UNIFORM MANAGED CARE MANUAL
16.5 Service Coordination and Assessment Requirements When Using Telecommunications

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	2.0	July 1, 2023	[Initial version Uniform Managed Care Manual Chapter 16.5, "SERVICE COORDINATION AND ASSESSMENT REQUIREMENTS WHEN USING TELECOMMUNICATIONS." Chapter 16.5 applies to MCOs administering the STAR, CHIP, STAR+PLUS, STAR+PLUS Medicare-Medicaid Dual Demonstration, STAR Health, and STAR Kids programs.
Revision			

1. Status should be represented as "Baseline" for initial issuances and "Revision" for changes to the Baseline version.
2. Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., "2.2" refers to the first version of the document and the second revision.
3. Brief description of the changes to the document made in the revision.

Contents

PURPOSE

The purpose of this chapter is to provide additional details related to the use of Telecommunications in managed care. This chapter also describes service coordination and assessment requirements when using Telecommunications, including privacy-related requirements and documentation of Member consent. This chapter also clarifies that MCOs must adhere to contract requirements for Telemedicine and Telehealth, including provisions requiring MCOs to conduct outreach to and conduct trainings for Providers to encourage and support them in offering Telemedicine, Telehealth and Telemonitoring.

STATUTORY AND REGULATORY AUTHORITY

Statutory and regulatory authority for this chapter includes, without limitation:

- Tex. Gov't Code § 533.039
- 1 Tex. Admin. Code § 353, Subchapter R, Telecommunications in Managed Care Service Coordination and Assessments
- 1 Tex. Admin. Code § 354.1430
- Tex. Gov't Code § 531.0216 and § 531.02161 (a), (c), and (d).
- Tex. Health & Safety Code § 62.1571 (CHIP)
- 1 Tex. Admin. Code § 353.7(d)
- Health Insurance Portability and Accountability Act (HIPAA) and all other relevant privacy and security laws relevant to communicating protected information with Members.

Medicaid MCOs have a contractual obligation to adhere to 1 Tex. Admin. Code § 353, Subchapter R, regarding Telecommunications in Managed Care Service Coordination and Assessments and all applicable contract provisions.

The definitions of Audio-only, Audio-visual, Face-to-face, Telecommunication, information technology, and telephonic have the meanings detailed in 1 Tex. Admin. Code § 353, Subchapter R.

Telehealth service and Telemedicine medical service have the meanings specified at Tex. Gov't Code § 531.001 (7) and (8).

For this chapter, "teleservices" means Telehealth, Telemedicine, and Telemonitoring, collectively.

INFORMATIONAL RESOURCES

- Uniform Managed Care Contract (UMCC), including:
  - 8.1.31 Telemedicine, Telehealth, Telepharmacy, and Telemonitoring Access
    - 8.1.31.1 School-based Telemedicine Services
  - 8.1.12 Services for Members with Special Health Care Needs
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- STAR Health Contract Terms
  - 4.3.11 Service Management and Service Coordination
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- STAR Kids Contract Terms
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  - 8.1.39 STAR Kids Initial Screening and Assessment Process
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- STAR+PLUS General Contract (Expansion Contract)
  - 8.1.34 Service Coordination
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  - 8.1.34.9 Service Coordination Using Telecommunications
  - 8.1.35.2 HCBS STAR+PLUS Waiver
  - 8.1.51 Telemedicine, Telehealth, Telepharmacy and Telemonitoring Access
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- STAR+PLUS Medicare-Medicaid Plan (MMP)
  - 2.5.4 Service Coordination Team Responsibilities
  - 2.6.2 Comprehensive Health Risk Assessments

- STAR+PLUS Medicaid Rural Service Area (MRSA) Contract Terms and Conditions
  - 8.1.34.9 Service Coordination Using Telecommunication

- 8.1.36 Service Coordination
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- 8.1.37.2 HCBS STAR+PLUS Waiver
- 8.1.52 Telemedicine, Telehealth, Telepharmacy and Telemonitoring Access
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- CHIP Rural Service Area MCO RFP, General Contract Terms & Conditions
  - 8.1.3.5 Telemedicine, Telehealth, and Telepharmacy
  - 8.1.12 Services for Members with Special Health Care Needs
    - 8.1.12.4 Service Plan and the Use of Telecommunication

- UMCM Chapter 16.1.30 MCO Text Message and Email Policy

BACKGROUND: SB 670 (86th R.S.) AND HB 4 (87th R.S.) REQUIREMENTS

SB 670, 86th Legislature, 2019, amended the Texas Government Code at Section 531.0216. Under Section 531.0216, MCOs:

- Must determine whether reimbursement for a Telemedicine medical service or Telehealth service is appropriate, while ensuring compliance with state and federal requirements. MCOs must consider the following factors in determining whether reimbursement for a Telemedicine medical service or Telehealth service is appropriate:
  - clinical effectiveness
  - cost-effectiveness
  - health and safety
  - patient choice and access to care
  - other criteria specific to the service
- Cannot deny reimbursement to contracted health care Providers for a Medicaid service or procedure just because it was delivered via Telemedicine or Telehealth;
- Cannot limit, deny, or reduce reimbursement for a covered health care service or procedure based upon the network Provider's choice of platform; and,
- Must ensure that Telemedicine and Telehealth services promote and support patient-centered medical homes by allowing a Member to receive a Telemedicine or Telehealth service from a provider other than the Member's Primary Care Physician (PCP) if:

a. The service is provided in accordance with the law and contract requirements applicable to the provision of the same health care service in an In-person setting, including care coordination requirements, and
b. The Provider of Telehealth or Telemedicine shares medical information with the Member's PCP or provider regarding the service they are providing, including a summary of the service, exam findings, medications prescribed, and patient instructions.

Compliance with SB 670 is required in the Telemedicine, Telehealth, Telemonitoring, and Telepharmacy provisions of the respective contracts.

Under SB 670, MCOs may use their discretion to determine which medical and Behavioral Health Services they will allow Providers to deliver by Telehealth or Telemedicine, HHSC has determined which medical and Behavioral Health Services may be delivered via Telehealth or Telemedicine in fee-for-service (FFS) Medicaid. Consult the Texas Medicaid Provider Procedures Manual (TMPPM) for more details about services that HHSC will allow via Telehealth or Telemedicine in FFS, and billing codes associated with these services.

HB 4, 87th Legislature, 2021, amends the Government Code by adding new Section 531.02161 requiring HHSC to allow more services to be delivered using Telemedicine, Telehealth, and Audio-only methods on a permanent basis following the end of the COVID-19 public health emergency, if clinically appropriate and cost-effective, whether delivered through managed care or FFS Medicaid. These services include preventative health and wellness services; case management, including targeted case management services; occupational, physical, and speech therapy services; nutritional counseling services; and assessment services. Further, HHSC was directed to develop rules to ensure Behavioral Health Services may be provided using an Audio-only platform if cost-effective and clinically effective. These rules are found at 1 Tex. Admin. Code §354.1435.

HB 4 requires HHSC to issue rules regarding assessments and service coordination using Telecommunications or information technology. These rules are found at 1 Tex. Admin. Code § 353, Subchapter R, regarding Telecommunications in Managed Care Service Coordination and Assessments. MCOs must follow these rules when providing service coordination and assessments to Members.

ACCESS TO CARE THROUGH THE USE OF TELEHEALTH, TELEMEDICINE, AND OTHER TELECOMMUNICATIONS

HHSC encourages MCOs to improve access to care under the Medicaid managed care program through the use of Telehealth services, Telemedicine medical services, home Telemonitoring services, and other Telecommunications or information technology.

NETWORK ADEQUACY FOR TELEMEDICINE, TELEHEALTH AND TELEMONITORING

MCOs must adhere to contract requirements for Telemedicine, Telehealth, and Telemonitoring including provisions requiring MCOs to:

- Conduct outreach to Providers to encourage more Providers to offer Telemedicine, Telehealth, and Telemonitoring,
- Include information about Providers with Telemedicine, Telehealth, and Telemonitoring capabilities in an MCO's hard copy and electronic provider directory,
- Conduct outreach to specialty providers as that term is defined in 1 Tex. Admin. Code § 353.7 and Behavioral Health Services Providers to assure engagement of qualified providers offering Telemedicine, Telehealth, and Telemonitoring, and
- Conduct trainings and supports for Providers to help establish Telemedicine, Telehealth, and Telemonitoring literacy and capabilities.

MCOs must ensure that Telemedicine and Telehealth services promote and support patient-centered Medical Homes.

Providers, including in-network Providers, who solely offer Telehealth or Telemedicine services cannot be counted toward the MCO's access standards as detailed in UMCM 5.28.1. Teleservices are not used to meet Network Adequacy standards. However, MCOs can inform HHSC of its teleservices use to support ways that they are ensuring a Member's ability to access services.

ADDITIONAL NETWORK REQUIREMENTS RELATED TO TELESERVICES

MCOs must display on their websites, and upon Member or Provider request, a list of services that are allowed using telecommunications based on the MCO's review of cost and clinical effectiveness under Texas Government Code § 531.0216(j). The

list must specify services allowed via Audio-visual communication, Audio-only communication, or both.

PROVIDER REIMBURSEMENT

By statute and contract, MCOs must not deny reimbursement to health care Providers for a Medicaid service or procedure solely because it was delivered via Telemedicine or Telehealth.

MCOs cannot limit, deny, or reduce reimbursement for Covered Services or procedures based upon the network Provider's choice of platform.

TELEHEALTH OR TELEMEDICINE MODIFIERS

For all claims with procedure codes that are reimbursable per the TMPPM and when billed with the 95 (synchronous audio-visual technology), 93 (synchronous audio-only), or FQ modifier (BH synchronous audio-only), MCOs must require Providers to bill with the appropriate modifiers when rendering Telehealth or Telemedicine services. MCOs must also require Providers to use these modifiers when billing for any other services that the MCO determines are allowed by Audio-visual or Audio-only delivery. Procedure codes that already indicate remote delivery in their description do not need to be billed with the 95, 93, or FQ modifiers. Capturing these modifiers will allow HHSC to accurately track utilization and trends over time.

SERVICE COORDINATION AND ASSESSMENTS

MEMBERS WITH SPECIAL HEALTH CARE NEEDS

HHSC encourages MCOs to offer Members with Special Health Care Needs (MSHCN) Audio-visual or In person communication in lieu of telephonic contacts where possible for the development of a Service Plan.

PRIVACY REQUIREMENTS

MCOs must adhere to all applicable state and federal security and privacy requirements, including the Health Insurance Portability and Accountability Act (HIPAA), in the use of Telecommunications for Service Coordination and assessments.

MCOs using Audio-visual products for service coordination or assessments must:

- Use a HIPAA-compliant product;
- Enter into HIPAA business associate agreements (BAAs) with vendors of the products; and

- Use products that conform to Level 2 Texas Risk and Authorization Management Program (TX-RAMP) requirements or FedRAMP Standards. Products that meet FedRAMP requirements automatically meet TX-RAMP requirements.

HHSC has determined that the following products meet HIPAA, TX-RAMP or FedRAMP requirements:

- Microsoft Teams
- Visuwell
- VSee
- GoToMeeting

MCOs must determine if the products used to conduct Audio-visual visits meet the required standards. The list above is not an endorsement or recommendation of a specific technology, software, application or product. There may be other technology vendors offering HIPAA, TX-RAMP, and/or FedRAMP-compliant video communication products that would enter into a HIPAA BAA with the MCO.

ADDITIONAL REQUIREMENTS FOR USE OF AUDIO-VISUAL TELECOMMUNICATIONS PRODUCTS

MCOs must ensure Members provide informed consent free of coercion to use Audio-visual communication for required Face-to-face service coordination visits or change in condition assessments that do not impact the Resource Utilization Group (RUG).

Both the Service Coordinator as well as the Member and their Legally Authorized Representative (LAR) or Medical Consenter, if applicable, must be proficient in the operation of the required information technology to use Audio-visual communication.

When Audio-visual communication is used for a required Face-to-face service coordination visit or change in condition assessment that does not impact the RUG, a Member must be offered appropriate support, including the use of any necessary on-site support-staff. In addition, MCOs must ensure appropriate equipment and access are available at the remote location to enable an Audio-visual visit, e.g., tablet, smartphone, laptop, and personal computer with speakers, webcam, and Wi-Fi/Data access.

DOCUMENTATION OF VERBAL CONSENT

STAR+PLUS and STAR Kids MCOs may determine whether it is appropriate to offer Audio-visual Service Coordination in place of an In-person visit, if no assessment or reassessment is being conducted. STAR+PLUS, STAR Kids, and STAR Health MCOs may also offer Members a choice of Audio-visual communication in place of In-person change in condition assessments, as long as the change in condition does not impact the RUG level. MCOs must document the Member's, Member's LAR, or Member's Medical Consenter verbal consent to use Audio-visual communication in a HIPAA-compliant manner.

MCOs may use their discretion on how to document verbal consent in a HIPAA-compliant manner. The MCO must be able to produce the documentation if an audit occurs. Verbal consent must be obtained each time Audio-visual or Telephonic communication occurs in lieu of In-person communication. Note that Telephonic assessments are allowed only when HHSC issues direction that Audio-only assessments may be conducted during a declared state of disaster, in accordance with 1 Tex. Admin. Code § 353, Subchapter R.

Consent obtained in verbal communication with the member and their legally authorized representative (LAR), as documented in the member's record by the service coordinator, is an acceptable form of documentation.

As described in UMCM Chapter 16.1.30 MCO Text Message and Email Policy, when a Member provides consent for text or email on the eligibility application or renewal form, the MCO may communicate Service Coordination or assessment appointment reminders, information about other health care matters such as Service Plan or Individual Service Plan (ISP) information by text or email. MCOs must communicate in a secure manner any information related to Service Plans or Individual Service Plans. However, if a Member has consented in writing to receive protected health information via email or other unsecure manner, the MCO must both document it and inform the Member of the risk associated with the unsecure communication before sending.

If the Member has not consented to text or email communications in the eligibility application, the MCO must ensure the Service Plan or Individual Service Plan information is communicated in a HIPAA-compliant manner (e.g., encrypted, or with a link to a secure Member portal), unless the Member requests that protected health information be sent in a manner that is not secure. When a Member requests Service Plan or ISP information be submitted in an unsecure manner, these requests must be documented, and the MCO must explain to the Member the risks of sending protected information in an unsecure manner.

MCOs must document the client choice of modality (In-person or Audio-visual) in the comments section of the assessment.

INFORMATION TECHNOLOGY AND SERVICE COORDINATION OR ASSESSMENTS

Information technology includes text, email, fax, secure transmission of clinical information, and HIPAA-compliant Telecommunication tools such as health plan websites where a Member or the Member's Legally Authorized Representative can access the Member's healthcare information, including ISPs, Healthcare Service Plans, and Service Plans.

Information technology, including text or email, may supplement Audio-visual or In-person assessments, but may not be used as the sole means of conducting an assessment, Service Coordination, or service management visit.

PUBLIC-FACING APPLICATIONS

Public-facing applications such as Facebook Live must not be used in the provision of Audio-visual Service Coordination or assessments.

ASSESSMENTS

DEFINITION OF ASSESSMENTS

Assessments, as that term is used in this chapter, means:

- **STAR+PLUS:** Medical Necessity/Level of Care initial and annual assessments for STAR+PLUS HCBS, as well as change in condition assessments, and functional assessments for personal assistance services, personal care services, Community First Choice, and day activity and health services using tools that include, but are not limited to, the following: H1700 series, H6516, 2330, H2060 and addendums, and the 3050.

- **STAR Kids (SK):** The SK Screening and Assessment Instrument (SAI), all associated modules, as applicable, and associated forms (including the 2603, 2604 and 2605), as specified in the STAR Kids contract and Handbook. All STAR Kids Members must be assessed using the SK SAI annually.
- **STAR Health:** The designated mandatory fields as specified in the SAI document map, all associated modules, as applicable, and all associated forms (including the 2604 and 2605, as specified in UMCM Chapter 16.2) when an initial telephonic screening indicates a Member may qualify for MDCP, CFC or PCS.

STAR+PLUS

STAR+PLUS MCOs must conduct the following assessments In-person using HHSC-developed tools:

- initial and annual reassessments for STAR+PLUS HCBS (MN/LOC, H6516, H2060 series, H1700 series)
- initial and annual functional reassessments for personal assistance services, Community First Choice (CFC), day activity and health services (H2060 series, 3050, H6516), or change in condition assessments that require or potentially require a change in the Member's RUG level.

For any assessment of a STAR+PLUS Member, the Member must be present for the assessment.

STAR Kids

STAR Kids MCOs must conduct the following assessments In-person using the HHSC-developed STAR Kids assessment tool (STAR Kids Service Assessment Instrument, including all applicable modules):

- initial assessments
- annual reassessments
- change of condition assessments that require or potentially require a change in the Member's RUG level

For any assessment of a STAR Kids Member, the Member must be present for the assessment.

STAR Health

STAR Health MCOs must conduct the following assessments In-person using the HHSC-developed tool (including the Service Assessment Instrument (SAI), and all applicable modules):

- initial Medically Dependent Children Program (MDCP) assessments
- MDCP annual reassessments
- change of condition assessments that require or potentially require a change in the Member's RUG level

- initial and annual reassessment for functionally necessary covered services such as personal care services, day activity and health services for Members 18 and older, and CFC Services

For any assessment of a STAR Health Member, the Member must be present for the assessment.

All MDCP recipients in the STAR Health program must receive an In-person assessment, at least annually, using the SAI.

STAR Health: CANS 2.0 Assessment

Per Section 8.1.11.3 of the STAR Health contract, the CANS 2.0 must be completed for Category 1 children ages 3-17 in state conservatorship within 30 days of STAR Health enrollment and annually thereafter.

A certified CANS 2.0 assessment Provider in the MCO's network must perform the CANS 2.0 assessment. The assessment may be administered using Audio-visual communication.

The CANS 2.0 may be completed via a secure portal that is HIPAA and TX-RAMP compliant, and meets additional requirements outlined below.

The remote site includes a foster home, residential treatment center, temporary shelter, DFPS or CPA office, etc.

The MCO must ensure Provider compliance with the following:

- A secure, HIPAA-compliant portal is used to ensure privacy protection of the Member and the information collected at the time of the assessment
- Appropriate equipment is available at the remote location, i.e. tablet, smartphone, laptop, and personal computer with speakers, webcam, and Wi-Fi/Data access
- The audio is clear and visual elements take place in a well-lit part of the remote site
- The CANS 2.0 assessment meets best practices as identified by the MCO
- Service gaps or concerns are identified and addressed
- Caregivers have been provided education and training to understand the appropriate use of the secure portal as well as requirements for CANS 2.0 completion from the remote site.

CHANGE OF CONDITION ASSESSMENTS (STAR KIDS, STAR+PLUS, STAR HEALTH)

STAR+PLUS, STAR Kids, and STAR Health MCOs may offer Members a choice of In-person or Audio-visual communication for change in condition assessments that do not involve a RUG change (e.g., changes related to service adjustments such as an increase or decrease in nursing hours). When offering a Member the option to use Audio-visual Telecommunication for change in condition assessments that do not involve a RUG change, the MCO must ensure:

- Protection of Member health and welfare;
- Member and assessor proficiency in the operation of Telecommunication products;
- Support is offered to a Member if needed, including any necessary on-site support staff;
- Informed verbal consent is received from the Member, Member's Legally Authorized Representative (LAR), or Medical Consenter and documented by the MCO;
- A HIPAA-compliant Audio-visual communication product is used;
- Member participation is free of any coercion to use Telecommunication for service coordination and assessments; and
- Member participation is free of coercion when speaking to a service coordinator, especially when participating from a provider-controlled or operated setting.

MCOs must inform Members who utilize Audio-visual communication for change in condition assessments that the Member's services will be subject to the following:

(i) MCO monitoring of services for fraud, waste, and abuse;
(ii) MCO determination of whether additional social services or supports are needed; and
(iii) MCOs confirmation that a Member's or medical consenter's verbal consent to use Audio-visual communication is documented in writing.

ADDITIONAL CONSIDERATIONS FOR AUDIO-VISUAL CHANGE IN CONDITION ASSESSMENTS

STAR+PLUS, STAR Kids, and STAR Health MCOs must conduct change in condition assessments in person if:

- A Member's or Member's LAR verbal consent to the use of Audio-visual communication is not received,
- A Member cannot be assessed by Audio-visual means (for example, there is not a HIPAA-compliant product available for use, or Wi-Fi is unavailable),
- In-person observation is required to complete the assessment, or
- The change in condition impacts, or potentially impacts the Member's RUG level.

ASSESSMENT TOOLS: BLANK FIELDS

MCOs may not leave blank fields in HHSC-developed assessment tools, including tools to evaluate home and community-based service needs, nursing needs, and functional needs. When a field does not apply to a member, enter "N/A", or follow the form skip logic. STAR Kids and STAR Health MCOs must follow the existing file layout, or schema, as completed today for submission of the SAI. Similarly, STAR+PLUS MCOs must follow the existing schema for the submission for the form H1700 for STAR+PLUS HCBS.

MCOs must make best effort to use available resources to ensure assessment tools are complete and accurate. Available resources may include prior authorization documentation for existing services, calls to the Member's providers, conversations with the Member or Member's LAR, and more.

ASSESSMENTS DURING A DECLARATION OF DISASTER

In a declaration of state of disaster, HHSC will issue direction to MCOs regarding whether initial, annual renewal, or change in condition assessments may be conducted through Audio-visual or Audio-only communication.

HONORING MEMBER CHOICE FOR IN-PERSON SERVICE COORDINATION OR ASSESSMENTS

An MCO must honor a Member's request to receive Service Coordination or assessments In-Person. Only when HHSC issues direction to MCOs during a declaration of state of disaster that Service Coordination or assessments using Audio-visual or Audio-only communication is required due to the specific nature of a

governor declared disaster may an MCO deny a Member's request for an In-person visit.

SERVICE COORDINATION

STAR+PLUS and STAR Kids

STAR+PLUS and STAR Kids MCOs must conduct required Service Coordination visits by Level as specified by contract. Service Coordination is a specialized care management service that is performed or arranged by the MCO to identify needs, facilitate development of a service plan or individualized service plan to address those identified needs, and coordinate services among the Member's primary care provider, specialty providers, and non-medical providers to ensure timely access to covered services, non-capitated services, and community services. Service Coordination addresses:

- physical health,
- mental health services,
- long term support services,
- non-capitated services,
- and needed social supports (e.g., housing, food, and other non-medical drivers of health.)

STAR+PLUS and STAR Kids

STAR+PLUS MCOs must ensure all Level 1 and 2 Members receive at least one In-person Service Coordination visit per year. Level 3 STAR+PLUS Members, by contract, receive two telephonic service coordination visits annually. If a level 3 STAR+PLUS Member has a change in clinical condition, or requests services such as STAR+PLUS HCBS or CFC that require use of a functional assessment or MN/LOC tools, the assessment must be done in person and the MCO must consider changing the level of service coordination for the Member based on the outcome of the assessment.

STAR+PLUS MCOs may offer the following Members a choice of Audio-visual Service Coordination visits in place of In-person visits if no assessment is occurring:

- Members in a Nursing Facility
- Level 1 (including Members with SPMI) or Level 2 Members

STAR Kids MCOs must ensure all Members receive one In-person Service Coordination visit per year.

STAR Kids MCOs may offer STAR Kids Members a choice of Audio-visual communication for Service Coordination visits if no assessment is occurring.

An In-person assessment using HHSC-developed tools satisfies the annual In-person Service Coordination visit requirement in both STAR+PLUS and STAR Kids.

STAR+PLUS AND MEMBERS IN A NURSING FACILITY

The STAR+PLUS MCO may determine it is appropriate to offer Level 1 Members in a Nursing Facility an Audio-visual Service Coordination visit in place of an In-person visit. Members in a Nursing Facility must have at least one In-person Service Coordination visit per year for service planning purposes. For nursing facility residents, this means that up to three service coordination visits per year may be conducted using audio-visual communication if the Member consents.

STAR+PLUS MCOs must conduct Nursing Facility discharge planning visits In-person, including when a Member is transitioning to the STAR+PLUS HCBS Program. The In-person Nursing Facility discharge planning visit satisfies the requirement for the In-person STAR+PLUS HCBS initial assessment if the MCO:

- uses the Member's valid Minimum Data Set (MDS) assessment to gather the information necessary to complete the STAR+PLUS HCBS individual service plan; or
- conducts a Medical Necessity and Level of Care assessment if the Member does not have a valid MDS or in lieu of the Member's valid MDS to gather the information necessary to complete the STAR+PLUS HCBS individual service plan.

STAR Health

Telephonic service coordination or service management required by contract may continue to be conducted telephonically. HHSC encourages MCOs to give Members a choice of Audio-visual communication or telephonic communication for required telephonic visits.

STAR Health MCOs must ensure that a Member receiving MDCP services continues to receive required contacts to ensure the Member's needs are met. These contacts are currently allowed telephonically, but HHSC encourages MCOs to provide

Members or their Medical Consenter a choice of Audio-visual or Audio-only (telephonic) visits.

STAR and CHIP

Telephonic service coordination (formerly called "service management" through August 31, 2022) required by contract may continue to be conducted telephonically (e.g., for Members with Special Healthcare Needs). HHSC encourages MCOs to give Members a choice of Audio-visual communication or telephonic communication for required telephonic visits.

ADDITIONAL REQUIREMENTS FOR TELECOMMUNICATION IN SERVICE COORDINATION

When offering a Member the option to use Audio-visual communication for required In-person Service Coordination, the MCO must ensure:

- Protection of Member health and welfare,
- Member and service coordinator proficiency in the operation of Telecommunication products,
- Support is offered to a Member if needed, including any necessary on-site support staff,
- Informed verbal consent is received from the Member, Member's LAR or Medical Consenter and documented by the MCO,
- Adherence to HIPAA, including the use of a HIPAA-compliant Audio-visual communication product,
- Member participation is free of any coercion to use Telecommunication for service coordination and assessments,
- Member participation is free of coercion when speaking to a service coordinator, especially when participating from a provider-controlled or operated setting,
- A Member's right to privacy, dignity, and respect. The process must include people chosen by the Member, the service planning must be person-centered and provide necessary information and support to ensure that the Member directs the process to the maximum extent possible and is enabled to make informed choices and decisions,
- The process is timely and occurs at times of convenience to the Member.

MCOs must inform Members who utilize Audio-visual communication for change in condition assessments that do not impact the RUG that the Member's services will be subject to the following:

(i) MCO monitoring of services for fraud, waste, and abuse;
(ii) MCO determination of whether additional social services or supports are needed; and
(iii) MCO's confirmation that a Member's or medical consenter's verbal consent to use audio-visual communication is documented in writing.

A Member must be present for Service Coordination visits.

MCOs must use In-person communication for Service Coordination visits if:

- a Member or Member's LAR verbal consent for audio-visual communication is not received and documented,
- A Member cannot adequately operate Telecommunication products, even with support or assistance, or
- In the MCO Service Coordinator's judgement, the Member has health and safety issues or other conditions that would warrant an In-person Service Coordination visit.

MEMBER AND PHYSICIAN SIGNATURES

If an assessment or service coordination visit is conducted by Audio-visual communication, MCOs must obtain an electronic or wet signature from a Member, Medical Consenter, or legally authorized representative (LAR) for initial person-centered service plans, annual reassessments, as well as changes to existing person-centered service plans, and related forms that require Member signature.

MCOs may document verbal consent for changes to existing person-centered service plans and related forms in the Service Coordinator notes and must follow-up with the Member or LAR within seven Days to obtain an electronic or wet signature.

Federal regulations at 42 CFR §441.301(c)(2)(ix) require a person-centered service plan to "be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation."

If after seven Days, a Member or their LAR has not signed the service plan, the MCO must make a good faith effort to obtain the signature. HHSC considers a good faith effort to be three attempts, one of which is in person, if necessary. MCOs must document these attempts in the Member's record, and note that the Member or Member LAR refusal to sign on the service plan and related forms.

In addition, MCOs may obtain an electronic signature in lieu of a wet signature from the physician when a physician signature is required on service plans and related forms for STAR+PLUS HCBS, MDCP, and CFC.

All Member and Provider signatures must be obtained in compliance with HIPAA and any applicable state laws and rules regarding signatures, including electronic signatures. MCOs must be able to produce the dated signature documentation, including electronic signatures, for audit and compliance purposes.

AUDIO-ONLY COMMUNICATION FOR SERVICE COORDINATION, ASSESSMENTS AND HEALTH SCREENINGS

MCOs may offer Members service coordination and health screenings via Audio-only (e.g., Telephonic) if allowed by contract.

In a declaration of state of disaster, HHSC will issue direction to MCOs regarding:

- whether service coordination required to be conducted using Face-to-face communication may be conducted through Audio-only communication, and
- whether initial, annual renewal, or change in condition assessments may be conducted through Audio-visual or Audio-only communication.

CASE BY CASE DISCONTINUATION

As specified at 533.039(f), Texas Government Code, on a case-by-case basis, the Health and Human Services Commission (HHSC) may require a managed care organization (MCO) to discontinue use of Telecommunications or information technology for assessment or service coordination services and resume In-person assessments and/or In-person service coordination services for Members:

- where a contact or complaint has been initiated with HHSC by a Member, LAR, Medical Consenter, Provider, HHSC staff Member, or others; or a

clinical consult from the Medicaid and CHIP Services (MCS) Department Office of the Medical Director (OMD); or Utilization Review (UR) has been requested for the review of the Member's authorized or requested services;

- where an issue has been identified during clinical review conducted by OMD/UR (i.e., High Needs, Long Term Supports and Services, or Acute Care Utilization Review); or
- where HHSC has identified circumstances that places the Member's health and safety at risk. This may include but is not limited to a Member:
  - ◊ with a confirmed history of abuse, neglect, or exploitation;
  - ◊ an identified pattern of frequent hospitalizations or emergency room visits;
  - ◊ who is a resident of a facility (i.e., assisted living or nursing facility) with identified health and safety concerns; or
  - ◊ whose requested services exceeds the assigned cost limit for a waiver program.

Upon identifying a Member to be assessed for discontinuation of Telecommunications or information technology for assessment or service coordination services, HHSC's clinical staff in the OMD will assess the individual circumstances and make a determination for each individual Member.

For any Member that HHSC determines that discontinuation of Telecommunications or information technology for assessment or service coordination services applies, HHSC will notify the MCO in writing that they must resume In-person assessments and/or In-person or service coordination services for a minimum of 12 months from the date of discontinuation.

When a Member who is on the case-by-case discontinuation list transfers to another MCO, the sending MCO must notify the receiving MCO that the member is on the case-by-case discontinuation list (including the end date for the case-by-case discontinuation) when transmitting the service plan information.

HHSC will reevaluate an individual's status every 12 months from the date the Member was placed on the case-by-case discontinuation list.

EXCEPTIONS TO REQUIRED IN-PERSON SERVICE COORDINATION OR ASSESSMENTS

MCOs may develop policy for exceptions to required In-person service coordination or assessments as determined by the MCO's clinical staff, such as the Chief Medical Director or designee. Audio-only assessments will not be allowed under the exceptions policy, unless HHSC issues guidance that the assessment may be conducted using Audio-only communication during a governor-issued declaration of disaster, including a public health emergency. An MCO's exception policy must be approved by HHSC. To receive approval, the MCO must send the draft policy to MCS_ManagedCareOMD@hhsc.state.tx.us with a copy to the MCO's HHSC Health Plan Specialist.

MCOs are expected to make good faith effort to conduct assessments and service coordination visits In person where required by contract. For example, the MCO may need to reschedule or postpone a visit if the Member or Service Coordinator is ill with a communicable disease. However, there may be circumstances that warrant an Audio-visual service coordination visit or assessment, as detailed below.

Parameters for MCO Exception Policy

Acceptable reasons for using Audio-visual communication in lieu of required In-person service coordination and assessments must be specific to the Member's health and safety and could include:

- A nursing facility has restrictions on who can enter the facility impacting the ability to conduct an In-person service coordination visit or transition planning visit. However, if HHSC Regulatory Surveyors are allowed in the facility, this is not an acceptable reason. If the Nursing Facility continues to ban entry, then the MCO must notify their HHSC Health Plan Specialist.
- The Member's community has public health recommendations in place due to elevated levels of COVID-19 or other communicable diseases.
- The Member has a disease or condition causing immunosuppression, or receives treatment that results in immunosuppression, such as cancer with active chemotherapy or radiation treatment, HIV, or SCID.

MCO Service Coordinators must document the rationale for the use of Audio-visual communication in the case notes.

Unacceptable reasons for Audio-visual communication in lieu of required In-person service coordination and assessments include:

- Member refusal or Member preference for Audio-visual visits (see exception above). Member preference for Audio-visual communication or refusal of an

In-Person assessment does not constitute an allowable exception to In-Person assessments. Members must be informed that HHSC requires an In-person assessment and refusal will result in a denial for HCBS services (MDCP, STAR+PLUS HCBS, and services requiring a functional assessment).

- MCO convenience or cost savings.
- MCO staffing issues that are not related to a high incident of communicable disease being tracked by public health agencies in the community.