus a day from the effective date of the ISP.

**Example of manual registration:** A reassessment ISP is received on June 5, 2016, for an ISP that ended May 31, 2016. To register this reassessment, register one service authorization record using "Service Code 13 — Nursing" with a begin date of June 1, 2010, and an end date of June 30, 2010. Then, register a second service authorization record using "Service Code 12 — Case Management" with a begin date of July 1, 2016, and an end date of May 31, 2011.

**Example of automatic registration:** *A reassessment ISP is submitted to the LTC portal on June 5, 2015, for an ISP that ended May 31, 2015. One service authorization record with "Service Code 13 — Nursing" will be system-generated with a begin date of June 1, 2015, and an end date of June 30, 2015. A second service authorization record with "Service Code 12 — Case Management" will be system-generated with a begin date of July 1, 2016, and an end date of June 30, 2017.*

### 5310 Using the Long Term Care Portal

The managed care organization (MCO) must submit the Medical Necessity and Level of Care (MN/LOC) Assessment through the Long-Term Care (LTC) LTC Portal to process a determination of MN and reimbursement rates. MCOs submit the MN/LOC Assessment as an:

- initial assessment, submitted when an applicant/individual is being assessed for HCBS STAR+PLUS Waiver (SPW); or
- annual assessment.

The MCO has the ability to correct or inactivate assessment forms submitted within specific time frames. Corrections are completed when data submitted incorrectly is updated; inactivation is completed when data needs to be removed from the LTC Portal system.

The MCO is given access to the LTC Portal to:

- check and verify MN status and Resource Utilization Groups (RUGs);
- review actions placed in a workflow status that result from the submittal of the MN/LOC Assessment at initial enrollment or annual assessment;
- manage and take action in response to workflow messages; and
- submit Form H1700-1, Individual Service Plan-SPW (Pg.1), for initial, change, and reassessment of members with the exception of age-outs and nursing facility residents transitioning to the Home and Community Based Services (HCBS) STAR+PLUS Waiver (SPW).

More information about submitting Form H1700-1 through the LTC portal is available in Appendix XXVI, MCO LTC Portal ISP User Guide.

Staff with access and responsibility to manage workflows related to their job duties include Claims Management System (CMS) coordinators, Provider Claims Services (PCS) coordinators and the Program Support Unit.

Submittal of the MN/LOC Assessment through the LTC Portal creates MN, Level of Service (LOS) and Diagnosis (DIA) records in the Service Authorization System (SAS). The RUG value is located in the LOS record.

Status messages appear in the LTC Portal workflow folder when an MN/LOC Assessment is submitted and certain requirements in Texas Medicaid & Healthcare Partnership (TMHP) processing cannot be completed. Status messages may be generated when:

- assessments have missing information;
- the system cannot match the assessment to an applicant/individual record;
- the individual is enrolled in another program;
- assessment forms are out of sequence;
- corrections are made to submitted assessments after SAS records have already been generated based on the initial assessment submitted;
- changes occur in MN or LOS status that affect applicant/individual services; or
- previous SAS records were manually changed within the current individual service plan period.

This list is not all inclusive.

Messages will appear in the workflow folder to indicate whether or not the LTC Portal action was processed as complete. In some situations, MN, LOS and Diagnosis records will not be generated to SAS; in other situations, SAS records will be generated but messages may still appear in the workflow for required action.

MCO and CMS coordinators:

- may filter the workflow messages by choosing specific criteria, such as individual name or type of MN/LOC Assessment;
- may update SAS records and/or take specific case actions based on the MN and RUG information found in the LTC Portal;
- must document responses to workflow messages appearing for an individual by clicking on applicable buttons related to the messages; and
- must check LTC Portal workflow items to process case actions.

Managed Care Operations may:

- filter the workflow messages by choosing specific criteria, such as individual name or type of MN/LOC Assessment; and
- update SAS records and/or take specific case actions based on the MN and RUG information found in the LTC Portal.

### **9110 Authorizing Agent**

There will normally be one authorizing agent registered for a STAR+PLUS Waiver (SPW) applicant.

Initial individual service plans (ISPs) submitted through the Long Term Care (LTC) portal have a system-generated authorizing agent. The LTC portal interfaces with the Service Authorization System (SAS) and records "STAR+PLUS" in the Authorizing Agent Field and records the managed care organization (MCO) service coordinator's name in the Name field.

The LTC portal generates changes to the SAS authorizing agent records for a member with a plan code change during an ISP year for which a current or future ISP is in a "processed/complete" status. In this case, a SAS authorizing agent record is created for the 'child' ISP with a begin date equal to the new plan effective date. The SAS authorizing agent record for the 'parent' (transferred) ISP is automatically ended with the prior plan enrollment end date.

PSU does not register an authorizing agent for electronic ISPs. PSU confirms the authorizing agent registration in SAS, takes a screenshot, and posts the screenshot to HHS Enterprise Administrative Report and Tracking System (HEART).

The Program Support Unit (PSU) or Health and Human Services Commission staff are registered as the authorizing agent when the initial authorization is authorized.

**To register an authorizing agent for an SPW applicant whose ISP is posted to TxMedCentral:**

1. Select the **Authorizing Agent** area in the **Case Worker** Functional area.
2. Select **Add** and a blank **Authorizing Agent Details** record will appear.
3. Move to the **Type** field and select **CM – Case Manager** from the drop-down menu.
4. Move to the **Group** field and select **19 - STAR+PLUS** from the drop-down menu.
5. Leave the **Send to TMHP** field at the default selection **N - NO**.
6. Move to the **Begin Date** field and enter the date the record is being created. Leave the **End Date** field blank.
7. Move to the **Authorizing Agent** field and enter **STAR+PLUS**.
8. Leave the **Agency** field at the default selection **324 - DHS**.
9. Move to the **Name** field and enter the **PSU/OC staff's name**.
10. Move to the **Phone** field and enter the **telephone number of the** authorizing agent. Enter the area code, phone number and extension.
11. Move to the **Mail Code** field and enter the appropriate Managed Care Organization (**MCO**) Plan Code from the table below. **Note:** Six service areas include Medicare-Medicaid Plans (MMP).

<b>MCO Plan Name</b>	<b>Service Area</b>	<b>MCO Plan Code</b>
Amerigroup	<b>Bexar</b>	45
Molina	<b>Bexar</b>	46
Superior	<b>Bexar</b>	47
Amerigroup MMP	<b>Bexar</b>	4F
Molina MMP	<b>Bexar</b>	4G

<b>MCO Plan Name</b>	<b>Service Area</b>	<b>MCO Plan Code</b>
Superior MMP	<b>Bexar</b>	4H
Molina	<b>Dallas</b>	9F
Superior Health Plan	<b>Dallas</b>	9H
Molina MMP	<b>Dallas</b>	9J
Superior MMP	<b>Dallas</b>	9K
Amerigroup	<b>El Paso</b>	34
Molina	<b>El Paso</b>	33
Amerigroup MMP	<b>El Paso</b>	3G
Molina MMP	<b>El Paso</b>	3H
Amerigroup	<b>Harris</b>	7P
United Healthcare	<b>Harris</b>	7R
Molina	<b>Harris</b>	7S
Amerigroup MMP	<b>Harris</b>	7Z
United Healthcare MMP	<b>Harris</b>	7Q
Molina MMP	<b>Harris</b>	7V
Cigna-HealthSpring	<b>Hidalgo</b>	H7
Molina	<b>Hidalgo</b>	H6
Superior	<b>Hidalgo</b>	H5
Cigna-HealthSpring MMP	<b>Hidalgo</b>	H8
Molina MMP	<b>Hidalgo</b>	H9
Superior MMP	<b>Hidalgo</b>	HA
Amerigroup	<b>Jefferson</b>	8R
United Healthcare	<b>Jefferson</b>	8S
Molina	<b>Jefferson</b>	8T
Amerigroup	<b>Lubbock</b>	5A
Superior	<b>Lubbock</b>	5B
Superior	<b>Medicaid Rural Service Area (RSA) Central Texas</b>	C4
United Healthcare	<b>Medicaid Rural Service Area (RSA) Central Texas</b>	C5
Cigna-HealthSpring	<b>Medicaid RSA Northeast Texas</b>	N3
United Healthcare	<b>Medicaid RSA Northeast Texas</b>	N4
Amerigroup	<b>Medicaid RSA West Texas</b>	W5
Superior	<b>Medicaid RSA West Texas</b>	W6
United Healthcare	<b>Nueces</b>	85
Superior Health Plan	<b>Nueces</b>	86
Amerigroup	<b>Tarrant</b>	69
Cigna-HealthSpring	<b>Tarrant</b>	6C
Amerigroup MMP	<b>Tarrant</b>	6F

MCO Plan Name	Service Area	MCO Plan Code
Cigna-Healthspring MMP	Tarrant	6G
Amerigroup	Travis	19
United Healthcare	Travis	18

12. Select the **Save** button.

### 9130 Service Plan

The **Service Plan** record is used to register an Individual Service Plan (ISP) for an SPW member. The record includes the annual SPW ISP cost limit based on the member's Resource Utilization Group (**RUG**) **value** and the **total estimated cost of SPW services** taken from the member's [Form H1700-1](#), Individual Service Plan *for individuals who do not have an electronic ISP*.

*If the Individual Service Plan (ISPs) is electronic, the Long Term Care (LTC) portal automatically generates service plan records in the Service Authorization System (SAS). PSU does not register service plan records for electronic ISPs. PSU confirms the service plan registration in SAS, takes a screenshot, and posts the screenshot to HHS Enterprise Administrative Report and Tracking System (HEART)*

#### **To register a service plan for an SPW applicant whose ISP is posted to TxMedCentral:**

1. Select the **Service Plan** area in the **Program and Service** Functional area.
2. Select **Add** and a blank **Service Plan Details** record will appear.
3. Leave the **Type** field at the default selection **AN - ANNUAL PLAN**.
4. Move to the **Service Group** field and select **19 - STAR+PLUS** from the drop-down menu.
5. Move to the **Ceiling** field and enter the **annual SPW ISP cost ceiling** for the **RUG value** entered on the **Level of Service** record. For an SPW member who is **ventilator**-dependent, enter the **annual SPW ISP cost limit** based on the **RUG** value and **ventilator use** of the member (6-23 hours or 24 hours continuous).
6. Move to the **Begin Date** field and enter the effective date of the **ISP coverage period**.
7. Move to the **End Date** field and enter the last day of the **ISP coverage period**.
8. Move to the **Amount Authorized** field and enter the **total estimated cost** of all SPW services authorized for the current **ISP coverage period**, from **Form H1700-1**.
9. Leave the **Amount Paid** field at the default setting of **0.00**.
10. Leave the **Units Authorized** field at the default of **0.00**.
11. Leave the **Units Paid** field at the default of **0.00**.
12. Select the **Save** button.

## 9140 Service Authorization

*If the Individual Service Plan (ISPs) is electronic, the Long Term Care (LTC) portal automatically generates service authorization records in the Service Authorization System (SAS). PSU does not register service authorization records for electronic ISPs. PSU confirms service authorization registration in SAS, takes a screenshot, and posts the screenshot to HHS Enterprise Administrative Report and Tracking System (HEART).*

Program Support Unit (PSU) staff create one service authorization record for STAR+PLUS Waiver (SPW) eligibility *for individuals who do not have an electronic ISP.*

### **To register a service authorization record for initial SPW eligibility for a member whose ISP is posted to TxMedCentral:**

1. Select the **Service Authorization** area in the **Program and Service** Functional area.
2. Select **Add** and a blank **Service Authorization Details** record will appear.
3. Move to the **Service Group** field and select **19 - STAR+PLUS** from the drop-down menu.
4. Move to the **Service Code** field and select **12 – CASE MANAGEMENT** from the drop-down menu.
5. Leave the **Fund** and **Term. Code** fields at the defaults.
6. Leave the **Agency** field at the default selection **324 - DHS**.
7. Move to the **Unit Type** field and select **2 – MONTH** from the drop-down menu.
8. Move to the **Units** field and enter **1.00**.
9. Leave the **Amount** field at the default.
10. Move to the **Begin Date** field and enter the effective date of the **ISP coverage period**.
11. Move to the **End Date** field and enter the last day of the **ISP coverage period**.
12. Move to the **Contract No** field and enter the appropriate contract number of the **MCO**. Use the following chart to determine the correct contract number. **Note:** Six service areas include Medicare-Medicaid Plans (MMP).

<b>MCO</b>	<b>Service Area</b>	<b>Contract Number</b>
Molina	Bexar	1014430
Molina MMP	Bexar	1026341
Molina	Harris	1014431
Molina MMP	Harris	1026344
Molina	Jefferson	1019598
Molina	Dallas	1018980
Molina MMP	Dallas	1026342
Molina	El Paso	1019987
Molina MMP	El Paso	1026343
Molina	Hidalgo	1019988
Molina MMP	Hidalgo	1026345
Superior	Bexar	1014433

<b>MCO</b>	<b>Service Area</b>	<b>Contract Number</b>
Superior MMP	Bexar	1026337
Superior	Nueces	1014434
Superior	Dallas	1018981
Superior MMP	Dallas	1026338
Superior	Hidalgo	1019985
Superior MMP	Hidalgo	1026339
Superior	Lubbock	1019986
Superior	Medicaid Rural Service Area (RSA) Central	1025731
Superior	Medicaid RSA West	1025730
United Healthcare	Harris	1014435
United Healthcare MMP	Harris	1026334
United Healthcare	Jefferson	1019600
United Healthcare	Medicaid RSA Central	1025732
United Healthcare	Medicaid RSA Northeast	1025734
United Healthcare	Nueces	1014437
United Healthcare	Travis	1014438
Amerigroup	Bexar	1014439
Amerigroup MMP	Bexar	1026326
Amerigroup	Harris	1014440
Amerigroup MMP	Harris	1026331
Amerigroup	Jefferson	1019599
Amerigroup	Travis	1014442
Amerigroup	El Paso	1019979
Amerigroup MMP	El Paso	1026328
Amerigroup	Lubbock	1019983
Amerigroup	Medicaid RSA West	1025729
Amerigroup	Tarrant	1018977
Amerigroup MMP	Tarrant	1026332
Cigna-HealthSpring	Tarrant	1018979
Cigna-HealthSpring MMP	Tarrant	1026333
Cigna-HealthSpring	Hidalgo	1019984
Cigna-HealthSpring MMP	Hidalgo	1026335
Cigna-HealthSpring	Medicaid RSA Northeast	1025733

13. The **NPI** field is read-only.

14. Select the **Save** button.

### 9230 Service Plan – Reassessment

A new **Service Plan** record must be created to register the **RUG cost level** and the **amount of services** authorized for the new **ISP** year.

*If the Individual Service Plan (ISPs) is electronic, the Long Term Care (LTC) portal automatically generates service authorization records in the Service Authorization System (SAS). PSU does not register service authorization records for electronic ISPs. PSU confirms service authorization registration in SAS, takes a screenshot, and posts the screenshot to HHS Enterprise Administrative Report and Tracking System (HEART).*

**To register a service plan for a new ISP year for SPW members whose individual service plan(ISP) has been posted to TxMedCentral:**

1. Select the **Service Plan** area in the **Program and Service** Functional area.
2. Select **Add** and a blank **Service Plan Details** record will appear.
3. Leave the **Type** field at the default selection **AN-ANNUAL PLAN**.
4. Move to the **Service Group** field and select **19 - STAR+PLUS** from the drop-down menu.
5. Move to the **Ceiling** field and enter the **annual SPW ISP cost limit** for the **RUG value** entered on the **Level of Service** record.
6. **Note:** For a member who uses a ventilator, enter the **annual SPW ISP cost limit** based on the **RUG value** and **ventilator use** of the member (6-23 hours or 24 hours continuous).
7. Move to the **Begin Date** field and enter the **effective date** of the **new ISP** year.
8. Move to the **End Date** field and enter the last day of the **new ISP** year.
9. Move to the **Amount Authorized** field and enter the **total estimated cost** of all SPW services authorized for the **new ISP** year.
10. Leave the **Amount Paid** field at the default setting of **0.00**.
11. Leave the **Units Authorized** field at the default of **0.00**.
12. Leave the **Units Paid** field at the default of **0.00**.
13. Select the **Save** button.

## **9240 Service Authorization – Reassessment**

If the **MCO** posts a timely reassessment packet, PSU staff creates one service authorization record for **SPW eligibility** for the **new ISP year**. To ensure there is no gap in service, the **Begin Date** of the authorization for the new ISP year is the day after the **End Date** of the previous **ISP** year.

*If the Individual Service Plan (ISPs) is electronic, the Long Term Care (LTC) portal automatically generates service authorization records in the Service Authorization System (SAS). PSU does not need to register service authorization records for electronic ISPs. PSU confirms service authorization registration in SAS, takes a screenshot, and posts the screenshot to HHS Enterprise Administrative Report and Tracking System (HEART).*

If the **MCO** does not post a timely reassessment packet, two service authorization records will be required for **SPW eligibility**. The first service authorization record for SPW eligibility will be entered with **SG 19/SC 13** for the month(s) for which the ISP was late. The second service authorization record for SPW eligibility will be entered **with SG 19/SC 12** for the remaining ISP period.

**To enter a service authorization record for a timely reassessment for SPW:**

1. Select the **Service Authorization** area in the **Program and Service** Functional area.
2. Select **Add** and a blank **Service Authorization Details** record will appear.
3. Move to the **Service Group** field and select **19 - STAR+PLUS** from the drop-down menu.
4. Move to the **Service Code** field and select **12 – CASE MANAGEMENT** from the drop-down menu.
5. Leave the **Fund** and **Term. Code** fields at the defaults.
6. Leave the **Agency** field at the default selection **324 - DHS**.
7. Move to the **Unit Type** field and select **2 – MONTH** from the drop-down menu.
8. Move to the **Units** field and enter **1.00**.
9. Leave **Amount** field at the default.
10. Move to the **Begin Date** field and enter the effective date of the **new ISP coverage period**.
11. Move to the **End Date** field and enter the last day of the **new ISP coverage period**.
12. Move to the **Contract No.** field and enter the appropriate contract number of the **MCO**. Use the following chart to determine the correct contract number. **Note:** Six service areas include Medicare-Medicaid Plans (MMP).

<b>MCO</b>	<b>Service Area</b>	<b>Contract Number</b>
Molina	Bexar	1014430
Molina MMP	Bexar	1026341
Molina	Harris	1014431
Molina MMP	Harris	1026344
Molina	Jefferson	1019598
Molina	Dallas	1018980
Molina MMP	Dallas	1026342
Molina	El Paso	1019987
Molina MMP	El Paso	1026343
Molina	Hidalgo	1019988
Molina MMP	Hidalgo	1026345
Superior	Bexar	1014433
Superior MMP	Bexar	1026337
Superior	Nueces	1014434
Superior	Dallas	1018981
Superior MMP	Dallas	1026338
Superior	Hidalgo	1019985

<b>MCO</b>	<b>Service Area</b>	<b>Contract Number</b>
Superior MMP	Hidalgo	1026339
Superior	Lubbock	1019986
Superior	Medicaid Rural Service Area (RSA) Central	1025731
Superior	Medicaid RSA West	1025730
United Healthcare	Harris	1014435
United Healthcare MMP	Harris	1026334
United Healthcare	Jefferson	1019600
United Healthcare	Medicaid RSA Central	1025732
United Healthcare	Medicaid RSA Northeast	1025734
United Healthcare	Nueces	1014437
United Healthcare	Travis	1014438
Amerigroup	Bexar	1014439
Amerigroup MMP	Bexar	1026326
Amerigroup	Harris	1014440
Amerigroup MMP	Harris	1026331
Amerigroup	Jefferson	1019599
Amerigroup	Travis	1014442
Amerigroup	El Paso	1019979
Amerigroup MMP	El Paso	1026328
Amerigroup	Lubbock	1019983
Amerigroup	Medicaid RSA West	1025729
Amerigroup	Tarrant	1018977
Amerigroup MMP	Tarrant	1026328
Cigna-HealthSpring	Tarrant	1018979
Cigna-HealthSpring MMP	Tarrant	1026333
Cigna-HealthSpring	Hidalgo	1019984
Cigna-HealthSpring MMP	Hidalgo	1026335
Cigna-HealthSpring	Medicaid RSA Northeast	1025733

13. The **NPI** field is read-only.

14. Select the **Save** button.

**To enter a service authorization record for an untimely reassessment for SPW eligibility for a member whose ISP is not electronic:**

1. Select the **Service Authorization** area in the **Program and Service** Functional area.
2. Select **Add** and a blank **Service Authorization Details** record will appear.
3. Move to the **Service Group** field and select **19 - STAR+PLUS** from the drop-down menu.
4. Move to the **Service Code** field and select **13 – NURSING SERVICES** from the drop-down menu.
5. Leave the **Fund** and **Term. Code** fields at the defaults.
6. Leave the **Agency** field at the default selection **324 - DHS**.

7. Move to the **Unit Type** field and select **4-PER AUTHORIZATION** from the drop-down menu.
8. Move to the **Units** field and enter **1.00**.
9. Leave **Amount** field at the default.
10. Move to the **Begin Date** field and enter the effective date of the **new ISP coverage period**.
11. Move to the **End Date** field and enter the last day of the month the packet was received.
12. Move to the **Contract No.** field and enter the appropriate contract number of the **MCO**. Use the following chart to determine the correct contract number contained in the preceding table. **Note:** Six service areas include MMP.

### **9310 Transfers from One STAR+PLUS Area to Another STAR+PLUS Area**

There are two different situations that can occur when a STAR+PLUS member transfers from one service area to another service area. The first is when a member transfers to a new service area that his or her **current MCO** also serves, and he or she wants to stay with that MCO. Even though he or she is staying with the same MCO, the contract number will change and his records will need to be closed under the previous contract number and opened under the new contract number. The second is when the member **changes MCOs** in the new service area.

*If the member's Individual Service Plan (ISP) is electronic and the member made a new MCO selection timely, the Texas Integrated Eligibility Registration System updates Long Term Care portal, which automatically closes the registration for the losing MCO and creates the registration for the gaining MCO in the Service Authorization System. If the member's plan change is not timely, PSU follow existing policy, stated below.*

To process the transfer the **losing** PSU staff close the existing **Authorizing Agent** and **Service Authorization (SC 12)** records. The **gaining** PSU staff open a new **Service Authorization** record (**SC 12**) using the **MCO contract number** in the new service area.

#### **To close the authorizing agent record:**

1. Open the SPW member's case in SAS.
2. Select the **Authorizing Agent** area from the **Case Worker** Functional area.
3. Select the check box for the **Authorizing Agent** record you wish to close.
4. Select the **Modify** button to open and modify.
5. Move to the **End Date** field and enter the *effective date of the termination which is the last day of the month in which the member was enrolled in the losing MCO*.
6. Select the **Save** button.

#### **To close the service authorization record:**

1. Select the **Service Authorization** area in the **Program and Service** Functional area.

2. Select the check box for the appropriate **Service Authorization** (SC 12) record you wish to close.
3. Select the **Modify** button to open and modify.
4. Move to the **End Date** field; *the end date field of the new authorizing agent record remains blank; the end date for the service plan and service authorization records is the last day of the ISP coverage period.*
5. Move to the **Termination Code** field and select “**23 - Transferred to another service**” (or the appropriate code) from the drop-down menu.
6. Select the **Save** button.
7. Select **Submit to SAS**.
8. Select **Outbox** and then **Inbox** to ensure the case processed accurately.

Once the gaining PSU staff verify the month in which the member moves to the new service area, he is responsible for opening the **Authorizing Agent** and **Service Authorization (SC 12)** records necessary to authorize SPW services in the new service area.

The **Service Authorization** records are opened according to procedures outlined in **Initial Service Authorizations** for SPW members with the following exceptions:

- The **Begin Date** for these records is the first day of the month following the month the member moved to the new service area.
- The **End Date** for the Service Authorization (SC 12) record is the same as the current ISP period.

**Example:** If an SPW member with an ISP period of Nov. 1, 2016 to Oct. 31, 2017 transfers to another STAR+PLUS service area on Jan. 15, 2016, the End Date for these records remains Oct. 31, 2017.

### **9320 Transfers from One MCO to Another MCO in the Same Service Area**

*If the member's Individual Service Plan (ISP) is electronic and the member made a new MCO selection timely, the Texas Integrated Eligibility Registration System updates Long Term Care portal, which automatically closes the registration for the losing MCO and creates the registration for the gaining MCO in the Service Authorization System. If the member's plan change is not timely, PSU follow existing policy, stated below.*

The Program Support Unit (PSU) processes the request by closing the existing Service Authorization record (SC 12) for the losing MCO and creating a new Service Authorization record (SC 12) for the gaining MCO.

#### **To close the existing service authorization records:**

1. Move to the **Service Authorization** area in the **Program and Service** Functional area.
2. Select the check box for the appropriate **Service Authorization** record you wish to close.
3. Select the **Modify** button.

4. Move to the **End Date** field and enter the *effective date of the termination which is the last day of the month in which the member was enrolled in the losing MCO.*
5. Move to the **Termination Code** field and select “**39 – Other**” (or the appropriate code) from the drop-down menu.
6. Select the **Save** button.
7. Select **Submit to SAS**.
8. Select **Outbox** and then **Inbox** to ensure the case processed accurately.

**To create a new service authorization record for the new MCO:**

1. Select the **Service Authorization** area in the **Program and Service** Functional area.
2. Select **Add** and a blank **Service Authorization Details** record will appear.
3. Move to the **Service Group** field and select **19 - STAR+PLUS** from the drop-down menu.
4. Move to the **Service Code** field and select **12 – CASE MANAGEMENT** from the drop-down menu.
5. Leave the **Fund** and **Term. Code** fields at the defaults.
6. Leave the **Agency** field at the default selection **324 - DHS**.
7. Move to the **Unit Type** field and select **2 – MONTH** from the drop-down menu.
8. Move to the **Units** field and enter **1.00**.
9. Leave the **Amount** field at the default.
10. Move to the **Begin Date** field and enter the new *MCO contract number/ plan code enrollment date.*
11. Move to the **End Date** field; *the end date field of the new authorizing agent record remains blank; the end date for the service plan and service authorization records is the last day of the ISP coverage period.*
12. Move to the **Contract No.** field and enter the appropriate contract number of the MCO. Use the following chart to determine the correct contract number. **Note:** Six service areas include Medicare-Medicaid Plans (MMP).

<b>MCO</b>	<b>Service Area</b>	<b>Contract Number</b>
Molina	Bexar	1014430
Molina MMP	Bexar	1026341
Molina	Harris	1014431
Molina MMP	Harris	1026344
Molina	Jefferson	1019598
Molina	Dallas	1018980
Molina MMP	Dallas	1026342
Molina	El Paso	1019987
Molina MMP	El Paso	1026343
Molina	Hidalgo	1019988
Molina MMP	Hidalgo	1026345
Superior	Bexar	1014433

<b>MCO</b>	<b>Service Area</b>	<b>Contract Number</b>
Superior MMP	Bexar	1026337
Superior	Nueces	1014434
Superior	Dallas	1018981
Superior MMP	Dallas	1026338
Superior	Hidalgo	1019985
Superior MMP	Hidalgo	1026339
Superior	Lubbock	1019986
Superior	Medicaid Rural Service Area (RSA) Central	1025731
Superior	Medicaid RSA West	1025730
United Healthcare	Harris	1014435
United Healthcare MMP	Harris	1026334
United Healthcare	Jefferson	1019600
United Healthcare	Medicaid RSA Central	1025732
United Healthcare	Medicaid RSA Northeast	1025734
United Healthcare	Nueces	1014437
United Healthcare	Travis	1014438
Amerigroup	Bexar	1014439
Amerigroup MMP	Bexar	1026326
Amerigroup	Harris	1014440
Amerigroup MMP	Harris	1026331
Amerigroup	Jefferson	1019599
Amerigroup	Travis	1014442
Amerigroup	El Paso	1019979
Amerigroup MMP	El Paso	1026328
Amerigroup	Lubbock	1019983
Amerigroup	Medicaid RSA West	1025729
Amerigroup	Tarrant	1018977
Amerigroup MMP	Tarrant	1026332
Cigna-HealthSpring	Tarrant	1018979
Cigna-HealthSpring MMP	Tarrant	1026333
Cigna-HealthSpring	Hidalgo	1019984
Cigna-HealthSpring MMP	Hidalgo	1026335
Cigna-HealthSpring	Medicaid RSA Northeast	1025733

13. The **NPI** field is read-only.
14. Select the **Save** button.
15. Select **Submit to SAS**.
16. Select **Outbox** and then **Inbox** to ensure the case processed accurately.

## **Section 9480, Money Follows the Person (MFP) Demonstration for an SPW Applicant**

At this time, the option to electronically submit an Individual Service Plan for a nursing facility resident is not available. MCOs must not use the Long Term Care portal MFPD check box. PSU continues to manually register this fund code in the Service Authorization System.

### **9700 Terminations**

If a member's Individual Service Plan (ISP) was created in the Long Term Care (LTC) portal, the Program Support Unit will terminate the ISP in the portal. Once this is completed and processed successfully, the service plan and service authorization records automatically close effective on the "to date" of the ISP.

The **Enrollment** and **Service Authorization** records must be **closed** in SAS when all services for an existing SPW member are terminated. When enrollment is terminated, the authorizing agent has to manually terminate each SPW service authorization record.

### **9710 Terminating All Services**

If a member's Individual Service Plan (ISP) was created through the Long Term Care (LTC) portal and is in "processed/complete" or "PSU processed/complete" status, PSU terminates the ISP through the LTC portal if the termination date precedes the ISP "to date". Once PSU selects the "Terminate ISP" option, the "to date" and "ISP Termination Reason" fields are activated. PSU selects the new "to date" (the termination date) and the termination reason, then clicks "submit to the Service Authorization System (SAS)". The LTC portal ends SAS service plan and service authorization records effective the amended ISP 'to date'.

### **To terminate all services for an existing SPW member whose ISP is not electronic:**

1. Search for the member's SPW case and open the file.
2. Move to **Programs and Services** Functional area and select **Enrollment** area.
3. Select the check box for the existing **Enrollment** record.
4. Select the **Modify** button.
5. Move to the **End Date** field and enter the effective date of the termination.
6. Move to the **Termination Code** field and select the appropriate code from the drop-down menu.
7. Select the **Save** button.
8. Next, open the **Service Authorization** (SC 12) records from this area to close any open records.
9. Select the check box for any open records.
10. Select the **Modify** button.
11. Move to the **End Date** field of each record and enter the effective date of the termination.

12. Move to the **Termination Code** field of each record and select the appropriate code from the drop-down menu.
13. Select the **Save** button.
14. **Submit** the records.

It is not necessary to close all the existing records for an SPW service authorization (Medical Necessity/Applied Income, if applicable/Level of Service) unless the member will be transferred to another service group. However, PSU staff can close all these records as well, using the effective date of termination in the End Date fields. If the SPW member will be transferred to another service group or if he reapplies when these records are still valid, all the existing records for SPW services must be closed using the effective date of termination in the End Date fields.

If you have any questions regarding this memorandum, you may contact Amanda Dillon at 512-462-6396 or [amanda.dillon@hhsc.state.tx.us](mailto:amanda.dillon@hhsc.state.tx.us).