3413 STAR+PLUS Home and Community Based Services Program Member Transferring from One MCO to Another Within the Same Service Area

Revision 20-1; Effective March 16, 2020

Once the initial enrollment period of one full month has passed, a member is eligible to change managed care organization (MCO) plans. A member may request a transfer to another MCO in the service area through the state-contracted enrollment broker at any time for any reason. Texas Health and Human Services Commission (HHSC) will make only one plan change per month. When a member wants to change from one MCO to another MCO in the same service area, the member or authorized representative (AR) must contact the enrollment broker via phone call to 1-800-964-2777. If the member calls to change MCO on or before the monthly HHSC MCO enrollment cut-off date, the change will take place on the first day of the next month following the change request. If the member calls after the monthly HHSC MCO enrollment cut-off date, the change will take place the first day of the second month following the change request. The HHSC MCO enrollment cut-off date is not always on the same day of every month, but it is typically mid-month.

**Examples**:

* If the member calls on April 9, the change will likely take place on May 1.
* If the member calls on April 20, the change will likely take place on June 1.

HHSC Enrollment Resolution Services (ERS) prepares and sends a Monthly Plan Changes report to Program Support Unit (PSU) staff. The MCO can find the member-specific report located in the Monthly Enrollment (P34) File in TxMedCentral. The report gives a list of STAR+PLUS Home and Community Based Services (HCBS) program members who have changed MCOs from the previous month.

Within **five business days** of receiving the list and determining any new members, the gaining MCO must request from the losing MCO all applicable forms and documentation related to the new member, including: all H1700 forms; all H2060 forms; any 1500 forms; the Medical Necessity and Level of Care (MN/LOC) assessment; Form H6516, Community First Choice Assessment; and any prior authorizations, as well as any one-time/lifetime limits that have been met. Within **five business days** of receiving the request, the losing MCO must provide the requested documents to the gaining MCO. If the gaining MCO experiences issues obtaining this information, the MCO must notify Managed Care Compliance and Operations (MCCO) staff.

The gaining MCO is responsible for service delivery from the first day of enrollment. Within 14 days of notification of the new member, the gaining MCO must contact the member to discuss services needed by the member. Within 30 days of notification of the new member, the gaining MCO must conduct a home visit to assess the member's needs. individual service plan ()the new assessment is completed and thea new, Needs Assessment Questionnaire and Task/Hour Guide,,(s).