



COMMISSIONER
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June 5, 2014

To: Deaf Blind with Multiple Disabilities Program Providers
Financial Management Services Agencies

Subject: Information Letter 14-26
Maintaining Continuously Current Waiver Program Eligibility

The purpose of this Information Letter (IL) is to provide information and recommendations for Deaf Blind with Multiple Disabilities (DBMD) program providers regarding maintaining 1) continuously current level of care (LOC) authorizations through approved Intellectual Disability/Related Conditions (ID/RC) forms, 2) continuously current service authorizations through approved Individual Plans of Care (IPCs), and 3) continuously current financial eligibility for all individuals enrolled in the DBMD program. Financial Management Services Agencies (FMSAs) are included on this IL for informational purposes only.

As described in [IL 14-04](#), the Health and Human Services Commission (HHSC) is expanding the State of Texas Access Reform Plus (STAR+PLUS) program to include the provision of basic health services (acute care) to individuals receiving long-term services and supports (LTSS) through the DBMD program. Acute care includes services such as doctor visits, hospital or emergency room services, and prescription medications. Effective September 1, 2014, individuals enrolled in the DBMD program will begin receiving their acute care services from managed care organizations (MCOs) through the STAR+PLUS program with the following exceptions:

- **Excluded:** Individuals residing in state supported living centers and individuals receiving both Medicaid and Medicare Part B benefits are not included in this expansion.
- **Voluntary:** Individuals 20 years of age or younger who receive Supplemental Security Income (SSI) or SSI-related services may choose to continue receiving acute care services through traditional Medicaid or enroll in STAR+PLUS for acute care services.

For MCOs to determine and maintain DBMD individuals' eligibility for acute care services through STAR+PLUS, individuals must have authorized LOCs and authorized IPCs for the DBMD program. Individuals must also have a current certification of Medicaid financial eligibility for the DBMD program as determined by HHSC.

Lapses in individuals' LOC or IPC authorizations or loss of financial eligibility for the DBMD program may result in individuals not being eligible to enroll in or maintain eligibility for acute care services through the STAR+PLUS program. This would put individuals at risk of being unable to access needed services, such as doctor visits, hospital or emergency room services, and prescription medications. Therefore, it is important that DBMD program providers make every effort to ensure that individual's LOC authorizations, IPC authorizations, and financial eligibility for the DBMD program are current and remain continuously current with no lapses in coverage. Although processes currently exist in the DBMD program for program providers to request

coverage of an LOC authorization lapse by submitting a Purpose Code E ID/RC, DBMD program providers should review and, if necessary, revise their internal business processes to avoid the need to submit a Purpose Code E ID/RC by ensuring timely submission of renewal packets (ID/RCs and IPCs) and preventing lapses in LOC or IPC authorizations.

DBMD program providers are also encouraged to actively monitor statuses of individuals' financial eligibility for the DBMD program and, in particular, to keep track of Medicaid redetermination dates for those individuals who are required to submit annual Medicaid redetermination packets to HHSC. DBMD program providers should assist individuals, their legally authorized representatives (LARs), and authorized representatives (ARs) with redetermination activities to prevent individuals' loss of financial eligibility for the DBMD program. Refer to the "*Requirement to Maintain Continuously Current Financial Eligibility for DBMD*" section of this letter for more information.

Requirement to Maintain Continuously Current LOC Authorizations for DBMD

The Department of Aging and Disability Services (DADS) rule at Texas Administrative Code (TAC), Title 40, Section 42.223 requires DBMD program providers to submit renewal ID/RC forms to DADS within 10 business days after the date of service planning team (SPT) meetings but at least 30 calendar days before the expiration date of the individuals' ID/RC.

Requirement to Maintain Continuously Current IPC Authorizations for DBMD

DADS rule at 40 TAC Section 42.223 requires DBMD program provider case managers to meet with SPTs to review IPCs at least annually, but within 90 calendar days before the end of the IPC. Section 42.223 also requires DBMD program providers to submit copies of the completed renewal IPCs to DADS within 10 business days after the date of the SPT meeting but at least 30 calendar days before the end of the current IPC.

To allow sufficient time for ID/RC and IPC processing timeframes, DBMD program providers are encouraged to submit renewal packets (ID/RCs and IPCs) as close to 90 calendar days before the expiration dates as possible to avoid lapses in LOC and IPC authorizations.

Requirement to Maintain Continuously Current Financial Eligibility for DBMD

DADS rule at 40 TAC Section 42.201 requires all individuals enrolled in the DBMD program maintain financial eligibility for the DBMD program.

Individuals enrolled in the DBMD program who receive SSI benefits from the Social Security Administration (SSA) are categorically eligible for SSI Medicaid. Annual redeterminations for Medicaid eligibility through HHSC are not required for these individuals. However, individuals or their representative payees must work with the SSA to maintain their SSI benefits and ensure continued eligibility for SSI Medicaid through HHSC to remain financially eligible for the DBMD program. Individuals or their representative payees must maintain current mailing addresses with the SSA. If individuals lose their eligibility for SSI benefits through the SSA, individuals will also lose his or her eligibility for SSI Medicaid. If individuals lose eligibility for SSI Medicaid, DBMD program providers should assist individuals, LARs, or ARs with submitting Medicaid applications to HHSC.

For all other individuals enrolled in the DBMD program, HHSC requires annual redeterminations of Medicaid eligibility. Individuals or their ARs may call 2-1-1 to find out their Medicaid redetermination due date. HHSC mails Medicaid redetermination packets to the individuals' last known mailing addresses at least 60 calendar days in advance of their redetermination due date. Individuals or ARs must maintain current mailing addresses with HHSC. DBMD program providers are encouraged to actively monitor Medicaid redetermination dates for these individuals and contact individuals, LARs, or ARs before the redetermination due dates to offer assistance with submission of Medicaid redetermination packets to HHSC to prevent loss of financial eligibility for the DBMD program.

DADS recommends DBMD program providers educate individuals, LARs, and ARs about the importance of maintaining financial eligibility for the DBMD program and frequently remind them to contact their DBMD program provider for assistance regarding any communication they receive from HHSC about their Medicaid eligibility or from the SSA about their SSI benefits.

Recommendations to avoid lapses in LOC authorizations, IPC authorizations, and loss of financial eligibility for DBMD

Listed in this section are possible organizational strategies in DBMD program providers could implement to prepare for the upcoming STAR+PLUS acute care expansion.

1. Develop a tracking method, such as a spreadsheet, to record ID/RC and IPC expiration dates for individuals served in your program. Use this tracking method to begin working on renewal documents well ahead of the expiration dates and submit renewals in sufficient time to avoid a lapse (up to 90 calendar days before the expiration date).
2. Attempt to schedule SPT meetings well in advance to account for difficulty in coordinating schedules for all required attendees. Encourage individuals, LARs, and ARs to avoid delaying SPT meetings to prevent a potential negative impact on individuals' Medicaid acute care eligibility.
3. When submitting renewal packets (ID/RC and IPC) to DADS for review, conduct thorough quality checks before sending the packets. Make sure all of the necessary documentation is included in the submission to avoid the need for DADS to request additional information before making authorization determinations. When DBMD program providers receive requests for additional information from DADS, providers must respond as quickly as practicable, ensuring a return of all information requested in their response.
4. For individuals enrolled in the DBMD program who receive SSI Medicaid, frequently remind individuals or their representative payees to notify you of any communication they receive from the SSA regarding their SSI benefits. Offer to assist with submission of requested information or documentation to the SSA before the deadline to maintain individuals' SSI benefits and to avoid the loss of financial eligibility.
5. For individuals enrolled in the DBMD program who are not receiving SSI Medicaid, develop a tracking method, such as a spreadsheet, to monitor Medicaid redetermination due dates for individuals served in your program. Using this tracking method, inform individuals, their LARs, or ARs that they should notify you of any communication they receive from HHSC regarding their Medicaid eligibility. Offer to assist with completing Medicaid redetermination packets and ensuring submission to HHSC before the deadline.

6. DADS rule at 40 TAC Section 42.407 requires DBMD program providers to subscribe to receive email alerts and notifications when DADS publishes information regarding the DBMD program. DADS recommends that DBMD program provider staff with responsibilities related to ID/RC renewals, IPC renewals, or monitoring of financial eligibility, to subscribe to receive email alerts and notifications when DADS publishes information regarding the DBMD program. There is no cost for subscribing and no limit to the number of staff who may subscribe. To subscribe, go to <https://public.govdelivery.com/accounts/TXHHSC/subscriber/new>.

DADS reminds DBMD program providers of their obligation to comply with DADS rules, provider manuals, and provider communications, including provider ILs and policy clarifications.

More information and resources regarding the expansion of Medicaid managed care is available on HHSC Medicaid managed care initiatives website at <http://www.hhsc.state.tx.us/medicaid/managed-care/mmc.shtml>. This website can also be accessed directly from the DADS DBMD program page at <http://www.dads.state.tx.us/providers/DBMD/index.cfm>. From this page, click on the STAR+PLUS (HHSC) navigation button on the left of the screen, then “STAR+PLUS Medicaid Managed Care Initiatives.”

DADS is developing additional resources to provide information about the importance of avoiding lapses in LOC and IPC authorizations and loss of financial eligibility for the waiver programs. These resources may include alerts, webinars, trainings, an electronic frequently asked questions document, and other stakeholder forums.

Please send questions related to this IL to the DBMD mailbox at dbmd@dads.state.tx.us.

Sincerely,

[signature on file]

Elisa J. Garza
Assistant Commissioner
Access and Intake

[signature on file]

Donna Jessee
Director
Center for Policy and Innovation