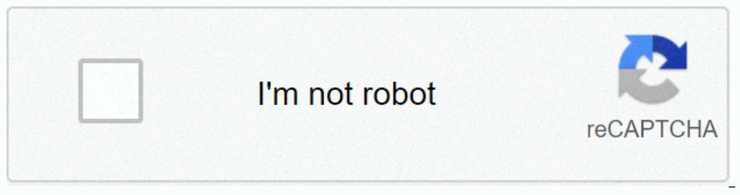

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9000 Usage Review Purpose Section 1000, State of Texas Access Reform Plus (STAR+PLUS) Managed Care Revision 20-2; With effect from 1 October 2020 1100 Programme Overview Review 19-1; As of June 3, 2019, the 74th Texas Legislature has implemented the State of Texas Access Reform Plus (STAR+PLUS) program to create a cost-neutral managed care system to combine acute care with long-term services and support (LTSS). The STAR+PLUS program does not change the eligibility of Medicaid or services. It changes the way Medicaid services are provided. The STAR+PLUS programme combines acute care and LTSS, such as assisting a member at home with activities of daily life (ADLs), home changes, respite (short-term counselling) and personal assistance (PAS). These services are provided through providers who are contracted with managed care organizations

(MCOs). The STAR+PLUS program provides a continuum of care with a wide range of options and more flexibility to meet individual needs. The program has the number and types of providers available to Medicaid members. Service coordination, available to all members, is the main feature of the STAR+PLUS program. It is a specialized case management service for program members who need or request it. Service coordination means that plan members, family members, and providers can work together to help members get acute care, LTSS, Medicare services for eligible members, and other community support services. The STAR+PLUS Home and Community Based Services (HCBS) program is a program approved for the managed care delivery system, designed to allow individuals who are eligible for nursing home (NF) care to receive LTSS in order to be able to live in the community. Elements of the STAR+PLUS system differ from traditional services. See the dictionary for the definition of terms specific to the STAR+PLUS program. For a dictionary of abbreviations used in the STAR+PLUS program, please refer to Appendix VII, abbreviations. 1110 Revision of the legal basis 19-1; As of June 3, 2019 Legal basis for the STAR+PLUS program: 1120 Values Revision 19-1; As of June 3, 2019 The principles and practices that form the basis for the STAR+PLUS Home and Community Based Services (HCBS) program are based on the following values: Members receive services based on their choices and ongoing assessment of their medical and functional needs. The service delivery system is accessible to the member, responds to his or her needs and preferences and is flexible in honoring choices regarding accommodation, services and mode of service. Members make use of available family, and external services and resources, as well as services and resources provided through the STAR+PLUS HCBS program to meet their needs and identified goals. Services provided to the member must be safe, cost-effective and medically or functionally functional Alternatives to nursing home (NF) placement that give the member the ability to use and maintain family and community contacts and services. The Individual Service Plan (ISP) reflects the member's active participation in the assessment and planning process and his or her responsibility to provide as much self-care as possible. Services should support the member's efforts to maintain or regain as much independence as possible in the activities of daily life (ACLs), housing supply and other areas of personal choice, and in achieving any goals. Individuals and members receive the education, support and services needed to support the member's efforts to stay in the community or return. Within the restrictions imposed by the cost limit for a member's ISP, the program promotes the active involvement of the member and the choices regarding the services provided. 1130 Service Model Revision 18-2; As of September 3, 2018 1131 Service Delivery Model Revision 19-1; As of June 3, 2019, people enrolled in the STAR+PLUS program will be able to select a service delivery model for personal assistance services (PAS) or Community First Choice (CFK) services identified on Form H2060, Needs Assessment Questionnaire and Task/Hour Guide, Form H6516, Community First Choice Assessment, and Form H2060-A, Addendum in Form H2060. Individuals providing STAR+PLUS Home and Community Based Services (HCBS) program services can live alone, with family members or others at locations of their choice in the community, including adult foster care (AFC) homes or licensed assisted living facilities (ALFs). The STAR+PLUS HCBS program provides individuals with a range of services needed to enable the individual to stay or return to a community setting. Providers are contracted with managed care organizations (MCOs) to provide STAR+PLUS HCBS program services identified on the Individual Service Plan (ISP). The MCO completes all initial and annual service planning activities and verifies, authorizes, coordinates and monitors services. Program Support Unit (PSU) staff coordinate with Medicaid for the elderly and people with disabilities (MEPD) specialists to determine financial suitability for individuals who are not eligible for supplemental security income (SSI). SSI eligible individuals are eligible for Medicaid and can obtain STAR+PLUS HCBS program services without additional financial screening. (See Section 3110, Medicaid, Medicare, and Dual-Eligibles.) STAR+PLUS members choose to participate in the agency option (AO), the consumer-facing services (CDS) option or service option (SRO) delivery models. Members who choose the AO work with the MCO to coordinate the service for each service in the ISP. Members who choose the CDS model will be given the power to provide self-driving services. If the member chooses to lead self-directed services, provision of non-member targeted designated services. In the CDS model, providers employed by the member or the authorised representative (AR) must be qualified personnel to provide all authorised services when services are needed. These staff can be deployed directly through or through personal service agreements or subcontracts with the providers. A member's services and service providers should be based on an MCO assessment of the member's individual needs. More information is available in Appendix XXVIII, Consumer Directed Services (CDS) Training for Service Coordinators and CDS Training Manual. In the SRO model, the provider is the employee's employer and handles the company data (e.g. paying taxes and doing payroll). The provider also orients counselors on provider policies and standards before sending them to members at home. The member or designated representative (DR) shall be responsible for most of the day-to-day management of the supervisor's activities, starting with interviewing and selecting the person who will be the supervisor. 1140 Program Services Revision 18-2; As of September 3, 2018, 1141 Services available under STAR+PLUS Revision 19-1; From June 3, 2019 If the service coordinator finds a need, or the member requests additional services, the managed care organization (MCO) will assess the member and develop an appropriate individual service plan (ISP). As MCOs are at risk of paying for a range of acute care and long-term services and support (LTSS), there is an incentive to provide innovative, cost-effective care from the outset to avoid or delay the need for more expensive institutionalisation. STAR+PLUS members who do not have Medicare must choose an MCO and a primary health care provider (PCP) in the MCO's network. These individuals can choose a specialist to be their PCP and they receive all services, both acute care and LTSS, from the MCO. Members who receive both Medicaid and Medicare (dual-eligible) choose an MCO, but not a PCP, because members who qualify receive acute care from their Medicare providers. The STAR+PLUS program does not affect Medicare services or service delivery in any way. The STAR+PLUS MCO only provides Medicaid LTSS to eligible members. The STAR+PLUS program serves as an insurance policy if members need LTSS at a future time. For additional information on dual-eligible coverage, see Section 3110, Medicaid, Medicare, and Dual-Eligibles. Medicaid-only members (those who don't receive Medicare) receive traditional Medicaid acute care services plus an annual check-up. For these members, the costs of acute included in the capitation payment to the MCO. For dual-eligible members, the MCO capitation payment does not include the cost of acute care. 1142 Long-term services and support for review 17-5; As of September 1, 2017 Activity and Health Services (DAHS) and Personal Attendant Services (PAS) are available to STAR+PLUS members who meet functional eligibility requirements. Community First Choice (CFK) services are available to STAR+PLUS members who meet an institutional level of care, meet functional eligibility requirements, and who receive supplemental income (SSI) or receive SSI-related Medicaid. Additional services are available under the STAR+PLUS Home and Community Based Services (HCBS) program. For a full list of services offered under the STAR+PLUS program, see the managed care contracts for the STAR+PLUS program at . 1143 STAR+PLUS Services Revision 17-1; As of March 1, 2017, STAR+PLUS program members will have access to medically and functionally necessary services available in the state plan. In addition, some members are eligible for additional services available in the STAR+PLUS Home and Community Based Services (HCBS) program services, in addition to their traditional STAR+PLUS services state plan. See: Article 1143.1, Services Available to STAR+PLUS Members; and Section 1143.2, Services available to members of the STAR+PLUS Home and Community Based Services (HCBS) Program. 1143.1 Services available to STAR+PLUS Members Revision 19-1; As of June 3, 2019, the Texas Health and Human Services Commission (HHSC) has contracts with Medicaid managed care organizations (MCOs) to provide STAR+PLUS services. These Medicaid MCOs are responsible for providing a benefit package to members that includes all medically necessary services covered by traditional, fee-for-service (FFS) Medicaid programs, excluding non-capitated services provided to Medicaid members outside the MCO capitation and included in each managed care contract. (For example, Annex B-1, item 8.2.2.8, to the Uniform Managed Care Contract (UMCC). STAR + PLUS members also receive enhanced benefits compared to traditional FFS Medicaid coverage: waiver of the three-prescription per month limit for members not covered by Medicare; and waiver of the limitation of working time illness for members admitted to a facility due to their severe and persistent mental illness (SPMI). Medicaid MCO contractors are responsible for providing a benefit package to members that includes an annual adult well check for members and prescription drugs. STAR+ PLUS MCO contractors should refer to the current Texas Medicaid Provider Procedures Manual (TMPPM) and the Texas Medicaid Bulletin postings for a more inclusive list of restrictions and exclusions that apply to Medicaid benefit category. (These documents can be accessed online at: www.tmhp.com.) The services in managed care contracts (e.g. UMCC) are subject to changes based on state and federal laws regulations and program policy updates. 1143.1.1 Services covered by the MCO Capitation Payment Revision 19-1; As of 3 June 2019 Services covered by the managed care organisation (MCO) include: ambulance services; audiology services, including hearing aids; behavioural health care, including: inpatient mental health services; outpatient mental health services; ambulatory chemical dependency services; mental health rehabilitation for non-dual; mental health focused case management for non-dual; detoxification services; psychiatry services; and guidance services; birth services of a certified midwife in a birthing centre; chiropractic services; dialysis; durable medical equipment (DME) and supplies; Emergency Services (ERS); family planning services; home care services for acute conditions; hospital services; laboratory; long-term services and support (LTSS) (See section 1143.1.2 below); Medical Checks and Comprehensive Care Program (CCP) Services for Medicaid for Breast and Cervical Cancer (MBCC) Members Under the Age of 21; oncology services; optometry, glasses and contact lenses, if medically necessary; podiatry; prenatal care; prescription drugs; primary care; preventive services, including an annual good check for adults; radiology, imaging and X-rays; specialised medical services; therapies, including physical, occupational and speech for acute conditions; transplantation of organs and tissues; and vision services. 1143.1.2 Long-term services and review of the support list 19-1; As of June 3, 2019, the following is a non-exhaustive, high-level list of long-term services (LTSS) and support included in the STAR + PLUS program: Community First Choice (CFC) - Available to all Medicaid-eligible members (excluding members considered medical assistance only (MAO)) who meet an institutional level of care (LOC) for a hospital, nursing facility (NF) , intermediate care facility for persons with intellectual disabilities or related conditions (ICF-IID), or psychiatric hospital (also called a mental illness institution (IMD). CFC services are delivered in a community-based environment. Community-based institutions do not include: Hospitals NFs IMDs ICF-IIDs Any institution with the characteristics of an institution's CFC services include: Personal Assistance Services (PAS), which provide assistance in daily life activities (ACLs), instrumental activities of daily life (IADLs), and health-related tasks through hands-on assistance, supervision or cueing, including nursing delegated tasks; Habilitation services, which acquire, and improve skills needed for the individual to perform ACLs, ILDs and health-related tasks; Emergency services (ERS), which are backup systems and supports, including electronic electronic with a backup support plan to ensure continuity of services and support; and Support Management, which is given to members or authorised representatives (ARs) on managing and firing their supervisors. Personal Assistance Services (PAS), formerly known as Primary Home Care (PHC) — All members can receive medically and functionally necessary PAS. PAS includes assisting the member in the execution of daily life activities (ADL) and household tasks necessary to maintain the home in a clean, sanitary and safe environment. The level of assistance is determined by the needs of the member and the plan of care (POC). In order to be eligible for the PAS state plan, the MCO must personally assess applicants. Members are assessed using Form H2060, Needs Assessment Questionnaire and Task/Hour Guide or Form H6516, Community First Choice Assessment. To be eligible for PAS through programs other than CFC or STAR+PLUS Home and Community Based Services (HCBS) program, members must score at least 24 on Form H2060. PAS includes three service delivery options: Agency Option (AO); Consumer-facing services (CDS) option; and Service Responsibility Option (SRO). Day activity and health services (DAHS) — All members of a STAR+PLUS managed care organization (MCO) can receive medically and functionally necessary DAHS. DAHS includes nursing and personal assistance services, therapy expansion services, food services, transport services and other support services (PAS). These services are provided at state-approved facilities. STAR + PLUS HCBS program is for members who are eligible for such services – The state also provides an enriched range of services to members who would otherwise be eligible for NF care through the STAR+PLUS HCBS program. The MCO should also provide medically necessary services available to members who meet the functional and financial suitability for the STAR+PLUS HCBS programme. NFs – Institutional care to members whose doctor has stated that the member has a medical condition that requires 24-hour nursing care that meets the medical necessity (MN) requirements. The need for custodial sentences does not constitute an MN for an NF placement. Institutional care includes coverage for the medical, social and psychological needs of each resident, including room and board, social services, medications not covered by Medicare Part B or D, medical supplies and equipment, rehabilitation services and personal needs items. 1143.1.3 STAR+PLUS Personal Assistance Services (PAS) Practitioner's Statement of Need (PSON) Revision 20-2; With effect from 1 October 2020, the State Plan for Personal Assistance Services (PAS) authorized under the 42 Code of Federal Regulations (CFR) §440.167. STAR+PLUS managed care organizations (MCOs) must authorize state plan PAS in the service plan service plan and approved by the MCO for all STAR+PLUS members or by requiring a declaration of need (PSON) from a practitioner. Note: See Uniform Managed Care Contract Section 8.1.12.4, STAR+PLUS MRSA Contract Section 8.1.13.2 and STAR+PLUS Expansion Contract Section 8.1.13.2. All STAR+PLUS members are considered members with special care needs. If the MCO chooses to require a PSON, the PSON may be requested under one or more of the following circumstances: on first request; if the original approval was based on temporary needs; if the member experiences a significant change in condition, as defined in managed care contracts; or reassessment. A PSON may not be required for PAS provided under the STAR+PLUS Home and Community Based Services (HCBS) program or Community First Choice (CFK). The implementation of a PSON process should not delay a prior authorisation decision or the delivery of PAS that has been assessed as medically or functionally necessary. The PSON request shall be initiated 90 days before the expiry of the PAS authorisation, if necessary upon reassessment. For a significant change in the condition, the PSON should be initiated during the 21-day follow-up period for reassessment. The MCO must have a documented process for the steps they will take to follow up with the practitioner to secure the PSON. This process should include the steps that will be taken to notify the member and service provider of the status, including outreach attempts by phone, in writing or in person. The MCO must accept a PSON signature collected by the member's member or service provider. Authorization Extension and Outreach Efforts Previously authorized services should continue until a signed PSON is obtained. The MCO must have a process to extend the authorization to ensure that the member does not have a gap in the service while the MCO makes additional outreach efforts. The extended authorisation period may not exceed 45 additional days. During the extended authorisation period, the MCO must continue to reach the practitioner and allow the member to switch to a new practitioner. The MCO must inform the member's member and service provider of the potential impact on PAS services if a signed PSON is not obtained. The MCO should document in the member's report all outreach efforts and member education related to the PSON. Required data elements If the STAR+PLUS MCO chooses to require a PSON for STAR+PLUS PASS, the MCO must develop its own version of a PSON. The PSON must contain the following separate data elements: the of the paragraph; Identification number of the member; Date of birth of the member (DOB); Certification that the member has been evaluated by a doctor in the past 12 months; If the practitioner declares that he has evaluated the member in the last 12 months, has a medical diagnosis that results in one or more functional limitations, as indicated, or that the practitioner is unable to certify the member has a medical diagnosis resulting in one or more functional limitations; Notation of whether the medical diagnosis leads to a temporary need, together with the expected end date; All items in Parts III and IV on Form 3052, Practitioner's Statement of Medical Need; Practitioner printed name; Address of the practitioner; Phone number of the practitioner; License number of the practitioner; Signature of doctor, nurse, advanced practice registered nurse or doctor-assistant; and date form has been signed. The MCO must also provide the practitioner with a copy of the completed Form H2060, Needs Assessment Questionnaire and Task/Hour Guide, if requested. If the MCO has exhausted all efforts to obtain a PSON and intends to refuse, restrict, reduce, suspend, terminate or make any other negative determination regarding a member's services, the MCO must follow the procedures found in the Uniform Managed Care Manual, Chapter 3.21, Medicaid MCO's Notices of Actions Required Critical Elements. 1143.2 Services available for STAR+PLUS Home and Community Based Services Program Members Revision 19-1; As of June 3, 2019, services needed for the individual to stay in the community or return to the community will be identified based on the range of services available through the STAR+PLUS Home and Community Based Services (HCBS) program. Star+PLUS HCBS program services include: Adaptive Aids and Medical Supplies — Medical devices and supplies that include devices, controls, or devices specified in the Care Plan (POC) that allow individuals to increase their skills to perform daily life activities (ACLs) or to observe, monitor, or communicate the environment in which they live. Adult Foster Care (AFC) - A 24-hour housing scheme for people who are unable to live in their own home due to physical or mental disabilities. Services may include meal preparation, housekeeping, personal care, assistance with ADL, supervision and provision of or arranging transport. Assisted Living (AL) Services — A 24-hour residential arrangement in approved personal care facilities that provides personal care, home management, escort, social and recreational activities, 24-hour supervision, provision or arrangement of transportation, and supervision, assistance with and direct administration of medicines. Under the STAR+PLUS HCBS programme, personal care facilities can close to provide services in two different types of residential facilities: AL apartments; or AL non-apartment settings. Cognitive Rehabilitation Therapy (CRT) - A service that helps an individual learn or re-learn cognitive skills that have been lost or altered due to damage to brain cells/chemistry to the individual to compensate for the lost cognitive functions. CRT is provided when found to be medically necessary through an assessment carried out by a suitable professional. The assessment is not covered by this service. CRT is delivered in accordance with the POC developed by the assessor, and includes strengthening, strengthening or restoring previously learned behavior patterns, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Dental Services - Services provided by a dentist to preserve teeth and meet the medical needs of the member. Permitted services include: emergency dental treatment needed to control bleeding, relieve pain and eliminate acute infection; preventive procedures necessary to prevent the imminent loss of teeth; the treatment of injuries to teeth or supporting structures; dentures and the costs of preparation and assembly; routine procedures necessary to maintain good oral health. Emergency Response Services (ERS) — An electronic monitoring system for use by persons with functional disabilities who live alone or are isolated in the community or are at high risk of institutionalisation. In an emergency, the member can press a call button to ask for help. The electronic monitoring system, which has a 24-hour, seven-day-a-week capability, helps ensure that the right persons or service provider respond to an alarm call from the member. Employment Assistance Services (EAS) — Services that help the member find competitive employment or self-employment. Financial Management Services (FMS) — Assistance to members with the management of funds associated with services chosen for the Consumer Directed Services (CDS) option and provided by the Financial Management Services Agency (FMSA). This service includes initial guidance and permanent training in relation to the responsibilities of being an employer and complying with legal requirements for employers. Home Delivered Meals (HDM) — Services that provide nutritional-healthy meals delivered to the member's home. Small home modifications (MMCs) — Services that assess the need, make changes or improvements to an individual's home to enable the individual to live in the community and ensure safety, safety and accessibility. Nursing Services – Includes, but is not limited to, assessing and evaluating health problems and the immediate delivery of nursing duties, providing treatments and health care procedures ordered by a doctor or required by professional practice standards state law, delegate nursing duties to unlicensed individuals under state rules promulgated by the Texas Board of Nursing, developing the health care plan and teaching individuals about good health maintenance. Occupational Therapy (OT) Services — — and procedures to promote or improve safety and performance in important activities of daily life (IADLs), education, work, play, leisure and social participation. Services include the full range of activities undertaken by an occupational therapist or a licensed OT assistant led by a licensed occupational therapist, under the therapist's state license. Personal Assistance Services (PAS) — Including assisting the member in the execution of ADL and household tasks necessary to keep the house in a clean, sanitary and safe environment. The level of assistance provided shall be determined by the needs of the Member and the POC. Services may also provide nursing duties delegated by a registered nurse in accordance with state rules promulgated by the Texas Board of Nursing and protective oversight solely to ensure the health and well-being of a member with cognitive/memory impairment and/or physical weakness. To be eligible for STAR+PLUS HCBS program PAS, the MCO must assess candidates in a personal visit. Members are assessed using Form H2060, Needs Assessment Questionnaire and Task/Hour Guide, or Form H6516, Community First Choice Assessment. STAR+PLUS HCBS program PAS eligibility requires only that the applicant or member needs help with at least one personal care task identified on Form H2060. The 24-point score that qualifies for State Plan PAS does not apply to STAR+PLUS HCBS program PAS. Physiotherapy (PT) Services — Specialized techniques for evaluation and treatment related to functions of the neuro-musculo-skeletal systems. Services include the full range of activities undertaken by a physical therapist or a licensed PT assistant led by a licensed physical therapist, under the therapist's state license. Respite Care Services - Temporary Relief to Persons Who Care for Functionally Disabled Adults in Community Settings Other Than Adult Foster Care (AFC) Homes or Assisted Living Facilities (ALF). Respite services are offered in-home and out-of-home and are limited to 30 days per individual service plan (ISP) year. Room and board is included in the payment for out-of-home settings. Speech and/or language pathology services — The evaluation and treatment of limitations, disorders or deficiencies related to a member's speech and language. Services include the full range of activities undertaken by speech and language pathologists under the scope of their state licensure. Supported employment services (SES) — Services assisting the member in maintaining competitive or self-employment. Transition Services (TAS) — Helps members with one-time set-up costs for transitioning from nursing homes to the community. Services may include bail assistance for leases on apartments or dwellings, dwellings, household furniture, set-up fees for utilities, removal costs, pest eradication or one-time cleaning. 1200 MCO review of the coordination of services 19-1; As of June 3, 2019, Managed care organizations (MCOs) must contact all members at the time of registration and at least annually thereafter. If a member receives long-term services and support (LTSS), has a history of health or substance use disorders (SUD), or who is duplicate, the identified MCO service coordinator must contact the member at least once by telephone and at least once in person each year. If the member receives the STAR+PLUS Home and Community Based Services (HCBS) program or has a complex medical condition, the identified MCO service coordinator must personally visit the member at least twice a year. If a member resides in a nursing home (NF), the MCO service coordinator must meet the member in person at least four times a year. All applicants or recipients of LTSS receive service coordination from the MCO. The coordination of services is intended to bring acute care and LTSS together. Service coordination includes the development of an individual service plan (ISP) with the person, family members and provider, as well as the authorization of LTSS for the member. MCO service coordination is responsible for working with the member and his or her acute care and LTSS providers to ensure that all of a member's medically and functionally necessary services are provided. This includes, but is not limited to, referring and assisting the member in obtaining appointments with specialists, participating in discharge planning for members in hospitals and/or NFs, referring members to community services organizations, and assistance not covered by Medicaid. Service coordination requirements for members receiving star+plus HCBS program can be found in Section 3000, STAR+PLUS HCBS Program Eligibility and Services, Section 6000, Specific STAR+PLUS HCBS Program Services, Section 5000, Automation and Payment Issues in STAR+PLUS, and Appendices. Service coordination requirements for members receiving Medicaid state plan LTSS can be found in the Uniform Managed Care Contract. The following sections describe the responsibilities of MCO service coordinator for members in certain facilities or programs. 1210 Service Coordinators and Nursing Facilities Review 19-1; As of June 3, 2019, members living in a nursing home (NF) (except members who receive hospice care or live outside the service area of the managed care organization (MCO) must receive at least quarterly personal visits for assessment purposes. NF staff should invite MCO service coordinators to their about the planning of resident care or other interdisciplinary team meetings, as long as the resident does not object. These meetings are not compulsory, but are highly recommended and participation may be or by phone. The MCO must, upon request, keep and make available documentation to verify the occurrence of required personal service coordination visits, which may coincide with or include participation in care planning or other interdisciplinary team meetings. Service coordination activities for members residing in an NF include, but are not limited to: Visiting members at least quarterly; Assessment of the member within 30 days of entry into an NF or registration in the health plan; Within 14 days of hearing that a significant change in the member's condition has taken place; Within 14 days of learning that a resident is requesting a transition to the community; Developing a plan of care (POC) to transfer the individual to the community (if applicable and the choice of the resident); If the first review does not support return to the community, a second review is performed 90 days after the first review; The transition from member to community in accordance with the Texas Promoting Independence Initiative, including Money Follows the Person (MFP), if applicable; Notify the specialist of the Moving Contract within three working days of a meeting with the member; Reporting the local authority for residents who meet the requirements of pre-admission screening and resident review (PASRR), local intellectual and developmental disability authority (LIDDA) or local mental health authority (LMHA), as appropriate; Working in collaboration with the NF redundancy planning team; Coordinating the transition with Community partners; Coordination of the transition if the resident moves to a service area which is not operated by this MCO, by setting up single case agreements, if necessary; Identifying and addressing the physical, mental or long-term needs of residents; Helping residents and families understand the benefits; ensure access to and coordination of the services required; Finding providers to meet specific needs; Coordination and notification of add-on services not included in the daily rate; and Assistance in collecting applied income. NF Business Office manager (BOM) is responsible for collecting applied income. The BOM can notify the MCO service coordinator for assistance in collecting the applied income after two collection attempts have been unsuccessful. The role of the MCO service coordinator is to inform the resident and his responsible party about the rules regarding the payment of applied income to the NF and the possible consequences of not doing so. As a member participating in the STAR+PLUS Home and Community Services (HCBS) program is admitted to an NF, the NF service coordinator must notify the Program Support Unit (PSU) within three working days of admission with Form H2067-MC, Managed Care Programs Communication. 1220 MCO Service Coordinators and Programs serving members with intellectual or developmental developmental disabilities 19-1; As of June 3, 2019, persons with intellectual or developmental disabilities (IDD) and living in a community-based intermediary care facility for persons with intellectual disabilities or related conditions (ICF-IID) or receiving services through one of the following IDD waivers will receive their acute care services only through the STAR+PLUS program and continue to receive their long-term services and support (LTSS) through Medicaid waivers in 1915(c) : Community Living Assistance and Support Services (CLASS); Deafblind with multiple disabilities (DBMD); Home and Community Services (HCS); or Texas Home Living (TxHmL). Individuals who receive services through one of these four programs and receive Medicare Part B (dual eligible) will not be included in the STAR+PLUS program. Members with IDD who meet the above criteria have a named managed care organization (MCO) service coordinator. The number of required service coordination visits or phone calls and the degree of service coordination varies by sharpness and the personal preference of the member or authorized representative (AMs). These members also have a LIDDA provider that is a person(s) outside the MCO that develops and implements an individual service plan (ISP) and monitors the delivery of LTSS service. The MCO service coordinator must respond to requests from the member's waiver application manager or service coordinator. The member's waiver application manager or service coordinator must invite MCO service coordinators to care planning meetings or other interdisciplinary team meetings, as long as the member does not object. These meetings are not mandatory, but are highly recommended and participation can be personal or telephone. The MCO service coordinator is responsible for coordinating the acute care of the member. 1230 Service Coordinators and Home and Community Based Services - Adult Mental Health Program Revision 19-1; From 3 June 2019, the Home and Community Based Services - Adult Mental Health (HCBS-AMH) programme serves individuals with serious and persistent mental illnesses (SPMI) and: a history of extensive (three cumulative or consecutive years) institutional residence in psychiatric institutions; SPMI and frequent visits to the emergency department; and SPMI and frequent arrests and stays in a correctional facility. HCBS-AMH offers a range of enhanced community-based services, including residential assistance, aimed at the program's population. HCBS-AMH is conducted on a fee-for-service (FFS) basis through the Texas Health and Human Services Commission (HHSC). Each individual is assigned a recovery manager (RM), who monitors and coordinates HCBS-AMH services through meetings of Members enrolled in HCBS-AMH receive their acute care through their managed care organization (MCO) and their improved improved services of providers who have entered into a contract with HHSC. Additional information about HCBS-AMH can be found at: . Program Point of Contact (PPOC) Each MCO must have a designated PPOC for the AMH program. The PPOC is responsible for the following: Ensuring that MCO service coordinators are aware of the HCBS-AMH services offered and their coordination responsibilities; and respond within three business days to concerns from HHSC or RM's to mitigate any service coordination issues, including non-cooperative MCO service coordinators, missed teleconferences, or other concerns regarding MCO participation in the AMH program. MCO Service Coordination Responsibility MCO service coordination should participate in telephone recovery plan meetings, as scheduled by HHSC or RMs, and any requested member-specific information prior to the meeting. MCO service coordinators must: Send requested information to the HHSC or RM three business days before the scheduled recovery plan meeting. This information includes, but is not limited to: updates relating to the member's condition; sharing relevant authorizations, such as an authorization or contact information from a provider when an HCBS-AMH member receives community first choice (CFK) services; upcoming MCO service coordinator face-to-face appointments and/or scheduled dates for telephone contacts with the member; relevant member treatment documents as requested by the RM or HHSC. Respond to RM or HHSC ad hoc requests within one business day with urgent in the subject line. Respond to non-urgent ad hoc requests in a timely manner. Coordinate with the Program Support Unit and RM or HHSC when a member transitions from STAR+PLUS Home and Community Based Services (HCBS) program to HCBS-AMH. HCBS-AMH can provide transitional planning for people who live in an institution and who are also enrolled in a STAR+PLUS MCO. MCO service coordinators must participate in scheduling meetings with an RM, by phone or in person, during the member's stay. Planning meetings focus on the coordination of services in the case of discharge from the psychiatric institution. MCO service coordinators are responsible for providing the treatment information requested by RM for transition planning purposes. STAR+PLUS MCOs must meet all discharge planning requirements as described in Uniform Managed Care Contract (UMCC), section 8.3.2.5. 1240 MCO Service Coordinators and section 811 Project Rental Assistance Program Revision 19-1; As of June 3, 2019, the Project Rental Assistance Program (PRA) provides section 811 subsidised rental housing in coordination with support to people with disabilities. Every tenant in the Pra program of section 811 has a Section Managed care organization (MCO) service coordinators are the Section 811 service coordinators coordinators STAR+PLUS members coming from nursing homes (NFs). Service Once a person has occupied a section 811 PRA housing unit, the MCO service coordinator must ensure that STAR+PLUS Home and Community Based Services (HCBS) are present so that the member manages to maintain his or her lease. Continued participation in these services is voluntary and not a condition for remaining in Article 811 PRA housing. The Section 811 PRA program relies on Medicaid services and service coordination to support the support an individual needs to stay safe in the community. The MCO service coordinator is responsible for informing individuals in NFs about the availability of this program and if they are interested, to assist them in submitting an application and the required documentation. The MCO can delegate this responsibility to the relocation specialist. If eligible, the MCO service coordinator must assist eligible individuals in obtaining the available funding to assist with relocations. Communication between MCO and Texas Health and Human Services Commission (HHSC) The MCO service coordinator must continually coordinate with the HHSC Section 811 Point of Contact (HHSC POC) with respect to members participating in the Article 811 PRA program. The HHSC POC is listed on the Texas Department of Housing and Community Affairs (TDHCA) Section 811 PRA web page: . MCO Responsibilities – Helping potential applicants Information about such laws and requirements will be transferred to the training provided by TDHCA and in the Texas Section 811 PRA Program Service Coordinator Manual. Specific responsibilities of the service coordinator of section 811 are listed below: Assist in recruiting and prescreening potential participants; The MCO service coordinator or relocation specialist will assist people in accessing Article 811 PRA homes; Inform NF residents who have expressed interest in moving to the community about the availability of the Section 811 PRA program. Inform persons who have switched from an NF to the community in the past 12 months about the availability of the Article 811 PRA programme; Assist interested parties in assessing available properties and their leasing criteria on the TDHCA website (; Inform interested parties based on information provided by TDHCA about the possible waiting time for an available unit; Assist interested parties in completing an application for rent and compiling the necessary documentation; Ensure that all methods of information and referral are in accordance with housing and civil rights, laws and regulations and positive marketing requirements; and help residents maintain their homes. MCO Point of Contact Requirements – for potential applicants applicants Members who have signed up for the Section 811 PRA program, the MCO must update information collected at the time of application to the program, if anything changes. This ensures that the member can be contacted and the information in the file with TDHCA is correct. The MCO must ensure that the HHSC Section 811 POC and the TDHCA POC have the means to identify and contact the member within one business day after receiving a notice that an Article 811 PRA program unit is available. MCO Responsibilities – for existing tenants Once an individual is accepted for lease in a section 811 PRA program unit, the MCO service coordinator will provide the following support to assist individuals in the maintenance of their property: Subject to an individual's consent to share this information, respond to an investigation by the HHSC Section 811 POC regarding a member's participation in Article 811 , including the services received by the member and who the service providers are; Meet the obligations of the Section 811 service coordinator in the conflict management process set out in the Texas Section 811 PRA Program Service Coordinator Manual, including: Working with section 811 POC and section 811 PRA program owner or the owner of the designated agent (such as the property management company) in the event of an incident, including a lease violation that violates the person's ability to maintain his or her lease in a Section 811 could jeopardize PRA program; and Work with section 811 POC and the section 811 PRA program owner or owner designated agent to support the member in such a way that they do not lose their housing due to a lack of services or a lack of coordination of services. As a tenant in a section 811 PRA program unit, a member may refuse services and this does not jeopardize his or her housing. The MCO must ensure that the HHSC POC and the TDHCA POC have the resources to identify and contact an individual's Section 811 service coordinator within one business day after receiving a notification from the owner of the department-PRA program, the owner's connector, or TDHCA POC. MCO Point of Contact Requirements – for existing tenants MCO service coordinators serving members participating in the section 811 PRA program should ensure that the HHSC POC has the MCO service coordinator contact information. If the information about the MCO service coordinator changes or no longer meets the roles and responsibilities associated with the Article 811 PRA program for a member, the MCO service coordinator should notify the HHSC POC. Additional references for section for MCOs MCO service coordinators serving members who leave an NF or other institution and participating in the Section 811 PRA programme must meet the tasks and responsibilities assigned to them in the Inter-Agency Agreement (HHSC Contract No. 529-12-0134-00001), as amended and where applicable, and MCO service coordinators agree to comply with the obligations assigned to Section 811 service coordinators in accordance with the Texas Section 811 PRA Program Service Coordinator Manual. MCO service coordinators serving members participating in the Section 811 PRA program can download and read the Texas Section 811 PRA Program Service Coordinator, available on TDHCA's web page. At HHSC's request, the MCO service coordinator or designer must receive training in the PRA program of Section 811. Training can include, but are not limited to, personal training, webinars, conference calls or responding to email requests. 1250 Service Coordinators and the Medicaid for Breast and Cervical Cancer Program Revision 19-1; As of June 3, 2019, people eligible for Medicaid through the Medicaid for Breast and Cervical Cancer (MBCC) program will be a mandatory population in the STAR+PLUS program. The MBCC program provides Medicaid services, including, but not limited to, cancer treatment and precancerous conditions for individuals with eligible diagnoses between the ages of 18 and their 65th month of birth. An MBCC program member aged 18 to 20 is enrolled in STAR+PLUS. If you are eligible for the MBCC program, a person under the age of 21 can participate in the STAR+PLUS program. Individuals in the MBCC program receive their Medicaid services through their STAR+PLUS managed care organization (MCO). The person is assigned a named service coordinator and receives at least one telephone contact and one personal visit each year, unless otherwise requested by the MBCC member. The MCO service coordinator assists the MBCC member with coordinating care. Coordination can include, but is not limited to, assistance in renewing Medicaid eligibility by recalling and helping with paperwork. Continued participation in MBCC requires a completed MBCC renewal application and physician certificate the individual requires continued, active treatment for breast or cervical or pre-cancer. The doctor's statement and eligibility paperwork must be filed every six months. An MBCC person under the age of 21 can also be on the Medically Dependent Children Program (MDCP) interest list. If the individual is at the top of the MDCP interest list, the individual can switch from STAR+PLUS to MDCP because MDCP provides additional services that are not available in STAR+PLUS or the STAR+PLUS HCBS programs. After the release of the MDCP interest list, the person is processed as a STAR member who switches to MDCP. When the individual reaches the age of 21, the MDCP member will switch to STAR+PLUS HCBS programme as medical assistance (MAO) upgrade using the transition process for high needs. MBCC members aged 21 or over requesting Star+Plus HCBS Program Services upgraded to the STAR+PLUS HCBS program without being on the interest rate list. However, PSU staff must submit an enrollment package that includes Form H1200, Application for Assistance – Your Texas Benefits, such as Medicaid for the Elderly and People with Disabilities (MEPD) is required to review the Medicaid application using ME-Waiver eligibility rules. After the registration package is received, PSU employees

send Form H1200, along with Form H1746-A, MEPD Referral Cover Sheet, to mepd. If the individual qualifies as an MAO applicant, MEPD will change the individual Medicaid from MBCC to ME-Waivers in the Texas Integrated Eligibility Redesign System (TIERS). Section 2000, revision of legal requirements 19-1; With effect from 3 June 2019 2100 Disclosure of information review 18-2; As of September 3, 2018 2110 Confidential nature of the case record overhaul 18-2; As of September 3, 2018, information collected in determining initial or ongoing eligibility will be confidential. The Texas Health and Human Services Commission (HHSC) and the Managed Care Organization (MCO) may disclose general information about policies, procedures, or other methods of determining suitability, and any other information that does not specifically identify a member or does not specifically identify. A member or authorised representative (AR) may view all information in the file and in HHSC or MCO manuals that contributed to the eligibility decision. 2111 Verification of the identity of an applicant, member, authorised representative or individual review 19-1 of third parties; As of June 3, 2019, all information that the Texas Health and Human Services Commission (HHSC) and the Managed Care Organization (MCO) have about a member or authorized representative (AR) about the member's case will be confidential. Confidential information includes, member's name, date of birth (DOB), address, Social Security number (SSN), Medicaid identification (ID) number or other individually identifiable health information. Before discussing or releasing information about a member or AR about the member's case, you take steps to reasonably ensure that the person receiving the confidential information is the member or person who authorized the member to receive confidential information (for example, a lawyer or AR). 2111.1 Telephone communication revision 19-1; With effect from 3 June 2019 Establish the identity of a person who identifies himself as an applicant or member by the person's knowledge of one of the following: applicant or member social security number (SSN) and date of birth (DOB); member's dob and Medicaid number; member's ssn and the answer to a security question; member's dob and answer to a security question; or two security questions Establish the identity of an AR by using the knowledge of the individual of one of the above and one of the following: AR's SSN and DOB; AR's SSN and answer to a security question; AR's DOB and answer a security question; or answer two security questions. Establish the identity of attorneys or AR by asking the person for Form 1826-D, Case Information Release, or a document containing all information in Section 2114, information that may be disclosed, completed and signed by the member. The managed care organization (MCO) must keep this documentation in the member's file. 2111.2 Personal contact communication review 19-1; As of June 3, 2019, determine the identity of the person presenting himself as an applicant, member or member of the Authorized Representative (AR) to a Texas Health and Human Services Commission (HHSC) or Managed Care Organization (MCO) office by investigating: At least one form of government-issued photo ID (ID): Valid U.S. passport; Texas Department of Public Safety (DPS) driver's license or identification (ID) card; DPS Texas Election Identification Certificate; DPS gun license; U.S. military ID card with the photo; or employee badge of public authority; and at least one form of other identification: birth certificate or birth certificate; SSN card (Social Security number); Medicaid ID card; hospital record; work or school card; voter registration card; paycheck; credit card (including gas cards); department store credit card; annual plastic membership ID card; or energy bill. Identify other HHSC or MCO employees, federal agency employees, investigators, or contractors by examining at least one source, such as: employee badge; or government-issued identity card with a photo. Identify that other HHSC or MCO employees, federal staff, research staff or contractors have access to protected health information (PHI) through one of the following: official correspondence or a telephone call from a state or regional office; or contact the HHSC Office of Chief Counsel. Contact regional or state agency personnel when federal agency personnel, contractors, investigators, or other HHSC employees or MCO employees come to the office without prior notice or identification and ask for permission to access records. If the person requests personally identifiable information (PII) or PHI, see Section 2111.4, Verification and Disclosure Documentation. 2111.3 Review of electronic postal communications 19-1; As of June 3, 2019, as managed care organization (MCO) employees receive email from an applicant, member, authorized representative (AR) or a third party providing protected health information (PHI) mco employees must respond by: copying the original investigation into a new email, removing PHI from the original request; please indicate in the reply that PHI has been removed from the original email; and respond using PHI. If the response to the investigation requires PHI to be included, MCO employees should respond by: copying the original investigation into a new email, removing PHI from the original request; inform the sender that this is not a safe method of PHI transmission; and the sender in writing requests by e-mail or fax. MCO employees may not email PHI to non-government employees, including applicants, members, ARs, or third parties. For approved methods of sending PHI to applicants, members, ARs and third parties to whom the applicant, member, ARs, and third parties have given written consent to the release of PHI, see Article 2111.4, verification and disclosure documentation, for approved methods of sending PHI to applicants, members, ARs, and third parties to whom the applicant, member or AR have given written consent. MCO employees may emailly share PHI with Medicaid for the Elderly and People with Disabilities (MEPD), Texas Medicaid & Healthcare Partnership (TMHP), the MCO with which the applicant or member is enrolled, and other employees of the Texas Health and Human Services Commission (HHSC) for work-related purposes, but only if the email is sent to a verified email address; sent as an encrypted message; does not include PHI in the subject line of the email; and contains this disclaimer: Confidential: This transmission is confidential and intended solely for the use of the person or entity to which it is directed. If you are not the intended recipient, you will be informed that any control, retention, disclosure, copying, distribution or taking of other actions relevant to the content of this transmission are strictly prohibited. If you received this transmission incorrectly, you return to the sender. Password-protected documents sent via email and electronic fax documents are not considered a secure method for sending PHI. 2111.4 Review and documentation of disclosure of disclosure 19-1; As of June 3, 2019, it is only acceptable to disclose personally identifiable information (PII) or Protected Health Information (PHI) to the applicant, member, authorized representative (AR) or a third party to whom the applicant, member or AR has given written consent to the release of PII or PHI information. If pii or PHI are made public, document transactions and keep documentation in the member's file regarding how the person's identity is verified when the contact is outside the interview and the method of how the information was released to the person. Verify the identity of the person requesting disclosure of PII or PHI by investigating: At least one form of government-issued with photo:valid passport of the United States;; Texas Department of Public Safety (DPS) driver's license ID card; DPS Texas Election Identification Certificate; DPS gun license; U.S. military ID card with the photo; American citizenship certificate with the person's photo; or employee badge of public authority; and at least least form of another identity document: birth certificate or birth certificate; SSN card (Social Security number); Medicaid ID card; hospital record; identification card for work or school; voter registration card; paycheck; credit card (including gas cards); department store credit card; annual plastic membership ID card; or energy bill. See Article 2111.1, Telephone Communications, Section 2111.2, Personal Communication and Article 2140, communication with the applicant or member, for acceptable communication channels for external partners. 2112 Custody of Records Revision 19-1; As of June 3, 2019, Texas Health and Human Services Commission (HHSC) employees must use reasonable dedication to protect, protect and preserve records and prevent disclosure of the information they contain, except as provided by HHSC and Managed Care Organization (MCO) regulations. Reasonable care for employees responsible for administration includes record keeping: in a closed office when the building is closed; well submitted during business hours; and at any time in the office, except when it is authorised to remove or transfer them. 2113 Removal of registers Revision 18-2; As of September 3, 2018, Texas Health and Human Services Commission (HHSC) personnel must follow the procedures laid down for the destruction of confidential data. Managed care organizations (MCOs) must follow the procedures in the Uniform Managed Care Contract. 2114 Information which may be published Revision 19-1; As of June 3, 2019, reasonable efforts should be made to limit the use, request or disclosure of Protected Health Information (PHI) to the minimum necessary to determine eligibility and manage the program. The PHI's disclosure of the PHI of the Texas Health and Human Services Commission (HHSC) and Managed Care Organization (MCO) should be limited to the minimum required to perform the requested disclosure. For example, if an applicant or member allows income verification, including income on disability, do not disclose related medical information cases unless specifically authorized by the applicant or member. PHI may only be disclosed to a person who has written consent from the applicant, member or authorised representative (AR) to obtain the information. The applicant, member, or AR authorizes the release of information by completing and signing: Form 1826-D, Case Information Release; or a document containing all the following information: that of the applicant or member: full name (including middle initials) and Medicaid identification number; or full name (including middle initial) and or Social Security number (SSN); a description of the information to be released. Note: If a general release is authorized, you must provide the information that may be provided to the applicant, member, or AR. Ar. PHI from the file, such as names of persons who provided household information without the knowledge of the household, and the nature of the ongoing criminal proceedings; a statement specifically authorising HHSC or the MCO to release the information; the name of the person or body to which the information will be released; the purpose of the release; an expiration date related to the member, the purpose of the release, or an expiration date of the release; a declaration on whether refusal to sign the release affects the suitability for the provision of services; a declaration describing the right of the applicant or the member to withdraw the consent for the release of information; the date on which the document is signed; and the signature of the applicant, member or AR. Note: If the case information to be released includes PHI, the request for the information document must also tell the applicant, member or AR that information released under the document may no longer be private and may be further released by the person receiving the information. Occasionally, requests for information from the files of deceased members are received. In these cases, protect the confidentiality of the members' former members and survivors. HHSC's Office of Chief General Counsel handles questions about the disclosure of information under the Open Records Act. All questions and problems that persons have with regard to the release of information should be submitted to these agencies. MCO employees can contact HHSC's Managed Care Compliance & Operations (MCCO). 2115 Confidentiality of medical information — HIPAA review 19-1; As of June 3, 2019, the Health Insurance Portability and Accountability Act (HIPAA) is a federal law that sets additional standards to protect the confidentiality of protected health information (PHI). PHI is information that identifies or can be used by an individual and relates to the: past, present or future physical, mental or behavioral health or condition of the individual; providing health care to the individual; or past, current or future payment for providing health care to the individual. PHI contains, but is not limited to, a person's name, date of birth (DOB), address, Social Security number (SSN) and Medicaid ID number. 2116 Review of the privacy statement 19-1; As of June 3, 2019, Employees of the Texas Health and Human Services Commission (HHSC) and Managed Care Organization (MCO) personnel must each member receive the Notice of Privacy Practices of the Health and Human Services Agencies in after certification. This message shall inform the member or the representative (AR) of: the member's privacy rights; the tasks of HHSC and the MCO to protect health information; and how HHSC and the MCO can use or disclose health information without consent of the member. Examples of use or disclosure include health care operations (e.g. Medicaid), public health purposes, reporting victims of abuse, law enforcement purposes, sharing with HHSC or MCO contractors and coordinating government programs that provide benefits. 2117 Recognised representatives Revision 19-1; As of 3 June 2019, only the authorised representative (AR) of the applicant or member may exercise the rights of the applicant or member in respect of protected health information (PHI). Therefore, only the AR of an applicant or member may consent to the use or disclosure of PHI or PHI on behalf of an applicant or member. Exception: Texas Health and Human Services Commission (HHSC) and the Managed Care Organization (MCO) are not required to disclose the information to the AR if the member is subjected to domestic violence, abuse or neglect by the AR. Please refer to the Office of Chief Counsel, as described in Section 2114, Information that may be disclosed, if it is assumed that health information may not be released to the AR Note. : A responsible party is not automatically an AR. 2117.1 Adults and emancipated minors Review 19-1; As of 3 June 2019 If the member is an adult or emancipated minor, including married minors, the member's authorised representative (AR) shall be a person empowered to make health care decisions about the member and includes a person who appointed the member under a medical power of attorney, a durable power of attorney with the power of attorney to make decisions on health care , or a power of attorney with the power to make decisions on health care; guardian for the member appointed by the court; or person designated by law to make health care decisions when the member is in a hospital or nursing home and is incapacitated or mentally or physically incapable of communication. Please refer to the Texas Health and Human Services Commission (HHSC) Office of Chief Counsel, as described in Section 2114, Information that may be disclosed, for approval. 2117.2 Unemancipated minors review 19-1; As of June 3, 2019, a parent will be the authorized representative (AR) for a minor child, except when: The minor child may consent to medical treatment. Under these circumstances, do not disclose to a parent information about the medical treatment to which the minor child may consent. An underage child may consent to medical treatment when the minor is on active duty in the U.S. Military; minor is 16 years of age or older, lives separately from the parents and manages her or his own financial affairs; Permission diagnosis and treatment of diseases to be reported to the local health official or the Texas Department of State Health Services (DSHS); minor is unmarried and pregnant and treatment (excluding abortion) relates to pregnancy; minor is 16 years of age or older and the consent includes examination and treatment treatment drug or chemical addiction, dependence or use in a treatment facility licensed by DSHS; consent includes research and treatment for drug or chemical addiction, dependence or use by a doctor or counselor at a location other than a state-licensed treatment facility; minor is unmarried, is the parent of a child, has actual custody of the child and agrees to the treatment of the child; consent concerns suicide prevention or sexual, physical or emotional abuse. A judge is making health care decisions for the minor child or has the authority to make health care decisions for the minor child to an adult other than a parent or to the minor child. Under these circumstances, do not disclose to a parent information about health care decisions not made by the parent. 2117.3 Deceased applicant or member revision 19-1; As of 3 June 2019, the authorised representative (AR) shall be an executor, administrator or other person competent to act on behalf of the applicant, member or estate of the member for a deceased applicant or member. These include: an executor, including an independent executor; an administrator, including a temporary administrator; a surviving spouse; a child; a parent; and an heir. Please refer to the Texas Health and Human Services Commission (HHSC) Office or Chief Council, as described in Section 2114, Information that may be disclosed, about whether a particular person is the AR of an applicant or member. 2120 Applicant or member correction of information revision 19-1; As of June 3, 2019, an applicant, member or representative (AR) has the right to correct any information that the Texas Health and Human Services Commission (HHSC) or the Managed Care Organization (MCO) has about the applicant or member and any other person in the member's case. A request for correction must be in writing and: identify the applicant or the member requesting the correction; identify the disputed information concerning the applicant or member; why the information is incorrect; evidence showing that the information is wrong; specify the correction requested; and include a return address, phone number or email address on which HHSC or the MCO can contact the applicant or member. If HHSC or the MCO agrees to change protected health information (PHI), the corrected information is added to the file record, but the incorrect information remains in the file with a note that the information has been changed at the member's request. Inform the applicant, member or AR in writing within 60 days (using stationery) the information is corrected, will not be corrected, and the reason. Inform the member if HHSC or MCO must extend the 60-day period by a further 30 days to complete the correction process or obtain additional information. If HHSC or the MCO makes a correction to the making of PHI, HHSC or the MCO, the member should ask for before it is shared with third parties. The Agency will make a reasonable effort to share the correct information with individuals who have received the incorrect information if they have relied on or can rely on the information and if it is to the detriment of the member. HHSC employees should contact the HHSC Office of Chief Counsel for an overview of information. MCOs must follow HHSC procedures as stated in the Uniform Managed Care Contract, Section 11.03, Member Records. Note: Do not follow the above procedures when the accuracy of the information provided by an applicant, member, or AR is determined by another review process, such as a: honest hearing; civil rights hearing; or any other appeal suit. The decision in the above review processes is the decision on the request to correct information. 2130 Communication with the Managed Care Organization Revision 19-1; As of June 3, 2019 To comply with the Health Insurance Portability and Accountability Act (HIPAA), it is necessary that a member's protected health information (PHI) is shared only with the selected managed care organization (MCO). This makes it critical that when documents containing member information are uploaded into the incorrect MCO folder in TxMedCentral, they are corrected immediately after realization an error has been made. Send a notification of all upload errors to txmedcentraladmin@tmhp.com. Include the document recognition information, the name of the folder in which the folder was incorrectly uploaded, and the name of the folder in which the folder should have been uploaded. Please state the time the correction was made. Example: Placed 9F_2067_123456789_ABCD_2S.doc in SUPSPW at 8:54 a.m. on December 20. Should have been uploaded to MOLSPW. Corrected at 9:22 a.m Dec. All emails containing member information must be sent using encryption software. No PHI may appear in the subject line. See also: 2140 Communication with the applicant or member Revision 19-1; As of June 3, 2019, the Texas Health and Human Services Commission (HHSC) and the Managed Care Organization (MCO) must respond to a reasonable request from an applicant, member or authorised representative (ARs) to receive communications alternatively or in alternative locations The applicant, member or AR must specify in writing the alternative postal address or contact means and include a statement that the use of the home address or the normal way of contact may endanger the applicant or member of the member. 2200 review of the rights and responsibilities of members, 19-1; As of 3 June 2019, the rights and responsibilities of members will be included in the Members' Handbook. The required critical elements for members' manuals can be found . The members' manual shall be provided to the member on request. This document is shared the language preference of the applicant/member. In addition, an applicant, member, or AR may refer to Title 1 Texas Administrative Code (TAC) Part 15 §353 Sub chapter C, Member Bill of Rights and Responsibilities, to view the full list of membership rights and responsibilities. 2210 Notifications Revision 19-1; As of June 3, 2019 2211 Program Support Unit Notification Requirements Revision 19-1; As of June 3, 2019, Program Support Unit (PSU) employees will be responsible for preparing and sending notifications to the applicant, member or authorised representative (AR) who advises on actions taken regarding the suitability of programs and the right to a fair hearing. Form H2065-D, Notification managed care program services, is the legal notice sent to an applicant, member or AR of actions taken regarding STAR+ PLUS Home and Community Based Services (HCBS) program. Form H2065-D must be completed in clear language, which can be understood by the applicant, member or AR. The language preference of the applicant, member or AR should be considered. The applicant, member or AR must be notified on Form H2065-D within two working days of the date on which a case is certified. Form H2065-D also contains information about the individual's room and administrative costs and, if applicable. Form H2065-D is also used to prevent an applicant who is denied program eligibility or a member whose program is eligible is denied or terminated. PSU staff shall inform the applicant, member or AR on Form H2065-D of the refusal of the application within two working days of the decision. See section 3630, refusal or termination procedures. Depending on when the notification is generated, it will be uploaded to the managed care organization's (MCOs) STAR+PLUS folder following the instructions in Section 5110, TxMedCentral Naming Convention, and file maintenance, on the date of the case action. 2212 MCO notification requirements revision 19-1; As of June 3, 2019, the managed care organization (MCO) is responsible for notifying the member or delegate (AR) when a service is denied or reduced. This is considered to be an unfavourable action and the member or AR has the right to appeal. Professional rights of STAR+PLUS members can be found in the Uniform Managed Care Manual (UMCM), which can be found at: . 2220 notifications with MEPD engagement review 19-1; As of June 3, 2019 Some actions are based on decisions regarding Medicaid financial eligibility determined by Medicaid for the elderly and people with disabilities Specialist. Program Support Unit (PSU) personnel must coordinate changes, approvals and refusals of Home and Community Based Services (HCBS) program services with the MEPD specialist. Although the MEPD specialist is required, the applicant, member or authorized representative (AR) of all Medicaid eligibility decisions, the PSU is required to send the STAR+PLUS HCBS program applicant, member or AR notification of denial of STAR+PLUS HCBS program services on Form H2065-D, Notice of Managed Care Program Services. Section 3000, STAR+PLUS HCBS Program Eligibility and Services Revision 20-2; With effect from 1 October 2020 3100 Additional review of Member States 18-2; As of September 3, 2018 3110 Medicaid, Medicare and Dual-Eligibles Review 18-2; As of September 3, 2018 3111 Dual-Eligible Members Revision 19-1; As of June 3, 2019, Managed care organizations (MCOs) must contact all members upon registration. If there is a need or a request from the member, the MCO will assess the member when developing an appropriate care plan (POC). McOs are expected to provide innovative, cost-effective care from the outset to prevent or delay unnecessary institutionalization. Star+PLUS Medicaid-only members are required to choose an MCO and a primary health care provider (PCP) in the MCO's network. These members receive all covered services, both acute care and long-term services and support (LTSS), from the MCO. Members who receive both Medicaid and Medicare (dual-eligible) choose an MCO, but not a PCP, because members who qualify receive acute care from their Medicare providers. For members participating in the Texas Integrated Dual Demonstration, STAR+ PLUS Medicare-Medicaid Plans (MMPs) are responsible for both Medicare and Medicaid services by providing a single point of contact for the delivery, coordination, and management of Medicare and Medicaid services. 3112 Medicaid Eligibility Revision 19-1; As of June 3, 2019, the program support unit (PSU) staff must obtain information about the applicant's Medicaid and/or financial status. PSU staff must also verify the applicant's current suitability to obtain an appropriate type of Medicaid program through the Texas Integrated Eligibility Redesign System (TIERS). If there is no existing acceptable coverage type, PSU staff initiate the Medicaid financial eligibility provision process. Refer to Section 3114, applicants with Medicaid Eligibility, for Medicaid programs suitable for STAR + PLUS HCBS program financial eligibility status. Medicaid eligibility may already be established and should be used unless there are changes in the applicant's financial situation. Applicants who currently have Form H1200, Application for Assistance – Your Texas Benefits, file with the Texas Health and Human Services Commission (HHSC) may not need to complete a new Form H1200. Note: Completing or signing a for an applicant or member, it is not automatically a person to receive protected health information from PSU personnel or the managed care organization (MCO) in relation to that applicant or member. For individuals who may receive or permit the release of individually identifiable health information from an applicant or member under the privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), see Section 2119, Personal Representatives. 3113 Transfer of Form H1200 or Form H1200-EZ Revision 18-2; As of September 3, 2018 When sending Form H1200, Application for Assistance - Your Texas Benefits, or Form H1200-EZ, Application for Assistance - Age and Disability, Medicaid for The Elderly and People with Disabilities (MEPD), Program Support Unit (PSU) Personnel Fax Form H1200 or Form H1200-EZ to MEPD. Employees of the Texas Health and Human Services Commission (HHSC) retain the original Form H1200 or Form H1200-EZ with the valid signature of the applicant in the file. The original form must be kept for three years after the case has been rejected or closed. Staff must also keep a copy of the successful fax confirmation in the file. If HHSC employees are housed together with mepd, the original Form H1200 or Form H1200-EZ is delivered by hand to the MEPD specialist and HHSC employees retain a copy of the form in the file. If there are unusual circumstances in which the original must be emailed to the MEPD specialist after faxing, HHSC staff shall mark DUPLICATE on the top of the form and keep a copy of the form in the file. Scan form H1200 or form H1200-EZ and send by email is prohibited. 3114 Applicants with Medicaid Eligibility Revision 18-2; As of September 3, 2018, the program support unit (PSU) staff must obtain information about the applicant's Medicaid and/or financial status. PSU staff must verify the current applicant's eligibility for an appropriate type of Medicaid program from Medicaid for the elderly and people with disabilities (MEPD) specialist or through research into the Texas Integrated Eligibility Redesign System (TIERS). To be financially eligible for the STAR+PLUS HCBS program, see the mandatory population described in Section 3221, Mandatory Groups. Applicants who receive supplemental security income (SSI) are financially eligible for Medicaid and do not require financial determination; the Social Security Administration (SSA) has already made this determination. Applicants who receive services through Community Attendant Services (TIERS TP14) are not automatically eligible for the STAR+PLUS HCBS program. For these applicants, specialists from the parliament will be consulted. Applicants Who Currently Have Form H1200, Apply for Assistance – Your Texas Benefits, file with the Texas Health and Human Services Commission (HHSC) can't fail to complete a new Form H1200. 3115 applicants without Medicaid eligibility review 19-1; As of June 3, 2019, the Code of Federal Regulations (CFR), Section 42 CFR 431.10, stipulates that Medicaid must be eligible by one government agency. The Texas State Plan designates the Texas Health and Human Services Commission (HHSC) as the only agency with the authority to make eligibility provisions for medical assistance-only (MAO) cases. Financial suitability for non-supplemental Security Income (SSI) STAR + PLUS Home and Community Based Services (HCBS) program is determined solely by the Medicaid for the Elderly and People with Disabilities (MEPD) specialist. The staff of the Program Support Unit (PSU) may not: screen applicants from referral to the SPD due to apparent financial ineligibility; or refuse requests or recertification on the basis of criteria for financial eligibility, unless the MEPD specialist has informed the financial ineligibility specialist. If the applicant's individual income exceeds the SSI federal benefit (FBR) per month, the applicant applies for Medicaid through HHSC by filling out Form H1200, Application for Assistance - Your Texas Benefits, for MAO. If the combined income of the applicant and the spouse exceeds the SSI FBR for a couple, the applicant can apply to HHSC. For the current SSI FBR, see Appendix VIII, monthly income/resource limits. 3116 Monthly income under the supplemental income security Standard Payment Revision 19-1; As of June 3, 2019, a community applicant (without an ineligible spouse) who has less income than the supplemental benefit rate (SSI) for SSI must apply through the Social Security Administration (SSA). Texas Health and Human Services Commission (HHSC) personnel cannot determine financial suitability for these individuals except for cases where the SSI application for disability has been pending for more than 90 days and a decision is made by HHSC Determination Disability Unit (DDU) personnel. If there is a question as to whether the applicant should apply for ssi or only medical assistance (MAO), the staff of the Program Support Unit (PSU) can consult the regional Medicaid for the Elderly and People with Disabilities (MEPD) specialist. 3117 Coordination with Medicaid for Elderly and People with Disabilities Staff Overhaul 18-2; As of September 3, 2018, program support unit (PSU) personnel must inform the applicant or member without pre-existing Medicaid coverage and/or his or his authorized representative (AR) that the Medicaid for the Elderly and People with Disabilities (MEPD) specialist will complete a financial eligibility (Medicaid) provision. PSU staff should be encourage the applicant, member or AR to cooperate with the MEPD specialist and to provide all required verifications in a timely manner. All information, including information about third parties obtained by PSU staff, it must be shared with the MEPD specialist to prevent the applicant or member from having to provide the information twice. PSU employees should inform the MEPD specialist of the request for the STAR+PLUS Home and Community Based (HCBS) program in accordance with regional procedures. For those applicants or members already on a suitable type of Medicaid program, PSU staff must obtain a copy of the most recent: Form H1200, Application for Assistance - Your Texas Benefits; Form H1200-A, Medical Assistance Only (MAO) Recertification; or Form H1010, Texas Works Application for Assistance – Your Texas Benefits An applicant for the STAR+PLUS HCBS program providing medical assistance only (MAO) coverage type Medicaid services can only receive the STAR+PLUS HCBS program after a program transfer to Medicaid waivers has been completed by the MEPD specialist. If an applicant for the STAR+PLUS HCBS program has mao coverage type, as indicated in the Texas Integrated Eligibility Redesign System (TIERS), a completed Form H1200 must be sent to the applicant. The completed application must be forwarded to the MEPD specialist for processing. PSU employees should also send an email to the MEPD specialist with the following information: the name of the applicant; Applicant's Medicaid Identification Number (ID); individual has MAO coverage-type Medicaid, which will require a program transfer; and name and phone number of psu staff contact. The MEPD specialist will make the necessary changes to enable the MA coverage-type Medicaid individual to receive the STAR+PLUS HCBS program. Identification of MAO Coverage-Type Medicaid PSU staff can monitor tiers to determine a member's coverage type. TIERS displays the cover type on the Search/Overview screen with mao's foreword. An application form is not required for members who receive additional security income (SSI). If the application for a STAR+PLUS HCBS program for an application for SSI disability has been under consideration for more than 90 days, staff at the Texas Health and Human Services Commission (HHSC) Disability Determination Unit (DDU) may determine whether disabilities are pending the adoption of the Social Security Administration (SSA). The SSI decision should be adopted when it is received from SSA. To identify DDU employees with disabilities, DDU staff need Form H3034, Disability Determination Socio-Economic Report, Form H3035, Medical Information Release/Disability Determination and a copy of the Medical Necessity and Level of Care (MN/LOC) Assessment. If additional data are required, the MEPD specialist will be informed. 3117.1 Income and means verifications for for the elderly and people with disabilities review 19-1; As of June 3, 2019, all information, including information about third-party insurance, obtained by Program Support Unit (PSU) personnel should be shared with the for the elderly and disabled persons (SPD) to prevent the applicant or member from having to provide the information twice. All information obtained by Managed Care Organization (MCO) employees must be forwarded immediately to PSU employees so that it can be passed on to the MEPD specialist. Only inform medical aid (MAO) applicants of the importance of providing as complete a package as possible to the MEPD specialist. Explain that failure to submit the required documentation to the MEPD specialist may delay the completion of the application or result in the application being rejected. Ensuring that the following items are included significantly facilitates the process of financial suitability: bank accounts – bank accounts, account number, balance and account verification (e.g. a copy of the bank statement) Award letters with the amount and frequency of income payments Life insurance – business name, policy number, face value or a copy of the Policy A signed and dated Form H0003, Agreement to release your facts confirmation that Medicaid Estate Recovery Program information was shared with the applicant by checking the correct box on Form H1746-A, MEPD Referral Cover Sheet Preneed funeral plans - company name, policy or plan number and a copy of the pre-page need agreement Correct and up-to-date phone numbers Power of Attorney or custody – copy of the legal document PSU staff must inform the MEPD specialist about the request for the STAR+PLUS Home and Community Based Services (HCBS) program , in accordance with regional procedures. PSU staff must obtain a copy of the most recent Form H1200, Application for Assistance – Your Texas Benefits, for those applicants or members already on a suitable type of Medicaid program. Form H1200 is not required for members who receive additional security revenue (SSI). If the application for a STAR+PLUS HCBS program for an applicant or member for SSI disability has been under consideration for more than 90 days, staff at the Texas Health and Human Services Commission (HHSC) Disability Determination Services (DDS) may determine or disability, pending the adoption of the Social Security Administration (SSA). The SSI decision should be adopted when it is received from SSA. To identify DDS staff disabilities, DDS staff need Form H3034, Disability Determination Socio-Economic Report, Form H3035, Medical Information Release/Disability Determination and a copy of the Medical Necessity and Level of Care (MN/LOC) Assessment. If additional information is required, the MEPD specialist will be informed. 3117.2 MAO applicants who have not been previously in TIERS review 18-2; As of September 3, 2018 a new application is defined as an application for a Medicaid for the elderly and people with disabilities (MEPD) households not previously certified in the Texas Integrated Eligibility Redesign System (TIERS). Once Once determine whether applicants referred to the MEPD for a financial determination have no prior certifications in TIERS; Form H1746-A, MEPD Referral Cover Sheet, and Form H1746-B, Batch Cover Sheet, should be used to form H1200, Apply for Assistance - Your Texas Benefits, Form H1200-EZ, Application for Assistance - Age and Disabled, or Form H1010, Texas Works Application for Assistance - Your Texas Benefits, to the Midland Document Processing Center (DPC). Form H1746-B must be attached to the top of each batch with more than one form H1746-A sent to DPC. 3117.3 Review of unsigned applications 18-2; As of September 3, 2018, unsigned applications received by the Medicaid for the Elderly and People with Disabilities (MEPD) specialist will be returned to the sender. Employees of the Texas Health and Human Services Commission (HHSC) must ensure that applications are signed before referring them to the MEPD specialist; if not, HHSC employees must obtain signatures when unsigned requests are returned. The application forms are: Form H1200, Application for Assistance - Your Texas Benefits; Form H1200-EZ, Aid Application – Elderly and Disabled; Form H1200-A, Medical Assistance Only (MAO) Recertification; and Form H1010 - Texas Works Application for Assistance - Your Texas Benefits. If the MEPD specialist receives an unsigned application from HHSC with Form H1746-A, MEPD Referral Cover Sheet, MEPD will return the application to HHSC with a note on the cover form (Form H1746-A) that the application has not been signed and must be signed before HHSC can set a file date. Once HHSC employees receive an unsigned application from the MEPD specialist, it is the responsibility of HHSC employees to coordinate with applicants or members when receiving applications signed and returned to the MEPD specialist for processing. Sending unsigned applications delays the eligibility processes of the SPD and HHSC and can have a negative impact on the provision of services to applicants or members. 3117.4 Medicaid Eligibility Decisions pending the program expiration review 19-1; As of June 3, 2019 For most Medicaid for the elderly and people with disabilities (MEPD) applications, eligibility decisions are due by the 45th day. However, applications for persons under the age of 65 may require a period of 90 days to enable the Agency to obtain a disability provision. This applies where the age of the person is under 65 years of age and the person does not have Pension, Survivor and Disability Insurance (RSDI), Security Income (SSI) or Railroad Retirement (RR). A disability determination by the Texas Health and Human Services Commission (HHSC) is required even if the person has received a medical necessity and level of care (MN/LOC) determination under the STAR+PLUS Home and Community Based Services (HCBS) program fitness component criteria. For other cases cases (e.g. program transfers), the MEPD specialist may need time to verify revenue and resources. This is especially true if the previous case was community-based or included an individual declaration of income/resources. Employees of the Program Support Unit (PSU) can contact mesed as soon as they have been in treatment for more than 45 days. 3120 Other available services revision 18-2; With effect from 3 September 2018 3121 Prescription Medicines Revision 18-2; As of 3 September 2018, prescription drugs will not be part of the service of the managed care organisation (MCO). Effective September 3, 2018 Prescription drugs are not part of the managed care organization's (MCOs) array of services. STAR + PLUS Medicaid-only members continue to have prescriptions filled by a pharmacist participating in the Texas Health and Human Services Commission (HHSC) Vendor Drug Program (VDP). They receive unlimited medically necessary prescriptions instead of limiting the traditional three prescriptions per month. Drug coverage via VDP is limited to the formulas of the state and may not cover all prescribed medications needed for the individual. Medicare prescription drug coverage (Medicare Part D) is an insurance policy that covers both brand name and generic prescription drugs at participating pharmacies in the member's area. Medicare prescription drug coverage provides protection for people who have very high drug costs. Medicare members are eligible for this coverage regardless of income and resources, health status or current prescription costs. Members who qualify for both Medicaid and Medicare (dual-eligibility) receive the majority of their drugs through Medicare Part D. The MCO must inform individuals applying for the STAR+PLUS program about the prescription coverage available through the STAR+PLUS program and the Medicare Part D program. The following information regarding the impact of the Medicare Part D program on members should be explained to the applicant: If a member is considered dual-eligible (receiving from both Medicare and Medicaid), the member obtains prescriptions first through Medicare Part D or, for certain prescription drugs excluded from Medicare Part D, through the VDP. Drug coverage through Medicare is limited to the formulas of any drug plan and may not cover all prescribed medications needed for the member. Prescriptions not covered by Medicare Part D can be paid for by the Medicaid Vendor Drug Program; however, the Medicaid Vendor Drug formulas do not cover certain prescription drugs and over-the-counter medications. Members participating in Medicare Part D are responsible for purchasing medications and copayments for medications not covered by Medicare Part D The Medicaid VDP. Members who do not participate, or those who opt for private insurance on Medicare Part D, are also responsible for purchasing medications and copayments for medications not covered by Medicare Part D or the Medicaid VDP. Members who qualify for both Medicare and Medicaid can receive assistance from costs through the Low Income Subsidy Programme. These members pay little or no premiums and no excess. Drug money amounts can range from $1 to $5. Federal law prohibits the use of STAR+ PLUS program funds for Medicare Part D prescriptions, copayments and expenses. STAR + PLUS program funds cannot be allowed for prescriptions, copayments and expenses if the member qualifies for Medicare Part D and opts for private insurance instead of participating in Medicare Part D. Unsecured medications cannot be billed through the STAR+ PLUS program as medical supplies or adaptive devices. Copayments for prescriptions that fall under the Veterans Benefits Administration can be allowed as an adaptive aid through the STAR+ PLUS program. Members who contribute to the cost of their care may be eligible to count Medicare Part D expenses as an incurred medical expense if they: live in the community and have a qualified income trust (QIT); or received assisted living (AL) or adult foster care (AFC) services. For a member whose current Medicaid identity card does not include the statement it can receive more than three prescriptions, pharmacists can verify that the STAR+ PLUS program qualifies for more than three prescriptions by calling Pharmacy Billing at 1-800-435-4165. A list of THE STAR+ PLUS program enrollments is sent to the Medicaid VDP daily. VDP employees register the member on the system within two days of the member's enrollment record being registered for STAR+PLUS program services. Pharmacists should check the member's Texas Benefits Medicaid card monthly to ensure that the member remains eligible for Medicaid. Star+PLUS Home and Community Based Services (HCBS) program members who contribute to the cost of their care may be eligible to count Medicare Part D costs as medical expenses incurred. See Section 3123, Medical Expenses. 3122 Over-the-Counter Drugs Overhaul 18-2; As of September 3, 2018, the STAR+PLUS Home and Community Based Services (HCBS) program will not pay for over-the-counter medications, with or without a prescription or certificate from a doctor or health professional. Over-the-counter drugs are generally considered medications that can be sold to a customer without a prescription and do not require the direct guidance of a doctor or health care provider. Common over-the-counter medications include painkillers, decongestants, antihistamines, cough medications, vitamins, minerals and herbal supplements. This list is not all-inclusive.

Medications, including over-the-counter drugs not covered by the Texas Health and Human Services Commission (HHSC) Vendor Drug Program (VDP), Medicare Part D or other external drugs (TPR), cannot be star + PLUS HCBS program. For more information, see section 3121, prescription drugs. 3123 Medical expenses review 18-2; From 3 September 2018 2018 medical expenses (IE's) are out-of-pocket costs a medical aid only (MAO) member can make for the necessary medical services. IEs include the cost of medically necessary items that are not covered by Medicaid, such as Medicare Part D premiums. Members of the STAR+PLUS Home and Community Based Services (HCBS) program that contribute to the cost of their care, may be eligible for counting Medicare Part D costs (such as premiums, increased premiums, prescription drugs copayments/deductibles, drugs not covered by Medicare Part D, the Texas Health and Human Services Commission (HHSC) Vendor Drug Program (VDP) and non-formulary drugs) as IMEs if they: live in the community and have a Medicaid copayment due to a qualified income trust (QIT); or living in an adult foster home (AFC) or an assisted living facility. Members who wish to use ISEs to pay Medicare Part D costs must report these costs to the Medicaid for the Elderly and People with Disabilities (MEPD) specialist so that the cost can be included in the calculation of the copayment for the STAR + PLUS HCBS program. The statement from the member of Medicare Part D cost is acceptable. No written documentation is required from the member to support the statement. The arrangement for the payment of prescriptions is between the member and the pharmacist. Some drugs are not covered by Medicare Part D, Medicaid or private drug coverage. To prevent these non-formulary drugs from being considered IEs, a member must apply for an exception to the Medicare Part D plan for the drugs. The member is expected to use the procedure to apply for an exception, as required by her or his Medicare Part D plan. The member may submit the results of the requested exception directly to the MEPD specialist. If an exception is not requested, non-formulary drugs are not allowed IEs and the costs will be the responsibility of the member. The MEPD specialist applies the IME policy to all new members who meet the above criteria during the certification process. MePD also assesses Medicare costs and ESEs once every six months as part of regular case monitoring, or when the member makes a request to update IME costs. The member or his agent (AR) can identify and request IEs by contacting the MEPD specialist. 3124 Medical Transportation Revision 18-2; As of September 3, 2018, members of the STAR+PLUS Home and Community Based Services (HCBS) program, as recipients of Medicaid, will be eligible for the Medicaid medical transportation system for medical medical appointments. Effective September 3, 2018 STAR+PLUS Home and Community Based Services (HCBS) program members, recipients of Medicaid, are eligible to use the Medicaid medical transportation system for Medicaid-covered medical appointments. The Medicaid medical transportation system is accessible by calling the local authority whose number is available from the Texas Health and Human Services Commission (HHSC). Day activity and health services (DAHS) providers, adult foster care (AFC) and assisted living providers (AL) are responsible for planning transport for Residents. The local medical transportation contractors have procedures related to service area restrictions, schedules for travel to certain areas and requirements on the amount of notification required by STAR+PLUS HCBS program members. The AFC/AL provider must provide an escort for the member if necessary. There may be questions about the suitability of participants living in an AFC/ALF. In case of scheduling problems, or questions about suitability for transportation, participants should contact the managed health care organization to mediate on behalf of the participant in the local Medicaid medical transportation system. 3125 STAR+PLUS Home and Community Based Services Program members who request unmanaged care services review 18-2; As of September 3, 2018, the STAR+PLUS Home and Community Based Services (HCBS) program is required to provide services (except hospice) necessary to enable the member to live safely in the community. Therefore, community care for aged and disabled (CCAD) services cannot be authorized for members of the STAR+PLUS HCBS program. Star+PLUS HCBS program members requesting additional services should be referred to the managed care organization's (MCO) service coordinator. 3126 STAR+PLUS members requesting unmanaged care services revision 17-1; As of March 1, 2017, members receiving STAR+PLUS services may be eligible for a variety of Texas Health and Human Services Commission (HHSC) services. For specific information, see: 3126.1 Community Care for Aged and Disabled Services Revision 19-1; As of June 3, 2019 If members meet program requirements, star+PLUS service members will be eligible for the following Community Care for Aged and Disabled (CCAD) services: adult foster care; residential care; emergency services (ERS); home-delivered meals; and special services for people with disabilities. Members may also be eligible for informal care if the managed care organization (MCO) has rejected their request for personal counsellor services due to the lack of explanation of the practitioner's explanation of the need for the services; or lack of personal care tasks. STAR+PLUS members may never receive the following services from the Texas Health and Human Services Commission (HHSC): day time and health services (DAHS); Community Services (CAS); primary care (PHC); assisted living (AL). A person requesting CCAD services must be added to all applicable interest lists at the time of the request to protect the date and time of the request. Before processing a request, the Community Services Eligibility (CCSE) case manager must verify that the service array does not contain a service equivalent of the Title XX service requested. CCSE case manager can view the star+plus comparison charts for health plan and value-added services on the HHSC on: . Value-added services offered by an MCO are additional services approved by HHSC. Value-added services vary by MCO. HHSC employees do not have to wait for decisions on appeal from MCOs to process requests for Title XX services if the requested service is not a value-added service on the member's plan. Once the CCSE case manager has been removed from the Title XX interest list, he shall verify that the applicant's MCO does not offer an equivalent service as a value-added service and proceeds with the eligibility provision for the requested Title XX service. The member should be asked if he or she has requested the service from the MCO, if the requested service is not a value-added service, but is part of the MCO's service array. If the answer to that question is: no, the CCSE case manager refers the member to the MCO. Yes, and services were approved, the CCSE case manager refers the member to the MCO to start the delivery of services. Yes, and services are not approved or the member does not know if he or she is approved, the CCSE manager contacts the staff of the Program Support Unit (PSU). Once PSU employees confirm that the services have not been approved, the request can be processed. uncertain, the CCSE case manager refers the member to PSU staff. PSU employees will contact the MCO to inquire about the request. Once the interest list is released, CCSE case managers can decide whether you are eligible. Process requests for people enrolled in STAR+PLUS Managed Care Services only if they meet the criteria described above. Do not authorize Title XX Services for everyone who receives the STAR+PLUS Home and Community Based Services (HCBS) program. 3127 Health Insurance Premium Payment Program Revision 18-2; As of September 3, 2018, the Health Insurance Premium Payment (HIPP) program is a Medicaid program that reimburses eligible individuals for their share of an employer-sponsored HIPP. The state pays for copayments and deductions for Medicaid-covered services provided by Medicaid providers. HIPP individuals can also receive Medicaid benefits (provided by a Medicaid-enrolled provider) not covered by their employer-sponsored health insurance. To qualify for HIPP, an employee must either have Medicaid eligibility or have a family member who qualifies Medicaid. The fee may pay for individuals and their family members to receive employer-sponsored health insurance benefits when it is determined that the cost of insurance premiums and are lower than the cost of expected Medicaid spending. People participating in the HIPP program can participate in STAR+PLUS and remain enrolled in HIPP. 3200 eligibility review 18-2; As of September 3, 2018 3210 Service Areas Revision 18-2; Star+PLUS services will be available from September 3, 2018 afgebroken service delivery gebieden: Bexar Service Area: Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina en Wilson provincies Dallas Service Area: Collin, Dallas, Ellis, Hunt, Kaufman, Navarro en Rockwell provincies Harris Service Area: Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller en Wharton provincies El Paso Service Area: El Paso en Hudspeth provincies Hidalgo Service Area: Cameron, Duval, Hidalgo, Jim Hogg , Maverick, McMullen, Starr, Webb, Willacy en Zapata provincies Jefferson Service Area: Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler and Walker provincies Lubbock Service Area: Carson, Crosby, Doaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Lynn, Potter, Randall, Swisher en Terry provincies Medicaid Rural Service Area (MRSA) Central Texas Service Area: Bell, Blanco, Bosque, Brazos, Burleson, Colorado , Comanche, Coryell, DeWitt, Erath, Falls, Freestone, Gillespie, Gonzales, Grimes, Hamilton, Hill, Jackson, Lampasas, Lavaca, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Somervell en Washington provincies Medicaid RSA Northeast Texas Service Area: Anderson, Angelina, Bowie, Camp, Cass, Cherokee, Cooke, Delta, Fannin, Franklin, Grayson, Gregg, Harrison, Henderson, Hopkins, Houston, Lamar, Marion, Montague, Morris, Nacogdoches, Panola, Rains, Red River, Rusk, Sabine , San Augustine, Shelby, Smith, Titus, Trinity, Upshur, Van Zandt en Wood provincies Medicaid RSA West Texas Service Area: Andrews, Archer, Armstrong, Bailey, Baylor, Borden, Brewster, Briscoe, Brown, Callahan, Castro, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Concho, Cottle, Crane, Crockett, Culberson, Dallam, Dawson, Dickens, Dimmit, Donley, Eastland, Ector, Edwards, Fisher, Foard, Frio, Gaines, Glasscock, Gray, Hall, Hansford, Hardeman, Hartley, Haskell, Hemphill, Howard , Irion, Jack, Jeff Davis, Jones, Kent, Kerr, Kimble, King, Kinney, Knox, La Salle, Lipscomb, Loving, Martin, Mason, McCulloch, Menard, Midland, Mitchell, Moore, Motley, Nolan, Ochiltree, Oldham, Palo Pinto, Parmer, Pecos, Presidio, Reagan, Real, Reeves, Roberts, Runnels, Schleicher, Scurry, Shackelford, Sherman, Stephens, Sterling, Stonewall, Sutton, Taylor, Terrell, Throckmorton, Tom Green, Upton, Uvalde, Val Verde, Ward, Wheeler, Wichita, Wilbarger, Winkler, Yoakum, Young en Zavala counties Nue Service Area : Aransas, Bij, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kennedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio en Victoria provincies Tarrant Service Area: Denton, Hood, Johnson, Parker, Tarrant, en Wise provincies Travis Service Area: Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis en Williamson provincies 3220 In aanmerking komende groepen Herziening 18-2; Met ingang van 3 september 2018 3221 Verplichte groepen Herziening 18-2; Met ingang van September 2018 the following groups of groups services through STAR+PLUS. The program appointments are used in the following list. Additional Security Income (SSI) recipients, Texas Integrated Eligibility Redesign System (TIERS) TA 01, TA 02 and TA 22 - Individuals 21 years of age or older who are eligible for this needs tested program administered by the Social Security Administration (SSA) (full Medicaid recipients). Pickle Amendment Group, TIERS TP 03 — People aged 21 or over who would continue to be eligible for SSI benefits if the cost of living increases (COLA's) were deducted from their countable income. Disabled Widow(s) or Widower(s), TIERS TP 21 — Widow(s) or widower(s), age 60-65 years and with disabilities, who were denied SSI benefits because of the right to early age widow or widower benefits; not eligible for Medicare; and would continue to be eligible for SSI benefits without early age benefits of widow/widower and any increases in those benefits. Another group of TIERS TP 22 recipients include early widow (s) or widower (s), age 50-60 and with disabilities, who: ineligible for Medicare and were denied SSI due to an increase in widow or widower benefits due to relaxing disability criteria; and would continue to be eligible for SSI with the exclusion of pension, survivor and disability insurance (RSDI) benefit and all COLA increases. Disabled adult children, TIERS TP 18 - Adults over 21 years of age with disabilities who began before the age of 22 who would continue to be eligible for SSI benefits if qualified RSDI disabled adult children's benefits are excluded from countable income. Medicaid Buy-In, TIERS TP 87 (designated in TIERS as ME — Medicaid Buy In) - Disabled working adults over the age of 21 who receive full Medicaid benefits as a result of buying into the Medicaid program. Medicaid for breast and cervical cancer recipients, TIERS TA 67 — Persons aged 18 to 65 who meet the admission requirements defined in the Texas Administrative Code, Title 1 Part 15, Chapter 366, Sub chapter D. STAR+PLUS Home and Community Based Services (HCBS) program recipients who are only medical assistance (MAO), TIERS TA 10 (ME-Waiver) - Persons eligible for STAR+PLUS because they participate in the STAR+PLUS HCBS program. Most nursing (NF) residents, TIERS TP 38 or TA06 (SSI) or TP 17 (MAO) - Most persons living in an NF. The TIERS TA 10 ID also identifies individuals in Home and Community-based Services (HCS), Medically Dependent Children Program (MDCP) and Community Living Assistance and Support Services (CLASS). Because CLASS and MDCP people are excluded from STAR+PLUS, if a TIERS TA 10 recipient is identified as receiving any of these excluded services, contact the Program Support Unit (PSU) and provide the star+plus unsubscribing information. 3222 Revised groups excluded groups As of March 1, 2017 For excluded groups, refer to Texas Administrative Code (TAC) §353,603, Member Participation. 3223 Hospice Services in STAR+PLUS Revision 18-2; From 3 September 2018, hospice services can be provided in various environments, including nursing facilities (NFs). STAR+PLUS members may not be denied services or deregistered due to the receipt of hospice services. Hospice provides terminal illness services that are not available under the STAR+PLUS program. For example, hospice providers are able to administer painkillers that are not available to STAR+PLUS providers. NF hospice services can be identified in the Service Authorization System Online (SASO) as Service Group (SG) 8, Service Code (SC) 31. The NF counter is activated by non-hospice NF authorizations, which appear in SAS as SG1/SC1 or SG1/SC3. 3230 review of financial eligibility 18-2; As of September 3, 2018, Star + PLUS Home and Community Based Services (HCBS) program applicants who are not yet eligible to qualify Medicaid are required to complete Form H1200, Application for Assistance - Your Texas Benefits, to be assessed for financial suitability. The completed application form must be sent to the Medicaid for the elderly and people with disabilities (MEPD) specialist by proximity to business from the second business day from receipt. The MEPD specialist has 45 days (or up to 90 days if it is necessary to obtain a disability determination) to complete the application process. Application for Assistance - Your Texas Benefits, to be assessed for financial suitability. The completed application form must be sent to the MEPD specialist upon receipt of the second working day. The MEPD specialist has 45 days (or up to 90 days if it is necessary to obtain a disability determination) to complete the application process. Applicants have 30 days from the email date of the application to complete, sign and return Form H1200. After 30 days, the application must be rejected for not returning the information necessary to determine financial suitability. Before the Program Support Unit (PSU) personnel decline the application, the program support unit (PSU) personnel must first verify that the application form has not been sent directly to the MEPD specialist. If denial is necessary, document Your request is denied because you failed to return the application form sent to you on [date] in the comments section of Form H2065-D, Notice of Managed Care Program Services. For more information on financial eligibility, see Section 3112, Medicaid Eligibility the STAR + PLUS HCBS program. 3231 Income Diversion Trust Revision 18-2; As of September 3, 2018, an applicant with a qualified income trust (QIT) may be identified as eligible for the STAR+PLUS Home and Community Based Services (HCBS) program, even if his or her income is greater the special institutional income limit, if the applicant also meets all other eligibility criteria. Income converted into the trust does not count toward determining financial eligibility by Medicaid for the elderly and people with disabilities (MEPD) specialists; however, the total income (including income transferred to the trust) is taken into account for the calculation of the copayment for STAR+PLUS HCBS program services. An applicant may be eligible for services if all other eligibility criteria are met, even if the amount he or she has available for copayment is equal to or higher than the total cost of his or his individual service plan (ISP). The financial suitability for an applicant with a QIT is determined by the MEPD specialist. He or she shall be informed that all money deposited into the trust should be used as a copayment for the cost of services provided. The MEPD specialist calculates the amount of income from the copayment trust and provides the amount to the staff of the Program Support Unit (PSU). PSU employees report the managed care organization (MCO) via form H2067-MC, Managed Care Programs Communication. For an applicant who is financially eligible on the basis of a QIT, eligibility is determined on the basis of the ISP cost limit before considering the use of funds from the trust for the purchase of services. Funds from the trust available for copayment are used to purchase STAR+PLUS HCBS program services for the individual, but are not used to reduce the cost of the ISP until its suitability is determined to avoid the possibility of purchasing STAR+PLUS HCBS program eligibility. A member with a QIT copayment that covers all costs of the STAR+PLUS HCBS program will receive the benefit of contracted rates as opposed to private salary rates. First, a plan of care (POC) is being developed by the MCO without taking into account the trust. If the person is then eligible for the STAR+PLUS HCBS program based on the cost cap, the trust's excess funds (the monthly income above the institutional income threshold and allowable deductions for a spouse's needs and medical expenses) are allocated to pay for services identified on Form H1700-1, Individual Service Plan (Pg.1), as the STAR+PLUS HCBS program. The ISP total, and therefore the amount of licences to providers, is reduced by the amount of excess funds. The member must pay the provider directly for the amount of the services equal to the amount of the excess. The use of the trust fund documented on Form H1700-B, Non-STAR+PLUS HCBS Program Services. Continuing Medicaid eligibility through the STAR+PLUS HCBS program depends on the payment of the QIT copayment to the provider (s). Please refer to Section 3236, Copayment and Room and Board, and Section 3232, Payments of the Qualified Income Trust, for specific PSU and MCO procedures related to QIT copayments. 3232 Payments of the qualified qualified Trust review 19-1; As of June 3, 2019, applicants or members with a qualified income trust (QIT) will be responsible for a coexistence in adult foster care (AFC), assisted living (AL) or the home situation. The managed care organization (MCO) must clearly explain to the applicant or member that the funds of the QIT available for copayment should be used for the purchase of the STAR+PLUS Home and Community Based Services (HCBS) program. Payments are made directly to the AFC, AL or other provider. For applicants or members residing in AFC or AL institutions, the copayment amount is usually applied to the cost of AFC or AL first. If copayment funds continue after applying to the costs of AFC or AL, the remaining funds should be applied to other STAR+PLUS HCBS program services, such as nursing, personal assistance services (PAS) or medical supplies. For applicants or members at home, the copayment is first used for the purchase of PAS, nursing or medical supplies. The MCO calculates the type and amount of payment that the applicant or member will make directly to the service provider using the following steps: The MCO develops the individual service plan (ISP) with the total services requested and the total cost of the ISP without taking into account the amount of services that the QIT copayment will purchase. Once the ISP is developed, the MCO uses the QIT copayment amount provided by Medicaid for the elderly and people with disabilities MEPD specialist to determine the units of service purchase at the trust. The service units are determined by dividing the monthly copayment amount by finalizeing the unit rate for the service and the result to the next lower half unit. The MCO documents the amount of services that the member has to pay directly to the provider(s) and obtains the consent of the applicant or member. For specific details on documenting the agreement, see Section 3234, Qualified Income Trust Copayment Agreement. The MCO is developing a second form H1700-1, Individual Service Plan (Pg.1), to reflect the number of services reduced by the QIT copayment amount. The second form H1700-1 is annotated in the upper margin as Adjusted ISP for QIT Copayment. For the service category where the QIT payment will be applied, the monthly units to be purchased through the copayment are multiplied by 12 to determine an annual number of services to be purchased. This amount is deducted from the total allowable amount to determine the new service units to be authorized and the new ISP total. Form H1700-B, Non-STAR+PLUS HCBS Program Services, is used to provide the specific services the QIT are delivered, to be documented. The amounts on the custom ISP are entered in the Service Authorization System Online (SASO). The total available QIT amount is not entered on Form H1700-1 and is not reflected in SASO copayment screens for QIT members living at home. If the member in an AFC or AL setting, the calculated QIT copayment amount is displayed in the Copayment screens in SASO. Please refer to the information in Section 3233, Available QIT Copayment Amount exceeds the daily rate for AFC or AL, if the available QIT copayment amount is sufficient to pay in full for AFC or AL. The copayment amount for services other than AFC or AL is documented on Form 1578, Qualified Income Trust (QIT) Copayment Agreement, and Form H2065-D, Notice of Managed Care Program Services. The adjusted ISP and Form 1578 are sent to the service provider(s). The provider will review the custom ISP and attachments to determine the acceptance of a referral. Form H2065-D is used to inform the member and the provider(s) of the amount of the copayment to be made directly to the provider(s). QIT copayment amounts to the MCO contracted provider are displayed on Form H2065-D in the comments section. 3233 Available QIT Copayment Amount exceeds the daily rate for Adult Foster Care or Assisted Living Revision 18-2; As of September 3, 2018 If the available amount for qualified income trust (QIT) exceeds the daily rate for adult foster care (AFC) or assisted living (AL), the monthly AFC or AL amount should be calculated based on the exact number of days per month (28, 30 or 31 days). Example: The available QIT copayment amount is $1,400 per month. The member is authorized as an AL Apartment. The daily rate is $42.18. For April, the monthly copayment amount is $1,265.40 ($42.18 multiplied by 30 days in April). For May, the monthly copayment amount is $1,307.58 ($42.18 multiplied by 31 days in May). The managed care organisation (MCO) can complete Form 1578, Qualified Income Trust (QIT) Copayment Agreement, each month or complete the copayment amount for several months in the future. If the copayment amount changes for one of the months the member has been notified in advance, Form 1578 must be sent to display the new copayment amounts for each month. The MCO must keep a copy of each Form 1578 in the member's folder. If a QIT copayment amount remains after the monthly copayment amount has been calculated for the AFC or AL institution, the remaining copayment amount will be applied to services provided by the home provider. In these cases, the AFC or AL provider, in-home provider, member and trustee should be informed of the amounts to be collected from the member on the basis of the days in the month. Example: In the same example above, the member has a $134.60 copayment remaining in the month of April to pay for services provided by the provider. In May the member still has $92.42 to pay for services provided by the provider. Failure to pay the required QIT copayment may result in termination of services. Please refer to Section 3235, Refusal to Pay Qualified Income Trust Copayment. 3234 Theemmony copayment agreement for qualified income trustee; 18-2; Effective Effective 3, 2018 The managed care organization (MCO) completes Form 1578, Qualified Income Trust (QIT) Copayment Agreement and documents the: service purchased; available quantity for copayment; unit rate; units purchased; and monthly copayment amount for the specific services. The units to buy must be converted to a monthly fee if that service has not yet been reported in a monthly format. The monthly copayment amount may not exceed the total amount for that service for one month. If, after the calculation of the first service, there are additional copayment resources, the copayment will be applied to a second (or third) service if necessary. For individuals residing in an adult foster home (AFC) or assisted living institutions (AL), the amount is usually applied to the costs of AFC or AL. If copayment funds continue after applying to the costs of AFC or AL, the remaining money should be applied to other services, such as nursing, personal assistance services (PAS) or medical supplies. For people at home, the copayment is first used for the purchase of PAS, nursing or medical supplies. Form H2060, Needs Assessment Questionnaire and Task/Hour Guide, Form H2060-A, Addendum to Form H2060, Form H2060-B, Needs Assessment Addendum or other annexes to the individual service plan (ISP) should not be changed because the total number of units to be delivered is not changed by the copayment. 3234.1 Calculation example and completion of Form 1578 Revision 18-2; As of September 3, 2018, 1,400 units (hours) of personal assistance services (PAS) have been included in the initial individual service plan (ISP). The available copayment amount is $1,250, and divided by $10.86 (PAS hourly rate) it's equal to 115,101 units; Rounded to the next bottom half unit equals 115. (If the units were 115,633, it would be rounded down to 115.5.) On Form 1578, enter the Qualified Income Trust (QIT) Copayment Agreement in the Service column purchased by QIT Copayment pass; Enter $1,250 in the Monthly Copayment Amount Available column; enter 115 units in the Unit Rate column; and in the monthly Copayment Amount for units purchased, enter $1,248.90 (115 units multiplied by $10.86). Then calculate the annual number of units to be purchased through QIT by multiplying the monthly units by 12. For example, 115 units multiplied by 12 months is equivalent to 1,380 annual units to buy through QIT. Subtract this amount from the total authorization to determine the units to be authorized on the custom Form H1700-1, Individual Service Plan (Pg. 1). For example, 1,400 units minus 1,380 equals 20 units of enter the custom ISP. After determining the amount of copayment to be paid to the service provider(s), the managed care organisation (MCO) discusses the copayment with the applicant or member and the trustee of the trust. After explaining the requirements, the applicant, member or authorised representative and the liquidator must sign Form 1578. A copy of the signed agreement shall be given to the applicant, member and/or AR and the trustee. Services cannot begin until Form 1578 is signed, indicating the consent of the applicant or member to pay the required copayment. A copy of Form 1578 is sent to the service provider(s) together with the ISP. If an applicant or member refuses to sign the amended ISP or copayment agreement, services will be refused for non-payment of the required copayment. 3235 Refusal to pay qualified incomes trust Copayment Review 18-2; As of September 3, 2018, the Qualified Income Trust (QIT) trustee must pay the QIT copayment directly to the provider on the 10th day of the month, or no later than 10 days after star+plus home and community based services (HCBS) program services have been launched in situations where the services have not started on the first day of the month. If the liquidator refuses to pay the coyment for services, the provider must notify the managed care organisation (MCO) within two working days via Form H2067-MC, Managed Care Programs Communication. The MCO should contact the liquidator to learn the reason for refusing to pay. The MCO should also: write a letter to the member and the liquidator explaining the consequences of continuous non-payment; and the Medicaid for the Elderly and People with Disabilities (MEPD) specialist report that the trustee has refused to make the copayment. If the copayment is not paid in full within 30 days of the expiration date, the MCO initiates denial. If the Home and Community Support Services (HCSS) provider does not provide sufficient services to use the copayment amount, the HCSS provider must refund all remaining copayment to the trustee and notify the member and MCO via Form H2067-MC. Example: The provider collected a $400 QIT copayment to buy 36.5 hours of PAS, but only 15 hours were delivered because the member was going out of town. The provider must refund the dollar difference between 36.5 hours and 15 hours. The MCO must inform the MEPD specialist of the refund. Please refer to Section 7100, Adult Foster Care, for procedures related to non-payment of copayment. 3236 Copayment and Chamber and Administrative Review 19-1; As of June 3, 2019, members who are eligible for the Institutional Income Threshold (MAO) on the basis of special medical assistance may be required to share in the costs of STAR+PLUS Home and Community Based Services (HCBS) program services. The method for determining the copayment of the member has been documented on the Medicaid for the Elderly and People with Disabilities (MEPD) copayment worksheet for the STAR + PLUS Program. The copayment amount is the remaining income of the member after all permitted costs have been deducted. The copayment amount is applied only to the cost of services funded through the STAR+PLUS HCBS programme and specified to the individual individual plan (ISP). The copayment must not exceed the cost of the services actually provided. Members must pay the cost-sharing amount directly to the contracted provider to provide authorized STAR+PLUS HCBS program services. For more information, see Annex XIII, your financial rights in an assisted living facility. In order to determine the room and administrative amounts for members residing in an adult foster home (AFC) or assisted living (AL), the following calculations are applied after eligibility: for individuals, the amount of the chamber and administrative amount is the additional security income (SSI) federal benefit (FBR) minus the personal needs; For SSI couples, the room and board amount is the SSI FBR [for a couple] minus the personal needs for an individual multiplied by two; or for couples with an income that is higher than the SSI FBR for couples, the room and board amount is the income of the couple minus the personal needs fee for an individual multiplied by two. This amount should not exceed double the amount of the room and the board for an individual. Some individuals will be responsible for contributing to the cost of STAR + PLUS HCBS program services. This is referred to as copayment and/or room and board costs. The amount of copayment is not a factor in determining the suitability of the individual for services. The MEPD specialist calculates the copayment and deducts the permitted medical expenses for persons whose eligibility is based on the special institutional income limits, or for persons with a qualified income trust (QIT). See section 3123, Medical Expenses and Appendix XXII, §1915(c) Waiver Program Co-Payment Worksheets, of the MEPD Handbook. SSI recipients, including SSI recipients who also receive pension, survivor and disability insurance, are not required to make a copayment and they do not require a copayment calculation. Star+PLUS HCBS program members living in AFC or AL institutions may be required to pay a copayment. The managed care organisation (MCO) must clearly explain to the applicant if it is determined that the applicant must pay monthly that the copayment amount must be paid directly to the AL or AFC provider. All STAR+PLUS HCBS program members, including SSI recipients, must pay room and board in AFC and AL settings. The MCO must also explain to the member that the member is required to pay the AFC or AL provider a room and administrative fee. If the member does not pay the agreed room and board costs and/or copayment, the member may be dismissed from the STAR+PLUS HCBS programme. Employees of the Program Support Unit (PSU) shall inform the member and the of new copayment amounts to be collected on Form H2065-D, notification of managed care program services. See Section 3232, payments from the qualified income trust and Article 3234, Copayment Agreement for Qualified Incomes, Incomes, specific QIT copayment procedures. 3237 Review of room and administrative costs 18-2; As of September 3, 2018, all members of the STAR+PLUS Home and Community Based Services (HCBS) program must pay the room and administrative expenses to be eligible for assisted living (AL). Room and board cannot be waived, but an AL facility (ALF) can choose to accept a person for a lower amount. STAR+PLUS HCBS program policy does not lead to the ability to accept or reject the individual. The room and board fees for an individual is set at the amount remaining after deducting $85 from the Supplemental Security Income (SSI) federal benefit rate (FBR). The current FBR amounts can be found in Appendix VIII, monthly income/resource limits, which is updated when the FBR changes. For couples where both partners reside in adult foster care (AFC) or AL institutions, $170 is deducted from the couple's income, so each member of the couple holds $85 per month for personal needs and the rest is room and board expenses for the couple. Due to the difference in income between couples and individuals, the amount of room and board costs for a couple depends on the income. For SSI couples, the room and board charge is the FBR for a couple minus the $170 personal needs allowance. For couples who are not SSI recipients but whose income has doubled less than the current FBR for an individual, the room and board fee is for monthly income minus $170 for personal needs. For couples with an income of more than double the SSI FBR for an individual, the full room and board costs for two people is required. The AFC or AL participant holds $85 per month for personal needs. 3238 Fixing of copayment amounts Revision 19-1; As of June 3, 2019 after determining financial eligibility for Medicaid, Medicaid for the elderly and people with disabilities (MEPD) specialists determine the amount of money available for copayment. MEPD specialists send Form H2067-MC, Managed Care Programs Communication, or Form H1746-A, MEPD Referral Cover Sheet, and a copy of the completed MEPD Waiver Program Copayment Worksheet to the Program Support Unit (PSU) personnel indicating the amount available for the monthly ongoing copayment. PSU employees forward this information to the managed care organization (MCO) by uploading Form H2065-D, Notification of Managed Care Program Services, to TxMedCentral. 3239 Copayment Changes Revision 19-1; From June 3, 2019, a member's copayment may change during the time he receives the STAR+PLUS Home and Community Based Services (HCBS) program, usually as a result of a income or medical expenses. The changes of copayment should always be in force on the first day of the month. As copayment increases, program support unit (PSU) personnel must send the member and managed care organization (MCO) notification on Form H2065-D, Notified Managed Care Program Services, Services, the increase shall take effect on the first day of the month following the expiry of the unfavourable period of action. The MCO is responsible for notifying the provider. If the first day of the month takes place before the end of the adverse action period, the increase in copayment takes effect on the first day of the following month. For copayment reductions, Form H2065-D notification must take effect, but may be in effect on the first day of the month after the notification is sent. Copayments may also change due to other circumstances. Medicaid for the elderly and people with disabilities (MEPD) specialists are responsible for calculating and handling fraud referrals. Notices and letters on these issues are prepared by MEPD specialists with copies to PSU employees. MepD specialists inform PSU employees about fraud referrals and determine whether corrections are needed for the member's copayment based on a change in the amount available for copayment. PSU employees upload Form H2067-MC, Managed Care Programs Communication, to inform the MCO of any change in the copayment amount. Underpayments of the member who are not part of a fraud referral, such as those based on reconciliation of variable income, result in the MEPD specialist sending a letter to the member requesting that the member pay the MCO the amount of the underpaid payment. PSU staff are not responsible for determining whether the underpayment is made to the MCO. The underpayment shall not be taken into account retroactively in the calculation of the copayment. The MEPD specialist warns PSU employees if the current amount increases to the correct mailbox that is designated for the MEPD specialist to submit to PSU employees via the MEPD Communications Tool. If the amount does increase, PSU employees will have to upload Form H2065-D to TxMedCentral in the MCO's SPW folder, notifying the MCO of the monthly fee increase. The increase in copayment shall take effect on the first day of the month following the expiry of the unfavourable action period indicated on Form H2065-D. Refunds due to the member require a new copayment calculation to be completed. The copayment can be calculated to be refunded to be deducted from the member's next copayment amount attributable to the provider or member may be given a fee by the adult foster care/assisted living (AFC/AL) provider if there are no future copayments. The MCO determines whether the AFC/AL provider should file a negative billing. The effective date of the decrease in copayment is the first of the month after Form H2065-D has been sent. The ongoing copayment of the member is $100 per month. The MEPD specialist stipulates a copayment amount of $75 should be as of February 1. A refund of $25 per month for the months of February, March, April and May totaling $100. PSU employees will find out about the new amount on May 20 and immediately upload form H2065-D to notify the MCO. The MCO contacts the provider the member's new copayment amounts: June -$0, July -$50, August - $75, underway. 3240 STAR+PLUS Home and Community Based Services Program Requirements Revision 18-2; As of September 3, 2018, the STAR+PLUS Home and Community Based Services (HCBS) program will be delivered under authority granted to the State of Texas to enable the provision of long-term services and support (LTSS) that help members to live in the community rather than a nursing facility (NF). In order to be eligible for services under the STAR+PLUS HCBS programme, the following criteria must be met: medical necessity (MN) (see Article 3241, medical necessity determination); services under the set cost limits (see point 3242.1, maximum limit); the unmet need of the member for at least one STAR+PLUS HCBS programme (see Article 3242.2, Unmet Need for at least One Waiver Service); and full Medicaid coverage. 3241 Revision of the medical necessity provision 18-2; As of September 3, 2018, the applicant or member of a STAR+PLUS Home and Community Based Services (HCBS) must have a valid medical need (MN) before being included in the STAR+PLUS HCBS program. The determination of MN is based on a completed Medical Necessity and Level of Care (MN/LOC) Assessment. The cost limit for individual service plan (ISP) of the applicant or member is calculated on the basis of the MN/LOC assessment information. The managed care organization (MCO) completes MN/LOC Assessments with Texas Medicaid & Healthcare Partnership (TMHP) for STAR+PLUS HCBS program applicants or members. TMHP processes MN/LOC Assessments for applicants or members to determine MN and calculate a Resource Utilization Group (RUG). A University of Groningen is a measure of the staff intensity of the nursing facility (NF) and is used in the STAR+PLUS HCBS programme to: categorize needs for applicants or members; and the ISP cost limit. When TMHP processes an MN/LOC Assessment, a RUG with three alphanumeric digits appears in the Service Record in the Service Authorization System Online (SASO) and in the TMHP Long Term Care (LTC) Online Portal. An MN/LOC Assessment with incomplete information results with a BC1 code instead of a RUG value. An MN/LOC Assessment resulting in a BC1 code does not have all the information needed for TMHP to accurately calculate a University of Groningen for the member. Code BC1 is not a valid RUG to determine whether star+plus HCBS program qualifies. The MCO nurse must correct the information about the MN/LOC assessment within 14 days of submitting the assessment that resulted in a BC1 code. After 14 days, the MCO nurse must inactivate the MN/LOC Assessment and resubmit the assessment with the correct to TMHP. For applicants or members who need a Medicaid eligibility financial decision, Program Support Unit (PSU) staff should provide the Medicaid for the elderly and people with disabilities (MEPD) specialist meets MN. This notification can be documented by telephone or can be documented on Form H1746-A, MEPD Referral Cover Sheet, which PSU employees send to the MEPD specialist. The MEPD specialist may review the SASO or LTC Online portal to confirm that the applicant or member has met the MN criteria. 3241.1 Fixing medical necessity for applicants living in nursing homes review 19-1; As of June 3, 2019, the staff of the Program Support Unit (PSU) must examine the status of applicant or member in the nursing home (NF) and determine whether the applicant or member has a current medical need (MN). This information helps determine whether the managed care organization (MCO) should complete the Medical Necessity and Level of Care (MN/LOC) Assessment. Communication with the NF on the plans for submitting the MN/LOC assessment may be necessary. PSU employees should make every effort to determine whether allowing the MCO to complete the MN/LOC assessment is necessary and to avoid duplication of Texas Medicaid & Healthcare and Partnership (TMHP) for an MN provision. Approved MN's for NF residents can be verified through the Service Authorization System Online (SASO). In this situation, the MCO may not complete a new MN/LOC Assessment. The MN is accepted as valid MN. The MCO must ask the NF for a courtesy copy of the Minimum Data Set (MDS) completed by the NF. If the NF refuses, it is not mandatory for the MCO to have a copy. If an applicant or member applies for Medicaid as a resident of the NF while applying for the STAR+PLUS Home and Community Based Services (HCBS) program, the NF must complete the MDS. The MCO is instructed not to complete a new MN/LOC Assessment with the pre-registration assessment. PSU employees must inform the MCO that MN exists by entering the Resource Utilization Group (RUG) and expiration date in Section A, point 6, of Form H3676, Managed Care Pre-Enrollment Assessment Authorization. If the NF refuses to complete the MDS in a timely manner, PSU employees must give the MCO permission to complete the MN/LOC assessment on the applicant or member by entering N/A in Section A, point 6, of Form H3676 and uploading it to TxCentralMed in the MCO's XXXSPW folder using the appropriate naming convention. Another situation exists when a STAR+PLUS HCBS program applicant or member enters the NF on Medicare. PSU personnel should authorize the MCO to complete the MN/LOC assessment, as described above, in order to expedite the receipt of an MN and prevent a delay in the return of the applicant or member to the community. A rejected MN decision as a result of an MN/LOC assessment received by the MCO is not used to deny a STAR+PLUS HCBS program applicant who has a valid NF MDS. The NF MDS and Rug are used in the STAR+PLUS HCBS program. An MN record should be in the SASO, so that the individual service plan (ISP) registration is not suspended. The SASO MN record must match the effective date of the ISP input and must have an active MN period for the entire ISP period. The end date of the MN/LOC assessment should be adjusted as necessary to the ISP end date. 3241.2 Fixing medical necessity for applicants who do not live in nursing homes review 18-2; As of September 3, 2018 for STAR+PLUS Home and Community Based Services (HCBS) program applicants do not live in

nursing homes (NFs), the medical necessity (MN) provision is made by Texas Medicaid & Healthcare Partnership (TMHP) based on the Medical Necessity and Level of Care (MN/LOC) Assessment completed by the Managed Care Organization (MCO) conducting the pre-enrollment home health assessment. The MCO must submit the MN/LOC Assessment electronically to TMHP after it has been signed by the doctor. A copy of the MN/LOC Assessment shall be submitted in the member's file. 3242 Review of individual cost limit requirements 18-2; with effect from 3 September 2018 3242.1 Maximum limit review 17-1; As of March 1, 2017, the cost of the STAR+PLUS Home and Community Based Services (HCBS) program should not exceed 202 percent of the care costs that the State would pay if the member in a nursing facility (NF) were served. For initial eligibility, the STAR+ PLUS HCBS program applicant must develop an individual service plan (ISP) that is at or below 202 percent of what it would cost to provide services in an NF. For the first applications, the total cost of services for an applicant's ISP must be equal to or lower than the person's ISP cost limit. Applicants who exceed the cost limit cannot choose to receive reduced services to participate in the program if it would pose a risk to the health, safety and well-being of the individual. 3242.2 Unmet need for at least one STAR+PLUS Home and Community Based Services Program Service Review 19-1; As of June 3, 2019, the Code of Federal Regulations (CFR) indicates that individuals are not eligible for the STAR+PLUS Home and Community Based Services (HCBS) program unless they need at least one STAR+PLUS HCBS program service. Therefore, the Texas Health and Human Services Commission (HHSC) cannot approve an individual service plan (ISP) that has $0.00 as the Total Est. Waiver Cost at the bottom of Form H1700-1, Individual Service Plan (Pg. 1). When program support unit (PSU) employees receive an ISP from the managed care organization (MCO) with a $0.00 STAR+PLUS HCBS program cost, the following activities will take place. Within two business days: PSU employees upload Form H2067-MC, Care Programs Communication, to the correct XXXSPW folder in TxMedCentral, using the appropriate naming convention. This will inform the MCO to check that the ISP, which has no services, is correct. If the ISP is submitted incorrectly: the must re-submit a corrected ISP within two working days (e.g. the ISP uploaded correctly but lacks services); and PSU employees must honor the original date if the MCO uploads the corrected ISP within two business days of notification by PSU employees; or If the ISP is submitted correctly: the MCO must upload Form H2067-MC and inform PSU that the ISP reflects the member's needs; and PSU personnel: begin refusal procedures for these cases by completing Form H2065-D, Notice of Managed Care Program Services; e-mail the original Form H2065-D to the member; and upload form H2065-D TxMedCentral in the XXXSPW folder, using the appropriate naming convention. 3300 review of administrative procedures 19-1; As of June 3, 2019, program support unit (PSU) employees will be active in every Texas Health and Human Services Commission (HHSC) STAR+PLUS managed care service area. PSU employees provide support needed to coordinate long-term services and support (LTSS), including the STAR+PLUS Home and Community Based Services (HCBS) program, for members moving in and out of STAR+PLUS service areas. PSU employees are also the point of contact for the coordination and monitoring of members who move from: nursing facilities (NFs) to the community, and the Medically Dependent Children Program (MDCP) to the STAR+PLUS HCBS program. Responsibilities of PSU employees include: acting as an intermediary in the transmission of communication between staff of the Community Care Services Eligibility (CCSE) and the managed care organisation (MCO); receiving requests for services from CCSE staff performing intake tasks; coordinating the application process for the STAR+PLUS HCBS programme for NF residents wishing to transition to the community; assisting applicants in registration through the registration broker to select an MCO and primary care provider (PCP) if necessary; coordination with Medicaid for the elderly and people with disabilities (MEPD) specialists related to Medicaid eligibility, if any; sending Service Authorizations (Form H3676, Managed Care Pre-Enrollment Assessment Authorization) to the MCO to perform STAR+PLUS HCBS program assessments for non-members; as the primary contact for transitions in and out of STAR+PLUS service areas; assisting CCSE case managers in processing applications for non-Medicaid services by verifying that the MCO has refused the equivalent service under STAR+PLUS (see Article 3510, Money Follows the Person and Managed Care); assist MCO members who request placement on an interest list for services excluded from managed care (see article Excluded groups); remove members in STAR+PLUS provinces from the star+plus HCBS program interest list and process their applications; assisting members older than MDCP and/or Texas Health Steps/Comprehensive Care Program in transferring to the STAR+PLUS HCBS program (see Article 3420, Individuals Individuals From children's programmes); coordination of continuity of care for members suspended or deregistered from STAR+PLUS; approval of the STAR+PLUS HCBS programme on the basis of suitability; creating Service Authorization System Online (SASO) listings as required for actions involving STAR+PLUS HCBS program members; treatment of the administrative damages procedure; examination and application for deregistration where the member is wrongly registered; refusing to participate in the STAR+PLUS HCBS programme; and handling requests for Medicaid fair hearings for applicants or members who are denied STAR+PLUS HCBS program eligibility. 3310 Intake and registration revision 19-1; As of June 3, 2019, when Community Care Services Eligibility (CCSE) receives an application for the STAR+PLUS Home and Community Based Services (HCBS) program, ccse intake personnel must assess whether the request for services should be forwarded for processing to the: appropriate Texas Health and Human Services Commission (HHSC) unit; HHSC registration broker; Program Support Unit (PSU) staff; or appropriate managed care organisation (MCO). Use the chart below to determine how to process service requests in STAR+PLUS. Type individually registered with a STAR+PLUS MCO? How does CCSE handle this request? Full Medicaid recipient who signs up for the STAR+PLUS HCBS program No. Forward the intake request to the enrollment broker. Additional Security Income (SSI) or other full Medicaid program recipients never go on the STAR+PLUS PLUS HCBS program interest rate list, whether they are enrolled with STAR+PLUS or not. The enrollment broker determines what prevents MCO enrollment and takes action to resolve the issue, including referral to the Health and Human Services Commission (HHSC) or contact with the person. Full Medicaid recipient who signs up for the STAR+PLUS HCBS program Yes. Refer the receiver to the MCO for the STAR+PLUS HCBS program. This person will never be on the interest list. Medically dependent children's program (MDCP) member who becomes age 21 No. MDCP is excluded from STAR+PLUS. A quarterly report will be emailed to the PSU supervisor identing individuals who will be 21 years old within the next 18 months and receive MDCP and/or PDN. Review the procedures for transitioning from MDCP to the STAR+PLUS HCBS program in Section 3420, Individuals Aging Out of Children's Programs. These people never go on the interest list. Medical assistance only (MAO) applicant for the STAR + PLUS HCBS program No. The staff receiving the intake places the individual on the star+plus HCBS program interest list. Nursing home NF resident who signs up for the STAR+PLUS HCBS program Yes. The resident referred to the MCO for an upgrade to the STAR+PLUS HCBS program. NF resident who signs up for the STAR+PLUS HCBS program No. All Money Follows the Person (MFP) individuals are placed on the interest list by intake staff and and Assigned. The Community Services Interest List (CSIL) assignment automatically generates an email notifying PSU employees of the referral. When CCSE intake staff determine that an application for the STAR+PLUS HCBS program must be forwarded to PSU employees for processing, they must submit an email to HHSC Star Plus Waiver Interest List. The email must contain the following data elements: Name; Social Security number (SSN); Address; Contact phone number; Date of birth; Medicaid identification (ID) number, if applicable; and county of residence. If CCSE intake personnel are unable to obtain all of the applicant's data elements, the referral will still be processed by PSU employees, so that access to the star+plus HCBS program interest list is not denied. Although CCSE intake staff routinely provide the first four demographics, there may be times when an individual requesting service is unable to submit the date of birth. If this information is not included in the referral, PSU personnel must obtain it because the date of birth is required to access the Community Services Interest List (CSIL) system. PSU state office employees will monitor the interest list mailbox and process the referrals within three business days by placing the person on the STAR + PLUS HCBS program interest rate list, using the original date CCSE intake staff referred the request to PSU staff. Due to member-electing issues, MCOs is prohibited from contacting non-members without the consent of PSU employees to complete the required HCBS assessments. For MDCP members aging out, individuals on the STAR+ PLUS HCBS program interest list, or MFP and MFP Demonstration Initiative individuals, PSU personnel: full Section A of Form H3676, Managed Care Pre-Enrollment Assessment Authorization; and upload Form H3676 in the XXXSPW folder to TxMedCentral in the MCO folder, following the naming convention instructions in section 5110, TxMedCentral Naming Convention, and file maintenance. Note: When PSU employees check the Texas Integrated Eligibility Redesign System (TIERS) for enrollment, the designation on the Individual - Managed Eligibility Care screen is not a verification of enrollment. When enrollment is complete, the Individual - Managed Care screen displays Enrolled. Note: CCSE intake screeners should provide information about the all-inclusive elderly care (PACE) programme to individuals during the intake and referral process when it is determined that the individual requesting services are 55 years of age or older and are in a PACE service area. PACE services are available in areas of El Paso, Amarillo/Canyon and Lubbock. CCSE intake screeners should be aware of PACE service areas and referral procedures. Additional information about PACE can be found at: 3311 Interim Services for Individuals Inwaiting Managed Care Enrollment Revision 18-2; As of September 3, 2018 Pending registration in managed care, individuals are entitled to services from the Community Care for Aged and Disabled (CCAD) program. Referrals to CCAD should be made for all full Medicaid recipients. Case managers can rate these people by services if it appears that services can be authorized and delivered prior to enrollment. 3311.1 Earliest date for adding a member back to the interest list review 19-1; As of June 3, 2019 The earliest date on which an applicant or member can be added to the Community Services Interest List (CSIL) database for the same program that the applicant is denied is the date on which the applicant is determined to no longer be eligible for the program (for applicants) or (for STAR+PLUS Home and Community Based Services (HCBS) program members) , the first date on which the applicant or member is no longer eligible for the programme is refused. Example 1: The applicant will be dismissed from the STAR+PLUS HCBS programme CSIL on 2 March 2019. The case manager determines that the applicant is not eligible for star+plus HCBS program on March 28, 2019 and sends a notification to the applicant of ineligibility. The first date on which the rejected applicant can be added to the STAR+PLUS HCBS program interest rate list is March 28, 2019. Example 2: A STAR+PLUS HCBS program member will not be eligible on March 28, 2019, and PSU employees will send a notification to the STAR+PLUS HCBS program member of termination of employment conditions. Termination takes effect on April 30. The first date on which the rejected member can be added to the STAR+PLUS HCBS program interest list is May 1, 2019. If the applicant or STAR+PLUS HCBS program member's name is added to the interest list before the last date of the program's eligibility, the CSIL database interface is associated with the Service Authorization System Online (SASO), removing the name of the interest list for that program. Example 3: A member's STAR+PLUS HCBS program services are rejected due to medical necessity (MN) and end on March 30, 2019. The first date on which the member can be added to the STAR+PLUS HCBS program interest rate list is April 1, 2019. Example 4: A member's STAR+PLUS HCBS program services will be rejected and end on March 13, 2019. The first date on which the member can be added to the STAR+PLUS HCBS program interest rate list is March 14, 2019. If the member is already on another interest list, the bounce date for the STAR+PLUS HCBS program will not affect the member's original date on the other interest list. 3312 19-1; As of June 3, 2019, the enrolling agent will email enrollment packages to all Medicaid recipients who are candidates for STAR+PLUS. This package includes information about STAR+PLUS, instructions for completing the registration form, and information about the available STAR+PLUS managed organizations (MCOs) from which the recipient can choose. Recipients can return registration forms by email, fill out a registration form at a registration event or presentation, or call the enrollment broker and register by phone at 1-800-964-2777. Recipients have 30 days to select an MCO after receiving a registration package. If a selection is not made within 30 days, the recipient is assigned to an MCO and a primary care provider (PCP). If you don't choose an MCO, it can lead to service delays or default allocation to an MCO. Recipient assignments to an MCO or PCP are done automatically using a standard process. Recipients assigned through the standard process can still choose their STAR+PLUS MCO and PCP after registering for at least one month. However, he or she must receive Medicaid services through the assigned MCO and PCP until they contact the MCO or the enrollment broker at 1-800-964-2777 to request a change. Failure to select a PCP may delay services when a doctor's order or medical necessity (MN) determination is required. 3312.1 Registration procedures following the release of the review of the interest list 19-1; Starting June 3, 2019, Program Support Unit (PSU) employees will take the next steps to ensure that candidates are successfully enrolled in the STAR+PLUS Home and Community Based Services (HCBS) program. PSU staff shall contact the applicant or authorised representative (AR) to: provide a general description of STAR+PLUS HCBS programme services; a list of managed care organizations (MCOs) and encourage the member to contact for service information; discuss the importance of choosing an MCO so that assessments and initial individual service plans (ISPs) can be completed in a timely manner to avoid delaying suitability for the STAR+PLUS HCBS program; and inform the person the MCO in which he or she subscribes can be changed at any time after the first month of service. The applicant opts for an MCO and informs PSU employees orally or in writing. Within two business days of the MCO selection, PSU employees complete Section A of Form H3676, Managed Care Pre-Enrollment Assessment Authorization, and upload it to TxMedCentral in the MCO's SPW folder, according to naming convenities instructions in Section 5110, TxMedCentral Naming Convention and File Maintenance. The MCO shall complete: Part B of Form H3676; an assessment of medical necessity and level of care (MN/LOC); and form H1700-1, Individual ServicePlan (Pg. 1). Note: The Uniform Managed Care Contract (UMCC) requires the MCO to contact the to begin the assessment process within 14 days of receipt of Form H3676. The MCO has 45 days per UMCC requirement to complete all assessments and submit the results to PSU employees via Form H3676, Part B. The MCO uploads STAR+PLUS HCBS programs ISP to TxMedCentral in the MCO's ISP folder, according to the naming instructions in section 5110. The MCO uploads Form H3676 to TxMedCentral in the SPW folder, following instructions in section 5110. If the MCO does not upload ISP within 45 days of PSU employees uploading Form H3676, Part A, PSU staff by email, Managed Care Compliance & Operations (MCCO) personnel will notify the MCO. Within five business days of receiving all required STAR+PLUS HCBS program eligibility documentation, PSU employees verify eligibility based on Medicaid eligibility, medical necessity and care level (MN/LOC) and isp costs within the person's assessed cost limit based on the resource utilization group's established value. The start of the care (SOC) date for the STAR + PLUS HCBS program is the first day of the month after receiving the last of: MN/LOC; ISP; and Medicaid. Example: MN/LOC will be received at Texas Medicaid & Healthcare Partnership (TMHP) on May 15, the ISP will be uploaded to TxMedCentral on June 2, and Medicaid eligibility will take effect on May 1. The SOC date is July 1. The SOC date is the same as the ISP start date and will always be the first day of the month. Because individuals are not eligible for a STAR+PLUS HCBS benefits program between the signature date sign-up form and the ISP start date, PSU staff should take care when including the correct date on notification to the member. If eligibility is approved, PSU employees will complete Form H2065-D and email the original to the applicant; upload the form to TxMedCentral in the MCO's SPW folder, following the instructions in section 5110; faxes or send a copy to the MEPD specialist; and inform Enrollment Resolution Services (ERS) by email If eligibility is denied, PSU employees will complete Form H2065-D and email the original to the applicant; upload it to TxMedCentral in the MCO's SPW folder, according to the instructions in section 5110; and fax or e-mail a copy to the MEPD specialist. PSU employees create Service Authorization System Online (PSU) listings within five business days of receiving all required eligibility verification after procedures in the SAS Help file. After the person is determined to be eligible for the STAR+PLUS HCBS program, ERS updates the member's TIERS record to indicate the enrollment for managed care. 3313 Termination of CCAD services at STAR+PLUS Home and Community Based Services Program Enrollment Revision 19-1; As of June 3, 2019 Code of Federal Regulations (CFR) §431.213 Exceptions in advance. The Agency may send a notice by the date of appeal if — (a) the Agency is factual confirming the death of a consignee; (b) The Agency shall receive a clear written declaration signed by a recipient that – 1) He no longer wishes services; or (2) Provide information requiring termination or reduction of services, and whereas he understands that this must be the result of the provision of that information; (c) the beneficiary has been admitted to an institution where he is not eligible for the plan for further services; (d) The place of residence of the consignee is unknown and the post office shall return the post office addressed to him or him indicating no forwarding address (see §431.231(d) of this procedure sub-part if the recipient's whereabouts become known); (e) The Agency notes that the recipient has been accepted for Medicaid services by another local jurisdiction, state, territory or commonwealth; (f) A change in the level of medical care is prescribed by the recipient's doctor. Program Support Unit (PSU) personnel must coordinate the termination of other exemption or community care for the elderly and disability services with the Community Care Services Eligibility (CCSE) case manager, so that the person does not experience interruption of services and does not receive concurrent services through another waiver or CCAD service. The member of the STAR+PLUS Home and Community Based Services (HCBS) program member should be encouraged to contact the Managed Care Organization (MCO) to ask which services are being denied and which are not included in the STAR+PLUS HCBS (ISP) program. The 10-day prior notification requirement does not apply to persons who switch from CCAD or other waiver programs to the STAR+PLUS HCBS program. 3313.1 Procedure for STAR+PLUS Home and Community Based Services Program Applicants Revisions 19-1; As of June 3, 2019, program support unit (PSU) personnel must coordinate the termination of other exemption or community care for the elderly and disability services with the Case Manager Waiver of Community Care Services Eligibility (CCSE). This ensures that the individual does not experience interruption of the services and does not receive concurrent services through another waiver or CCAD service. There is no need to provide an unfavorable action period prior to the closing of the authorization in the Service Authorization System Online (SASO). CCAD services will be terminated by the CCSE case manager no later than the day before the registration of the STAR+PLUS HCBS program. This is crucial because no STAR+PLUS HCBS program can receive CCAD and STAR+PLUS HCBS program services on the same day. The CCSE case manager should send: Form 2065-A, Notice of Community Care Services, deny ongoing Texas Health and Human Services Commission (HHSC) services; and form 2101, Community Care Services License, to the provider. Include a format in the comments section that transfers the person to the STAR+PLUS HCBS program. Procedure for star+plus home and community based services program revision 19-1; As of 3 June 2019 that an existing STAR+PLUS Home and Community Based Services (HCBS) program member receives each Service Group (SG) 7 Community Care for the Aged and Disabled (CCAD) services, the Program Support Unit (PSU) staff should immediately begin refusal procedures for the SG 7 service. If CCAD services are authorized in SASO, the Community Care Services Eligibility (CASE Manager) must immediately send: Form 2065-A, Community Care Services Notification, including a notation to the provider in the comments section that transfers the person to the STAR+PLUS HCBS program; and Form 2101, Community Care Services License. 3314 Managed Care Organization Changes Revision 18-2; As of September 3, 2018, members can change the Managed Care Organization (MCO) plans as often as monthly by contacting the sign-up broker at 1-800-964-2777. The enrollment broker makes plan changes based on the monthly letdown periods, which occur around the middle of the month. Depending on which day of the month (before or after the cut-off of the registration broker), the change of plan will take place on the first day of the following month or the month after. The change is shown in the 834-day registration file notifying the MCO of the new member. The Program Support Unit (PSU), when the Member State or an MCO is notified that a member has chosen to modify MCOs, updates the Service Authorization System Online (SASO) to change the previous MCO to the new MCO. 3315 STAR+PLUS Home and Community Based Services Program Individuals who review unmanaged care services 18-2 requests; As of September 3, 2018, requirements of the STAR+PLUS Home and Community Based Services (HCBS) program provide all the services (except hospice) needed to enable the member to live safely in the community. Therefore, unmanaged healthcare services cannot be authorized for STAR+PLUS HCBS program member. Star+PLUS HCBS program member requesting additional services must be referred to the service coordinator of the managed care organization. Hospice services may be permitted, along with STAR+PLUS services or the STAR+PLUS HCBS program. 3315.1 Requests from persons awaiting registration of managed care 18-2; From September 3, 2018, people waiting to be enrolled in managed care can be assessed for interim community care for the elderly and disabled (CCAD). Texas Health and Human Services Commission (HHSC) case managers can assess all individuals whose managed care enrollment is pending as it appears CCAD services can be approved and delivered prior to enrollment in managed care. 3315.2 of members of star+plus home and community based services programs revision 18-2; As of September 3, 2018, the federal 1115 waiver requires the STAR+PLUS Home and Community Based Service (HCBS) program to provide the services (excluding hospice) needed to enable the member to safe in the community. Therefore, unmanaged healthcare services cannot be authorized for members of the STAR+PLUS HCBS program. Star+PLUS HCBS program members requesting additional services should be referred to the managed care organization's (MCO) service coordinator. Hospice services may be permitted, along with STAR+PLUS services or the STAR+PLUS HCBS program. 3315.3 Requests from STAR+PLUS Services members revision 19-1; As of June 3, 2019 When a STAR+PLUS service managed care member requests non-Medicaid services, Texas Health and Human Services Commission (HHSC) employees must first determine whether a lock is available for the requested service. If not, the person's name will be added to the relevant interest list by entering the information in the Community Services Interest List (CSIL) system. Members shall be removed from the interest list on a first-come, first-served basis; eligible provisions are implemented as slots for services become available. When a slot is available or before the release of the interest list, HHSC employees consult the Texas Integrated Eligibility Redesign System (TIERS) to determine whether the individual is a STAR+PLUS member (see Article 5130, Managed Care Data in TIERS). If it is determined that the individual is a STAR+PLUS member, the intake staff must contact the Program Support Unit (PSU) staff before it is transferred to a case manager to determine whether the managed care organization (MCO) already provides the managed care version of the requested service. Within two business days of being contacted by intake staff, PSU staff: contact the appropriate MCO by uploading Form H2067-MC, Managed Care Programs Communication, to TxMedCentral in the MCO XXXSPW folder using the appropriate naming convention. Form H2067-MC must contain: the person's name; Medicaid number identification (ID); and a request to determine whether the service is already being provided; and follow up over the phone every five business days until a response is received from the MCO. Within five business days of receiving the uploaded Form H2067-MC, the MCO must respond to PSU personnel by uploading Form H2067-MC to the XXXSPW folder in TxMedCentral using the correct naming convention. Within two working days of receiving the MCO's response, PSU staff must notify the referring HHSC staff by email or form H2067-MC. If PSU employees determine that the requested service is not provided by the MCO, the intake must be assigned to a case manager. The case manager processes the application and authorizes services if all eligibility criteria are met. The response of PSU staff should be included in materials the time of the assignment to the case manager. How the case manager proceeds with the suitability process depends on the documented response of the PSU. If PSU employees determine that the requested service is already provided by the MCO, PSU employees inform the member the MCO's answer. The Member is urged to consult the MCO if he or she disagrees or feels that the services are not sufficient to meet its needs. For more information on intake and referral procedures, see Section 3310, Intake and Registration. 3316 Requests for STAR+PLUS Home and Community Based Services Program from Participants in 1915(c) Medicaid Waivers Revision 19-1; As of June 3, 2019, participants in 1915(c) Medicaid waivers can request an assessment for the STAR+PLUS Home and Community Based Services (HCBS) program at any time if they: have Supplemental Security Income (SSI) Medicaid or any other full Medicaid program; or his medical assistance alone (MAO). When a 1915 (c) Medicaid waiver recipient requests the STAR+ PLUS HCBS program through the Texas Health and Human Services Commission (HHSC), a referral is made to Program Support Unit (PSU) personnel. PSU employees are responsible for completing the following activities within 14 days of the first request for a STAR+PLUS HCBS program review. All attempts at contact with the member or delays must be documented. PSU employees: Move the individual to the top of the STAR+PLUS HCBS program interest list with an assessment requested notation; contact the STAR+PLUS HCBS program member and explain the star+PLUS HCBS program services; and send a copy of the regional STAR+PLUS managed care organization (MCO) provider folders and comparison chart to the recipient of the 1915 waiver(c). Within two business days of notification of the MCO selection by the star+plus HCBS program applicant, PSU employees complete Section A of Form H3676, Managed Care Pre-Enrollment Assessment Authorization and upload it into the XXXSPW folder on TxMedCentral, using the appropriate naming convention. The MCO completes: Form H2060, Needs Assessment Questionnaire and Task/Hour Guide, or Form H6516, Community First Choice Assessment, as appropriate; Form H2060-A, Addendum to Form H2060; Form H2060-B, Addendum for needs assessment, where applicable; medical necessity and level of care (MC/LOC); Section B of Form H3676; Form H1700-1, Individual Service Plan (Pg. 1); Form H1700-2, Individual ServicePlan — (Pg. 2); Form H1700-3, Nursing Plan; Form H1700-A, Reason for STAR+PLUS HCBS Program Items/Services; and Form H1700-B, Non-STAR+PLUS HCBS Program Services. The MCO uploads both Form H1700-1 and Form H3676 into the XXXSPW folder on TxMedCentral using the appropriate naming convention. If the MCO package was not received within 45 days of the approval of the review, the E-mail from PSU employees managed care compliance & operations (MCCO) was sent as a notification of time frame for completing the individual service plan (ISP). Within two working days of receiving all required STAR+PLUS HCBS program fitness documentation, PSU personnel determine STAR + PLUS HCBS program eligibility based on medical necessity, necessity, an ISP cost within the resource usage group (RUG) cost limit. If the suitability for the STAR+PLUS HCBS program is denied or the applicant decides not to accept the STAR+PLUS HCBS program, PSU employees will complete Form H2065-D, Notification of Managed Care Program Services and: email the original to the 1915(c) Medicaid waiver filing, stating that this finding does not affect the suitability for the service the person currently receives; and notify the MCO by uploading a copy to TxMedCentral. If you are eligible and the person chooses to accept STAR+PLUS HCBS program services, the person will be enrolled in the STAR+PLUS HCBS program on the first day of the following month. Within two working days of determining the start of the care date for the STAR+PLUS HCBS program, PSU employees fill out Form H2065-D and send the original to the recipient of the 1915 Medicaid waiver(c); notify the MCO by uploading a copy to TxMedCentral; and inform Enrollment Resolution Services (ERS) by email. PSU personnel must coordinate with staff and providers, if applicable, to ensure that the current 1915(c) Medicaid waiver services end the day before enrollment in the STAR+PLUS HCBS program. 3320 Coordination with Medicaid for the Elderly and People with Disabilities Review 18-2; With effect from 3 September 2018 3321 General eligibility issues review 19-1; As of June 3, 2019 At first contact, program support unit (PSU) employees must inform the medical assistance only (MAO) applicant or member and/or authorized representative (AR) that Medicaid for elderly and disabled (MEPD) specialists will complete a financial eligibility (Medicaid) provision. PSU staff should encourage the applicant or member and/or AR to cooperate with the MEPD specialist and provide all required verifications in a timely manner. All information, including information on third-party insurance, obtained by PSU staff should be shared with the MEPD specialist to prevent the applicant or member from having to provide the information twice. PSU staff must inform the SPD specialists about the request for STAR+PLUS Home and Community Based Services (HCBS). 19-1. As of 3 June 2019 The following information will only be provided for informational purposes relating to the incapacity determination process. The staff of the Program Support Unit (PSU) has absolutely no role in this process. If a STAR + PLUS Home and Community Based Services (HCBS) program applicant or member application for supplemental income safety (SSI) disability is pending for Over 90 days, the Texas Health and Human Services Commission (HHSC) Disability Determination Unit (DDU) personnel can determine disability, pending the Social Security Administration (SSA) determination. PSU staff will not be notified of individual Medicaid for elderly and disabled people status is determined until the disability is determined. In order to ensure that DDU staff can make a disability assessment, the MEPD specialist must obtain the following: Form H3034, Socio-Economic Report on the Determination of Disability; Form H3035, Medical Information Release/Disability Determination; and a copy of the Medical Necessity and Level of Care (MN/LOC) Assessment. 3322 Actions awaiting the past of Medicaid for the Elderly and People with Disabilities Due Date Revision 19-1; As of June 3, 2019, as Program Support Unit (PSU) employees depend on medicaid for the elderly and people with disabilities (MEPD) to determine whether only medical assistance (MAO) applicants are eligible, there are times when PSU employees should contact MEPD employees about the status of an application or program change. Before the MEPD staff contacts the MEPD specialist, it must ensure that the MEPD deadline has expired. MePD specialists have 45 days to complete applications for people over the age of 65. For persons under the age of 65 whose disability has not yet been established by the Social Security Administration (SSA), MEPD specialists have 90 days. 3330 STAR+PLUS members requesting an upgrade to the STAR+PLUS Home and Community Based Services Program Revision 19-1; As of June 3, 2019, Medicaid members enrolled in STAR+ PLUS are eligible for Medicaid through various types of programs. Some members applying for the STAR+PLUS Home and Community Based Services (HCBS) program may be eligible for Medicaid through one of the following Medicaid program types: Pickle (Type Program (TP)-03); Disabled adult child (TP-18); Disabled Widow(er) (TP-21); Early Aged Widow (TP-22); Medicaid Buy-in (TP-87); or Medicaid for breast and cervical cancer (TA-67). Although these Medicaid programs represent full Medicaid eligibility, they do not consider asset transfer and significant home equity reviews needed to establish financial eligibility for the STAR+PLUS HCBS program. Therefore, these Medicaid types will not be eligible for upgrade and enrollment in the STAR+PLUS HCBS program until Medicaid for the Elderly and People with Disabilities (MEPD) tests specialists for the additional criteria. Managed care organizations (MCOs) must notify program support unit (PSU) personnel by uploading Form H2067-MC, Managed Care Programs Communication, to TxMedCentral within three business days of an upgrade application for a member who has one of these Medicaid program types. PSU employees must contact Member Form H1200, Request for Assistance - Your Texas Benefits within three business days of the upload date of Form H2067-MC, filled in and returned to PSU staff. As soon as the member returns Form H1200, PSU employees will send the signed and completed application form to the MEPD specialist within two business days of receipt, along with Form H1746-A, MEPD Referral Cover Sheet, which takes the action Taken. The MCO service coordinator must complete an assessment within 45 days of a STAR+PLUS member's application for the STAR+PLUS HCBS program to draw up the individual service plan (ISP); complete the Medical Necessity and Level of Care (MN/LOC) Assessment and submit it to Texas Medicaid & Healthcare Partnership (TMHP) to apply for medical necessity (MN); and upload form H1700-1, Individual Service Plan — (Pg. 1) in the Texas Medicaid and Healthcare Partnership (TMHP) Long Term Care (LTC) Online Portal. Within five business days of receiving form H1700-1 from the MCO, PSU employees will review the form to determine whether the member meets the eligibility criteria for the STAR+PLUS HCBS program. If MN is denied for a pending upgrade, the MCO must notify PSU employees within three business days by uploading Form H2067-MC to TxMedCentral. When this happens, PSU employees must send Form 1746-A to the MEPD specialist to report the refusal within three business days of receiving the MCO. PSU employees should apply the Star+Plus Program Support Unit Operational Procedures Handbook Policy regarding upgrades to determine whether the member meets the eligibility criteria for the STAR+PLUS HCBS program. This includes not only the assessment of functional criteria evaluated by the MCO, but also a provision that the member's Medicaid type qualifies for the STAR+PLUS HCBS program. 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 personnel: follow actions in Section 3632, Program Support Unit (PSU)-Initiated denials/terminations, to refuse the request; Form H2065-D, Notification of Managed Care Program Services, to be sent to the member within three business days; and upload form H2065-D to TxMedCentral to the MCO's SPWXXX folder. If the member qualifies, PSU staff will process the member's upgrade by: completing Form H2065-D and sending it to the member and (if applicable) the MEPD specialist; Upload Form H2065-D in TxMedCentral to the MCO's SPWXXX folder; and confirmation of Service Authorization System (SAS) entries to consent to the STAR+PLUS HCBS program. 3400 Switch to STAR+PLUS Revision 19-1; Starting June 3, 2019, members of the Star+PLUS program will continue to receive their current non-Medicaid services from the Texas Health and Human Services Commission (HHSC) until the managed care organization (MCO) can authorize Medicaid services. For example, a member could continue to receive Informal Care until the MCO consents to personal services STAR+PLUS members also have the right to be placed on an interest list for non-Medicaid services under the policy laid down in the Case Worker Community Care for Aged and Disabled (CW-CCAD) Handbook, Section 2230, 2230, List procedures. Any application for new long-term services and support (LTSS) from HHSC requires that the mandatory member be sent to his or his MCO first. This should be coordinated by the staff of the Program Support Unit (PSU). See section 3125, STAR+PLUS Home, and Community Based Services Program members requesting unmanaged care services. Some STAR+PLUS Home and Community Based Services (HCBS) program applicants or members who transfer in and out of STAR+PLUS have an individual service plan (ISP) that exceeds the cost limit and is approved for general income (GR) funds. For these applicants or members, the losing service area must inform the obtaining service area of the GR status. The obtaining service area must follow the GR process. 3410 Transfer Scenarios Revision 18-2; As of September 3, 2018, 3411 STAR+PLUS Home and Community Based Services program member moving to another service area with revision for advance knowledge 19-1; From June 3, 2019, when Program Support Unit (PSU) employees are notified within two business days of a transfer from a STAR+PLUS service area to another STAR+PLUS service area, the losing PSU: notify the losing PSU employee of a switch to its service area and member's name: Social Security Number; Medicaid identification (ID) number; current and future contact information; and the date of the move or expected relocation; Form H1700-1, Individual ServicePlan (Pg. 1) to the acquiring PSU staff; the Medicaid for the Elderly and People with Disabilities (MEPD) specialist using Form H1746-A, MEPD Referral Cover Sheet, on medical assistance only (MAO) individuals; remind members of supplemental security revenue (SSI) to contact the Social Security Administration (SSA) to change the address; and upload Form H2067-MC to the Managed Care Organization (MCO) XXXSPW folder in TxMedCentral using the appropriate naming convention, and request form H1700-1 and all forms below of the losing MCO: Form H1700-2, Individual Service Plan (Pg 2); Form H1700-3, Nursing Plan; Form H1700-A, Reason for STAR+PLUS HCBS Program Items/Services; Form H1700-A1, Certification of Completion/Delivery of STAR+PLUS HCBS Program Articles/Services; Form H1700-B, Non-STAR+PLUS HCBS Program Services; Form 8604, Assessment and Authorization of the Transitional Emergency Service (TAS); medical necessity/level of care (MN/LOC); Form H2060, Needs Assessment Questionnaire and Task/Hour Guide; Form H2060-A, Addendum to Form H2060; and Form H2060-B, Addendum for needs assessment, if any. Once the obtaining PSU form H1700-1 PSU employees follow the usual intake procedures. The process is abbreviated because the member already has a: medical necessity; Resource Usage Group; and the determination of financial suitability by the SPD, where applicable. The acquiring PSU coordinates all appropriate activities between losing PSU, MCOs, member, Enrollment Resolution Services (ERS) and other key parties to ensure a successful transition. For PSU employees, this includes tracking every step of the process through the start of the new STAR+PLUS Home and Community Based Services (HCBS) program in gaining areas. The obtaining PSU will be in contact with the member until the move is complete. Within five working days of the move, PSU staff: send an email to ERS with the notification ERS the member has moved; manually close all Service Authorization System Online (SASO) records for the losing MCO as of the month in which the member is moved; update SASO with the obtaining MCO's information; Form H2065-D, Notice of Managed Care Program Services, to send to the member and include the start and end date of the individual service plan (ISP) in the Comments section; and upload a copy of Form H2065-D to the correct MCO's XXXSPW folder in TxMedCentral, using the appropriate naming convention. Within three working days of notification of the move, ERS disenrolls the member as of the end of the month in which the member moves and re-enrolls the member to the acquiring MCO. For more information, see Annex XXXI, STAR+PLUS members Transitions from a nursing facility in one service area to the community in another service area. 3412 STAR+PLUS Home and Community Based Services program member who switches to another service delivery area without revision of the inside information 19-1; As of June 3, 2019, when the Program Support Unit (PSU) personnel are notified of a transfer from one STAR+PLUS service area to another STAR+PLUS area, the losing PSU staff will be informed within a working day: inform the acquiring PSU staff who have transferred a member to his service area and provide the member's name; Social Security number; Medicaid identification (ID) number; current and future contact information; and the date of the move or expected relocation; H2067-MC upload form, Managed Care Programs Communication, to the Managed Care Organization (MCO) XXXSPW folder in TxMedCentral, using the correct naming convention, and requests Form H1700-1, Individual Service Plan (Pg. 1), and all forms listed below from the losing MCO: Form H1700-2, Individual Service Plan (Pg. 2) Form H1700-3, Nursing Service Plan; Form H1700-A, Reason for STAR+PLUS HCBS Program Items/Services; Form H1700-A1, Certification of Completion/Delivery of STAR+PLUS HCBS Program Articles/Services; Form H1700-B, Non-STAR+PLUS HCBS Program Services; Form 8604, Assessment and Authorization of the Transitional Emergency Service (TAS); the medical necessity and level of care (MN/LOC); H2060, Needs Assessment Questionnaire and Task/Hour Guide; and form H2060-A, addendum to Form H2060; and Form H2060-B, Addendum for needs assessment, if any. medical message for the elderly and people with disabilities (MEPD) (MEPD) using Form H1746-A, MEPD Referral Cover Sheet, for medical assistance only (MAO) individuals; and remind supplemental income (SSI) members to contact the Social Security Administration (SSA) to change the address. Within two working days of notification of the losing PSU staff, the obtaining PSU staff: contact the member to select an MCO from the acquiring service area; send the package with the MCO comparison chart; and upload form H2067-MC to TxMedCentral in the MCO's XXXSPW folder, using the appropriate naming convention, which asks the MCO to inform the obtaining health plan of the move. Upon receipt of Form H2067-MC, the obtaining MCO must contact the member within one working day and begin services within two working days. Once obtaining PSU staff receive Form H1700-1, PSU staff follow the usual intake procedures. The process is abbreviated because the member already has an: MN/LOC; Resource Utilization Group (RUG); and the financial suitability determination by the MEPD specialist, if applicable. The acquiring PSU staff coordinates all appropriate activities between the losing PSU, MCOs, member, Enrollment Resolution Services (ERS) and other key parties to ensure a successful transition. For PSU employees, this includes tracking every step of the process through the

start of the new STAR+PLUS Home and Community Based Services (HCBS) program in gaining areas. Within two working days of completing the above steps, the obtaining PSU: send an email to ERS with the notification ERS the member has moved; close all service authorization records manually, as of the end of the month the member is moved; manually update the Service Authorization System Online (SASO) with the information initiated by the acquiring MCO, the first of the following month in which the move took place; Send Form H2065-D, Notice of Managed Care Program Services, to the member (with the start and end date of the ISP in the Comments section); and upload a copy of Form H2065-D to the correct XXXSPW folder in TxMedCentral, using the appropriate naming convention. Within two working days of the announcement of the move, ERS is considering coordinating claims to limit the provider's impact. For more information, see Appendix XXXI, STAR+PLUS members who move from an NF in one service area to the community in another service area. 3413 STAR+PLUS Home and Community Based Services program member who switches from one MCO to another within the same service area review 20-1; From 16 March 2020 After the initial tender period of one full month a member eligible for change of Managed Care Organization (MCO) plans. For whatever reason, a member may request a transfer to another MCO in the service area through the state-contracted registration agent. Texas Health and Human Services Commission (HHSC) will only make one plan change per month. When a wants to change from one MCO to another MCO in the same service area, the member or the authorized representative (AR) must contact the registration broker via a phone call to 1-800-964-2777. If the member calls to change MCO on or before the monthly HHSC MCO enrollment date, the change will occur on the first day of the following month following the change request. If the member calls after the monthly HHSC MCO enrollment date, the change will take place on the first day of the second month following the change request. The HHSC MCO enrollment date is not always on the same day of each month, but it is usually mid-month. Examples: If the member calls on April 9, the change is likely to take place on May 1. If the member appeals on 20 April, the amendment is likely to take place on 1 June. HHSC Program Enrollment & Support prepares and sends a monthly Changes report for programs (PSU) employees. The MCO can find the member-specific report in the Monthly Enrollment (P34) file in TxMedCentral. The report includes a list of STAR+PLUS Home and Community Based Services (HCBS) program members that mcos have changed from the previous month. Within five working days of receipt of the list and the determination of any new members, the acquiring MCO must request from the losing MCO all applicable forms and documentation relating to the new member, including all H1700 forms; all H2060 forms; 1500 forms; the assessment of medical necessity and level of care (MN/LOC); Form H6516, Community first-choice assessment; and any prior permits, as well as any one-time/lifetime limits that have been met. Within five working days of receipt of the request, the losing MCO must provide the requested documents to the acquiring MCO. If the MCO gained difficulties in obtaining this information, the MCO should notify managed care compliance and operations (MCCO) staff. The obtaining MCO is responsible for the service from the first day of registration. Within 14 days of notification of the new member, the acquiring MCO must contact the member to discuss the services the member needs. Within 30 days of notification of the new member, the obtaining MCO must make a home visit to assess the member's needs. The obtaining MCO must provide services and honor authorizations included in the prior individual service plan (ISP) until the re-assessment is complete and the obtaining MCO is able to complete a new Form H2060, Needs Assessment Questionnaire and Task/Hour Guide, or update Form H6516, the ISP and complete new service authorizations The obtaining MCO should enable the member to continue to receive services with his or her existing provider(s) and enable an out-of-network authorisation to ensure that the member's condition remains stable and the services are consistent to meet the member's needs. 3420 Persons switching to adult services revision 19-1; 19-1; June 3, 2019 STAR Kids and STAR Health are eligible, end the last day of the month in which the member's 21st birthday takes place and the member must receive services through adult programs. The following services end at the end of the month after the member's 21st birthday. Medically Dependent Children Program (MDCP) is managed by STAR Kids of STAR Health managed care organizations (MCOs); and The Texas Health Steps Comprehensive Care Program (CCP) /Private Duty Nursing (PDN) or Prescribed Pediatric Extended Care Center (PPECC) services. Note: Depending on eligibility requirements, some members may continue to receive services, except MDCP, through STAR Health until age 22. Members receiving MDCP and/or PDN/PPECC can request services through STAR+PLUS or the STAR+PLUS Home and Community Based Services (HCBS) program to continue receiving community services and prevent institutionalization from the 1st of the month after their 21st birthday. 3421 Procedures for Children Transition from STAR Kids/STAR Health Receiving Medically Dependent Children Program or Texas Health Steps Comprehensive Care Program/Private Duty Nursing of Prescribed Pediatric Extended Care Centers Review 18-2; As of September 3, 2018, members may receive a combination of the following services: Medically Dependent Children Program (MDCP); Private Duty Nursing (PDN); or Prescribed Pediatric Extended Care Center (PPECC) services. 3421.1 Twelve months before the 21st anniversary review of paragraph 19-1; Starting June 3, 2019 Twelve months before the 21st birthday of a STAR Kids or STAR Health member receiving the Medically Dependent Children Program (MDCP), Texas Health Steps Comprehensive Care Program (CCP)/Private Duty Nursing (PDN) or Prescribed Pediatric Extended Care Center (PPECC) services, the next process begins. Every quarter, the Texas Health and Human Services Commission (HHSC) Utilization Review (UR) Unit provides a copy of the MDCP PDN Transition Report, which members enrolled in STAR Kids/STAR Health lists and received MDCP, CCP/PDN or PPECC services, which can switch to STAR+PLUS or the STAR+PLUS Home and Community Based Services (HCBS) program over the next 18 months to the: Program Unit Support (PUS) supervisor; and UR Unit for Intellectual or Developmental Disabilities (IDD) Waiver/Community Services/Hospice. The STAR Kids and STAR Health managed care organizations (MCOs) identify all members who reach the age of 21 within the next 12 months and schedule a personal visit with the member's member and support person, including her or his authorized representative (AR), if applicable, to initiate the transition process. During the personal visit to the member, his or his support person or AR, the present an overview of STAR+PLUS, including the STAR+PLUS HCBS program, and the changes that will occur when when member switches to STAR+PLUS. Specific information to be provided during the personal visit can be found in the STAR Kids Handbook, Appendix VI, STAR Kids Transition Activities or for STAR Health, in the Uniform Managed Care Manual. THE STAR Kids MCO: Monitors transition activities with the member or supporting person, including her or his AR, every 90 days during the year before the member turns 21; and warns UR via email to indicate that the member appears to meet the criteria set out in Annex XIV, determining the high needs status for the STAR + PLUS HCBS program. This notification should include the number of PDN hours currently authorized. The STAR Health MCO warns UR via email that the member appears to meet the criteria set out in Annex XIV, Determining the high needs status for the STAR+ PLUS HCBS program. The notification must include the number of PDN hours currently authorized. The TRANSITION/High Needs Coordinator should: monitor the MDCP PDN Transition Report and identify all STAR Health members who turn 21 in 12 months and are not enrolled in any of the following IDD 1915(c) Medicaid waivers: Community Living Assistance and Support Services (CLASS); Deafblind with multiple disabilities (DBMD); Home and Community Services (HCS); and Texas Home Living (TxHmL). coordinate with UR personnel for the IDD waivers and PSU personnel if it is determined that the member has high needs and/or should be assessed for the STAR+PLUS HCBS programme. PSU personnel: Review the MDCP PDN transition report and identify all members receiving MDCP, PDN, or PPECC services that turn 21 in 12 months and are not enrolled in any of the following IDD 1915(c) Medicaid waivers: CLASS; DBMD; HCS; or TxHmL. Note: PSU employees may upload Form H3676, Managed Care Pre-Enrollment Assessment Authorization, to TxMedCentral in the XXXSPW folder no earlier than five months before the member's 21st birthday. The following graph describes the responsibilities for monitoring the MDCP PDN Transition Report and contacting members who are transitioning from STAR Kids/STAR Health who receive an MDCP waiver and/or PDN/PPECC 12 months before the member's 21st birthday. Twelve-month transition chart under age 21 MDCP under age 21 Other services received monitor mDCP PDN Transition Report 12 months Contact MDCP PDN-CCP or PPECC-CP PSU Staff MCO MDCP None PSU Staff MCO Does not apply PDN-CCP PSU staff MCO Does not apply PPECC-CCP PSU staff MCO 3421.2 Nine months before the 21st anniversary review of paragraph 19-1; From June 3, 2019 Nine months before the 21st anniversary of a member who is the Medically Dependent Children Program (MDCP), Texas Health Steps Care Program (CCP)/Private Duty Nursing (PDN) of Prescribed Pediatric Extended Care Center (PPECC) service ontvangt, begint het volgende proces. De STAR Kids en STAR Health managed care organisatie (MCO): monitoren monitoren activities with the member and the available support of the member, including her or his authorised representative (AR), every 90 days in the year before the paragraph turns 21; and alerts the staff of the Program Support Unit (PSU) of any problems or problems using Form H2067-MC, Managed Care Programs Communication and uploads to TxMedCentral. PSU employees: Monitor the MDCP PDN Transition Report and identify all members who transition from STAR Kids and receive MDCP and/or PDN/PPECC who turn 21 in nine months and are not enrolled in any of the following intellectual and developmental disorders (IDD)1915(c) Medicaid waivers: Community Living Assistance and Support Services (CLASS); Deafblind with multiple disabilities (DBMD); Home and Community Services (HCS); and Texas Home Living (TxHmL); send the STAR Kids member form 2114, nine-month transition letter, along with a STAR+PLUS registration package (including the STAR+PLUS MCO list and comparison table). The letter will serve as an introduction to the process and advise the member, support person or AR. PSU staff will contact the member or member support person, or AR, within 30 days to discuss the transition process and review the enrollment package; and update the matter in the Administrative Report and The Health and Human Services (HHS) Tracking System (HEART): The date on which the first transitional letter was sent; uploading the letter for initial transition to HEART; documenting the expiration date for the telephone contact 30 days after the date on which the STAR+PLUS Home and Community Based Services (HCBS) program enrollment package is sent; and uploading Form H2067-MC if the MCO documented problems or issues. Note: PSU employees may upload Form H3676, Managed Care Pre-Enrollment Assessment Authorization, to TxMedCentral in the XXXSPW folder no earlier than five months before the member's 21st birthday. Within 30 days of registration packet mailing, PSU schedule and completing a telephone contact with the member or member's available supports, including her or his authorized representative, to explain the following: STAR Kids fitness, MDCP or PDN/PPECC services will end on the last day of the month in which the paragraph's 21st anniversary takes place. The STAR+PLUS HCBS program is an option available to eligible members at the age of 21. PSU employees also provide an overview of the range of services available within the STAR+PLUS HCBS program. The STAR+PLUS program enrollment package sent to the member will be reviewed. The package includes a list of the STAR+PLUS MCOs in the service area and a comparison chart to help the member create a selection. The member chooses a STAR+PLUS MCO in his or his service area that performs the service assessment and oversees the provision of services. The importance of choosing an MCO six months before the 21st anniversary to a gap in services. The member may change mcos at any time after the first month of registration. The STAR+PLUS HCBS program has a cost limit based on a medical assessment, the Medical Necessity and Level of Care (MN/LOC) Assessment. The assessment results in the cost limit for the individual service plan (ISP). To be eligible for the STAR+PLUS HCBS program, an ISP must be developed within the cost limit that meets the member's needs and ensure health and safety. If an ISP cannot be developed within the cost limit that guarantees the health and safety of members in the community, the STAR+PLUS HCBS program will be rejected. The ISP takes into account all available resources to meet the member's needs, including community support, other programs, and what the member's informal support system can provide to meet the member's needs. The STAR+PLUS HCBS program review process begins six months before the member's 21st birthday. PSU employees contact the member to start the application process and find out which MCO is selected. If an MCO is not selected, 30 days is allowed for a selection. After 30 days, an MCO is selected for the member. After the MCO is selected, the MCO service coordinator will contact the member to initiate the service assessment and assist the member, member or representative support person in identifying and developing additional resources and community support to help meet the member's needs. The MCO service coordinator will assist the member in determining the services required within this service array to meet his needs and ensure health and safety. Example: If other needs are met, but the member primarily needs nursing, an ISP can be developed with the maximum number of nursing hours within the cost limit, while the other needs of the member is met through other means. Reassure the member, supporter, or AR that every effort will be made to help him or her make a successful transition to the STAR+PLUS HCBS program. The member may receive a registration package from the Texas Health and Human Services Commission (HHSC) enrollment broker and the importance of selecting the same MCO. 3421.3 Five months before the 21st anniversary review of paragraph 19-1; From June 3, 2019 Five months before the 21st birthday of a member who is medically dependent children program (MDCP) or Texas Health Steps Comprehensive Care Program (CCP)/Private Duty Nursing (PDN) or Prescribed Extended Care Centers (PPECC) receive telephone contact with the member or representative (AR) within 30 days of the previous contact. If the member or ar receiving MDCP and/or CCP/PDN or PPECC has made a managed care organization (MCO) and primary care provider (PCP) choice: inform the member or ar receiving MDCP and/or informs CCP/PDN or PPECC staff of the MCO choice; and PSU employees inform the member that he or she should remain with this MCO during the first month of the STAR+PLUS registration in order to ensure a smooth transition and continuity of service; MCO of the member's choice by uploading Form H3676, Managed Care Pre-Enrollment Assessment Authorization, to TxMedCentral in the XXXSPW folder, using the appropriate naming convention; and MCO of a member who receives 50 or more PDN hours by indicating the PDN hours in the Comment Box of Form H3676, Section A. If the member or AR has not made an MCO and PCP choice: PSU employees inform the member or ar that if an MCO is not selected within seven days of the PSU contact, one is assigned; and if the selection is not made within seven days of contact with the PSU, the PSU staff selects an MCO for the member; to inform the member that: the State has selected an MCO; and he or she should remain with this MCO during the first month of the STAR+PLUS registration to ensure a smooth transition and continuity of service; and inform the MCO about the choice by uploading Form H3676 to TxMedCentral in the XXXSPW folder, using the appropriate naming convention. Note: Within 14 days of the PSU form H3676 upload date, the MCO must schedule the first home visit with the MDCP or CCP/PDN member or AR. 3421.4 Within 45 days of receipt of a form H3676 Reference revision 19-1; As of June 3, 2019 within 45 days of receipt of email notification of Form H3676, Managed Care Pre-Enrollment Assessment Authorization, Section A, the Managed Care Organization (MCO): complete Form H2060, Needs Assessment Questionnaire and Task/Hour Guide, or Form H6516, Community First Choice Assessment; completes the Medical Necessity and Level of Care (MN/LOC) Assessment, using Service Group 19, and submits the form to the Long Term Care (LTC) Online Portal (Note: The first MN/LOC may not be submitted until 150 days before the first day of the month after the member's 21st birthday); makes a reference to a Local Intellectual and Developmental Disability Authority (LIDDA) for members with intellectual or developmental disabilities (IDD) so that the LIDDA can complete the necessary assessments to determine whether the member complies with the intermediary care facility for persons with intellectual disabilities or related conditions (ICF/IID) care level (LOC) needed to qualify for Community First Choice (CFC); completes Form H1700-1, Individual ServicePlan (Pg. 1) and Form H1700-2, Individual Service Plan (Pg. 2), according to star+PLUS HCBS program that is eligible in section 3421.6 that follows; uploads Form H1700-1 and Form H1700-2 to in the MCO's XXXISP folder, using the appropriate naming convention. An approved MN/LOC must be received before form H1700-1 is uploaded, if the member needs the STAR+PLUS HCBS program; Completes Completes B of Form H3676; and uploads Form H3676 to TxMedCentral in the MCO XXXSPW folder, using the appropriate naming convention. 3421.5 Confirm Star+PLUS Home and Community Based Services Program Eligibility Revision 19-1; As of June 3, 2019, Program Support Unit (PSU) employees confirm that within five working days of receipt of all required fitness documentation from the managed care organization (MCO) and Texas Medicaid & Healthcare Partnership (TMHP), it is eligible, based on: a recognized medical necessity and level of care (MN/LOC); Note: A valid MN does not exceed 150 days after the date of TMHP approval. If MN exceeds more than 150 days after the date of TMHP approval, PSU staff must complete Form H2067-MC, Managed Care Programs Communication, advising the MCO, and requesting the MCO process a significant change in condition to the MN. PSU employees must upload Form H2067-MC to TxMedCentral in the MCO's SPW folder. at least one STAR+PLUS Home and Community Based Services (HCBS) program service is included in the individual service plan (ISP); and an ISP cost within 202 percent of the Resource Utilization Group (RUG) cost limit. Note: If the ISP exceeds 202 percent of the RUG, refer to Section 3421.6, ISP Cost exceeds 202 Percent of the RUG Cost Limit. PSU employees must request star+plus HCBS program enrollment from Enrollment Resolution Services (ERS) no later than 60 days before the individual's 21st birth date, so the Texas Health and Human Services Commission (HHSC) enrollment broker does not send a STAR+PLUS HCBS program enrollment package to the person. If star+plus HCBS program is approved within two business days, PSU employees will be approved: set the start date, the first of the month after the member's 21st birthday; For example, the 21st anniversary of the member providing the Medically Dependent Children Program (MDCP) or Comprehensive Care Program (CCP) /Private Duty Nursing (PDN) or Prescribed Pediatric Extended Care Centers (PPECC) is March 3, 20XX: STAR + PLUS HCBS program registration is in effect April 1, 20XX; ISP has been introduced for the STAR+PLUS HCBS program ISP period; and STAR+PLUS HCBS program registration is April 1, 20XX, until March 31, 20XX; Form H2065-D, Complete Managed Care Program Services Notice and send the original to the member; Upload H2065-D form to the HHS Enterprise Administrative Report and Tracking System (HEART); and upload from H2065-D to TxMedCentral in the MCO's XXXSPW folder, using the appropriate naming convention. Within five business days of receiving Form H2065-D from PSU staff, ERS: forces member registration in STAR +PLUS in the Texas Integrated Eligibility Redesign System (TIERS); and states that in operation on the first day of the month following the 21st birthday of the member receiving MDCP or CCP/PDN or PPECC. Note: If the member's birthday is the first day of the month, is the same day and month after the 21st birthday of the member receiving MDCP or CCP/PDN or PPECC. 3421.6 Cost for individual service plans exceeds 202 percent of the resource usage group 19-1 cost limit change; As of June 3, 2019 If the cost of the individual service plan (ISP) exceeds 202 percent of the Resource Utilization Group (RUG) cost limit, the Managed Care Organization (MCO) submits the following documents to the Texas Health and Human Services Commission (HHSC) Utilization Review (UR) Transition/High Needs Coordinator: Medical Necessity and Level of Care (MN/LOC) Assessment Form H1700-1, Individual Service Plan (Pg.1); Form H1700-3, Nursing Plan; Form H1700-A, Reason for STAR+PLUS HCBS Program Items/Services; Form H1700-B, Non-STAR+PLUS HCBS Program Services; Form H2060, Needs Assessment Questionnaire and Task/Hour Guide, or Form H6516, Community First Choice Assessment, as appropriate; Form H2060-A, addendum to Form H2060, where applicable; Form H2060-B, Addendum for needs assessment; and two weeks of nursing notes, including Medication Administration Records, seizure, vent and infant logs, if any. UR will conduct a desk review once all of the documents listed above have been received and may request a clinical review by an HHSC Associate Medical Director of the case to consider the use of State of Texas General Revenue funds to cover costs that exceed the cost limit of 202 percent. Note: MCOs may not discuss with applicants or members, or use, state Texas General Revenue funds for services above the cost limit. 3422 Intrapulmonary Percussive fan revision 19-1; With effect from 3 June 2019, members approved for and using an intrapulmonary percussive fan (IPV) may continue to use the IPV if it is deemed to have a beneficial effect on the health of the member. The member may not be abruptly removed. The member will continue to receive ongoing IPV treatment until a final decision is made by the STAR+PLUS managed care organization (MCO), on a case-by-case basis, including thorough review and documentation by the MCO and explicit approval by Texas Health and Human Services Commission (HHSC) Office of the Medical Director. 3500 Money follows the person revision 18-2; As of September 3, 2018 See section 3311.1, Interest List Procedures, for information on the use of the Community Services Interest List as a tracking system for money The Person (MFP) follows requests from persons who are not yet members of a managed care organization (MCO). 3510 Money Follows the Person and Managed Care Overhaul 19-1; As of June 3, 2019 the Money Follows the (MFP) procedure allows Medicaid-eligible nursing home (NF) residents to receive community services by transitioning to long-term services and support (LTSS). For residents who need the Home and Community Based Services (HCBS) program, the managed care organization (MCO) will perform the functional assessment and service planning. Note: MCOs can use an NF's Minimum Data Set (MDS) Assessment, Medical Necessity and Level of Care (MN/LOC), and Program Support Units (PSUs) can accept an NF's MDS Assessment for MFP applicants as long as they have been approved and have not yet expired. The NF's MDS rating should not be used for upgrades. For more information about upgrades, see Section 3330, STAR+PLUS members requesting an upgrade to the STAR+PLUS Home and Community Based Services Program. One of the eligibility requirements for MFP is that the individual is approved for the STAR+PLUS HCBS program before leaving the NF. Persons must remain in the NF until a final determination has been established indicating the approval of the STAR+PLUS HCBS programme. People who leave before receiving Form H2065-D, Notified from Managed Care Services, for approval are denied with denial code 39 (Other). Once the assessment process is complete and the resident is eligible for the STAR+PLUS HCBS program, the MCO should be prepared to launch the individual service plan (ISP) after the notification of eligibility. Individuals are enrolled in managed care on the first day of the month in which dismissal from the NF is scheduled. This flexible enrollment process only applies to MFP. For more information about MFP, see Section 3310, Intake and Enrollment. The MCO participates in community planning groups (for example, the Community Transition Team) and other activities related to the state's Promoting Independence Initiative. 3511 Money follows the person procedure review 18-2; As of September 3, 2018, a referral will be made through the Texas Health and Human Services Commission (HHSC) Access and Eligibility when a resident of the nursing facility (NF) wishes to receive services in the community through the STAR+PLUS Home and Community Based Services (HCBS) program. Intake staff must follow all money the person (MFP) requests for Program Support Unit (PSU) staff. Referrals can be made by anyone, including family members, NF employees, relocation specialists and HHSC case managers. 3512 Money follows the person's applications pending due to delay in nursing discharge review 19-1; As of June 3, 2019, the Program Support Unit (PSU) and managed care organizations (MCOs) are required to assist the applicant or member of the nursing facility (NF) who wishes to return to the community by providing information and references to possible sources in the community. However, in situations where specific eligibility criteria will not be met in the near future, PSU employees have the option to refuse the request for services. Deadlines are set as a guideline for refusing requests pending with the service service A time frame of four months is the directive used in determining pending or refusal of requests for services. The review process does not stop during this period; however, eligibility can only be established after the member is ready to be dismissed from the NF. Examples: A STAR+PLUS Home and Community Based Services (HCBS) program applicant has a clear discharge date within four months of the date services were requested. Allow the reference to remain open until the member is ready to discharge and coordinate the transfer to the community. A STAR + PLUS HCBS program applicant is in the process of making living arrangements that will allow him to leave the NF within four months of the date on which services were requested. Let the application remain open. If the applicant has an estimated date of discharge that may not exceed the four-month period, PSU staff must keep the request for services open. For information about requests that have been pending for more than four months, see section 3513 below. 3513 Applications pending more than four calendar months due to delay in nursing discharge review 19-1; As of June 3, 2019, Program Support Unit (PSU) and Managed Care Organization (MCO) staff should use their judgment and work with applicants who have pending arrangements but have not yet been finalized. If the applicant has an estimated redundancy date that goes beyond the four-month period, PSU staff must keep the request for services open. Applicants who have not made living arrangements to return to the community cannot decide when to return to the community, or have no viable plan or support system in the community, should be refused. PSU employees refuse to send the request for services by Form H2065-D, Notice of Managed Care Program Services, to the applicant within two business days of the end of the pending four-month period. PSU employees will upload Form H2067-MC, Managed Care Programs Communication, to TxMedCentral in the MCO's SPW folder. If a candidate for assisted living meets the eligibility criteria but is on an interest list for a contracted STAR+PLUS HCBS program AL Facility (ALF), PSU employees check through the MCO whether the applicant is on the list and can have the service request pending until the slot is opened. 3514 STAR+PLUS members residing in a facility overhaul 19-1; As of June 3, 2019 When a managed care organization (MCO) receives a request from or is notified of a STAR+PLUS member requesting a move to the community the MCO service coordinator must contact the applicant or member within five working days and contact the member within 14 working days to explain the transition process to the community. Within three working days of a meeting with the member, the MCO service coordinator must make a referral for relocation assistance by completing Form 1579, Relocation Referral where applicable. Inform the Program Support Unit (PSU) staff about the request to transition to the community by uploading Form H2067-MC, Managed Care Programs Communication, to TxMedCentral using the appropriate naming convention for money follows the person (MFP). Within two business days of the MCO's upload of Form H2067-MC, PSU employees must: Inform the MCO if the member is on a 1915 Medicaid interest list, in a 1915 Medicaid waiver that is listed as open enrollment or services that have been temporarily suspended, or neither, by uploading Form H2067-MC to TxMedCentral. Within 45 days of being informed of a member requesting a community transition, the MCO service coordinator must have completed the assessment for the applicant or member for appropriate services and community settings. The MCO performs the following work: The MCO completes the Medical Necessity and Level of Care (MN/LOC) assessment if there is no valid Minimum Data Set (MDS) assessment or the ability to complete its own MN/LOC assessment instead of using the MDS (Nursing facilities). The MCO should ask the NF for a courtesy copy of the MDS assessment completed by the NF. If the NF refuses, it is not mandatory for the MCO to have a copy. A rejected MN/LOC decision resulting from the MCO's review is not used to deny an applicant for a STAR+PLUS Home and Community Based Services (HCBS) program that has a valid NF MDS. The NF MDS and Resource Utilization Group (RUG) are used for STAR+PLUS HCBS program eligibility provisions. An MN record must be placed in the SASO so that the individual ISP registration (ISP) registration is not suspended. The SASO MN record must match the effective date of the ISP input and must have an active MN period for the entire ISP period. The MN/LOC end date should be adjusted to the ISP end date if necessary. If a supplemental security income (SSI) or SSI-related member receives only long-term services and support (e.g. state plan) Personal Assistance Services (PAS) or Day Activity and Health Services (DAHS)), the MCO must notify PSU personnel by uploading Form H2067-MC to TxMedCentral If the member meets functional criteria for the STAR+PLUS HCBS program, the MCO follows the policy in Section 3514.1, Transition to Community with STAR+PLUS Home and Community Based Services Program. 3514.1 Transition to community with STAR+PLUS Home and Community Based Services Program Revision 19-1; As of June 3, 2019 during the first 45-day review period, if the member is temporarily suspended from a Texas and Human Services Commission (HHSC) 1915(c) Medicaid waiver, the service coordinator of the managed care organization (MCO) explains the STAR+PLUS Home and Community Based Services (HCBS) program to the member so that he or she can choose between the STAR+PLUS HCBS program or remain in her or his previous HHSC 1915(c) Medicaid waiver. Continue. the member chooses the STAR+PLUS HCBS program, the MCO service coordinator: assess the current form H1700-1, Individual ServicePlan (Pg. 1), or develops a new individual service plan (ISP) if none existed before or if the ISP has expired; coordinates Transition Assistance Services (TAS) as part of the STAR+PLUS HCBS program, if necessary; warns the Program Support Unit (PSU) personnel that the member has selected the STAR+PLUS HCBS program; and alerts PSU staff of selection by uploading Form H2067-MC, Managed Care Programs Communication, to TxMedCentral using the Money Follows the Person (MFP) naming convention. If the member chooses to remain with the HHSC 1915(c) Medicaid waiver, the MCO service coordinator will notify PSU employees of the selection by uploading Form H2067-MC to TxMedCentral using the MFP naming convention. Within two business days of receiving Form H2067-MC from the MCO notifying them of the member's selection, PSU personnel will complete the following activities: If the member opts for the STAR+PLUS HCBS program, PSU personnel: upload form H2067-MC to the Texas Health and Human Services (HHS) Administrative Report and Tracking System (HEART); add the member to the STAR+PLUS interest rate list, if applicable; and immediately release the member of the interest rate list. If the member chooses to return to the HHSC 1915(c) Medicaid waiver for services, PSU personnel: upload form H2067-MC to HART; and closes the case in HEART. For Medicare/Medicaid dually eligible individuals who joined during the nursing home (NF) stay but have chosen to return to the HHSC 1915 (c) Medicaid waiver, PSU staff report Enrollment Resolution Services (ERS) to request disenrollment at the time of discharge. When the member opts for the STAR+PLUS HCBS program, the MCO coordinates with HHSC relocation contractors and the Service Coordinators of the Local Intellectual and Developmental Disability Authority (LIDDA), if necessary, to ensure that all that is needed for community life is in place at the time of dismissal of the NF. Additional Transition Support (STS) services should be specialists between the removal contractor and the MCO service coordinator when the removal specialist determines that the member can benefit from STS services. See Annex XXX, Relocation Function, for responsibilities of relocation specialists and MCOs. The MCO is not responsible for obtaining independent accommodation for the member, but is responsible for identifying foster care for adults (AFC) or assisted living (AL) alternatives available in the network. For all members who to the STAR+PLUS HCBS program, within 45 days, the MCO uploads the following information to TxMedCentral: Form H1700-1, if the ISP has expired or if the ISP did not exist before; and form H2067-MC, which informs PSU staff if the NF's discharge date is known. PSU employees send an email to the Managed Care Compliance & & if the MCO does not upload the above information within 45 days of the member's request to return to the community. PSU employees will continue to check for receipt of the above information if necessary. Within five business days of receiving all required documentation, PSU staff: confirm STAR + PLUS HCBS program eligibility based on: Medicaid eligibility for STAR + PLUS; a recognised medical necessity; and an ISP with: at least one STAR+PLUS HCBS program service per year; and a cost within the cost limit of the individual; send a first form H2065-D, Notice of Managed Care Program Services, to the member as notification that he or she has fulfilled the admission qualifications to participate in the STAR+PLUS HCBS programme; and upload a copy of Form H2065-D to TxMedCentral within two business days to inform the staff of the MCO PSU of the first eligibility determination to the member. As soon as star+plus HCBS program is eligible, the MCO, the relocation specialist, NF, NF resident and PSU employees will work together to identify a proposed discharge date. The MCO is responsible for informing PSU employees of the discharge date by uploading Form H2067-MC to TxMedCentral. If another entity contacts PSU personnel with a discharge date, PSU staff must notify the MCO within two business days by uploading Form H2067-MC to TxMedCentral to determine whether the date is acceptable. The MCO must respond with the correct scheduled discharge date by uploading Form H2067-MC to TxMedCentral within two business days of the PSU employee upload date. Within two business days of discharge from the NF, the MCO uploads form H2067-MC to TxMedCentral to communicate the discharge to PSU employees. Within one working day, PSU employees fill out a second form H2065-D with the effective date of the service and: mail the original to the member; Upload a copy to TxMedCentral in the MCO's XXXSPW folder using the appropriate naming convention; for members of medical assistance (MAO), fax or email a copy of Form H2065-D, as well as Form H1746-A, MEPD Referral Cover Sheet, to the Medicaid for the Elderly and People with Disabilities (MEPD) specialist to facilitate the Medicaid program transfer; and email form H2065-D to the E-mail resolution services (ERS) mailbox requesting registration with STAR+PLUS, if applicable. Within a business day of sending the final form H2065-D to the member, PSU personnel create Service Authorization System Online (SASO) items documented in Section 9400, Money follows the person 'MFP) Authorization for a STAR +PLUS HCBS Program Applicant, except creating a one-day STAR + PLUS service authorization for the first day of the month in which an MFP individual is fired from an NF. There is no need to complete a one-day service authorization record for members who discharge mid-month and start receiving the HCBS program. If the NF records in SASO do not reflect the NF end date within three business days of the person's termination date, PSU employees will contact the HHSC Long Term Care (LTC) Provider Claims Services department to request closure of the NF service authorization in SASO. The hotline for HHSC Provider Claims is 512-438-2200. Select Option 1 when prompted. If star+plus HCBS program is eligible, PSU employees will complete Form H2065-D and email the original to the member; and upload it to TxMedCentral in the MCO's XXXSPW folder using the appropriate naming convention. If a Medicaid eligible NF MAO member chooses to leave the NF and return to the community before being determined to be eligible for the STAR+PLUS HCBS program, PSU staff perform the following steps in addition to the above mentioned: fax or email a copy of Form H2065-D, along with Form H1746-A, to the MEPD specialist; e-mail a copy to ERS requesting the registration of STAR+PLUS; and upload form H2065-D to HEART. 3515 Non-STAR+PLUS members residing in a nursing facility revision 19-1; As of June 3, 2019 for requests to transition to the community for a non-STAR+PLUS member, texas health and human services commission (HHSC) Access and Eligibility staff will refer to the program support unit (PSU) staff. Within two business days of referral from HHSC, PSU staff: determine whether the person has either an open enrollment or services have been temporarily suspended in an HHSC 1915(c) Medicaid waiver according to the following: For either the Texas Home Living (TxHmL) or Home and Community-based Services (HCS) waivers, check the Client and Assignment Registration (CARE) System, Screen 397 series Client, ID information screens , to check that the person is enrolled in one of these programs. The screen specific to waiver consumer assignment history identifies enrollment, if applicable. For Community Living Assistance and Support Services (CLASS) (Service Group 2) and Deaf Blind with Multiple Disabilities (DBMD) (Service Group 16), see the Service Authorization System Online (SASO) to see if the service authorization record for these waivers has an end date and a termination code. If the service authorization has an end date and there is no termination code, it indicates that the waiver has been temporarily suspended. coordinate with the Local Intellectual and Developmental Disability Authority (LIDDA) to schedule a conference call with the individual to explain the benefits of the STAR+PLUS Home and Community Based Services (HCBS) program and the HHSC 1915(c) Medicaid waivers; opening a case at the Texas Health and Human Services Enterprise Administrative Report and Tracking System (HEART); and document the member's STAR+PLUS HCBS program choice in HEART. Within two working days of receiving the notification of nursing home establishment Resident's STAR+ PLUS HCBS program selection, PSU staff determine the individual Medicaid status to evaluate for proper coordination with the Medicaid for the elderly and people with disabilities (MEPD) specialist. When the person has chosen to sign up for the STAR+ PLUS HCBS program, PSU staff must complete the following activities within two business days of notification of selection: Check the Texas Integrated Eligibility Redesign System (TIERS) to verify that a Form H1200, Application for Assistance - Your Texas Benefits, has already been submitted for the NF stay, or the person already has full Medicaid eligibility for a type of program applicable to the STAR+ Plus HCBS Program. Contact the NF resident or delegate (AR) party by phone to explain the Medicaid application process, if applicable, the selection of a managed care organization (MCO) and the importance of quickly returning the forms that PSU staff mail to the person. Inform the NF resident during the telephone contact that he or she may change the MCO in which he or she is registered at any time after one full month of the STAR+PLUS HCBS program provision. If applicable, send Form H1200 and the correct STAR+PLUS MCO registration package to the NF resident, responsible party or AR. Check the Community Services Interest List (CSIL) to see if the resident is already on the star+PLUS HCBS program interest list. If not, add the person and immediately release it from the star+plus HCBS program interest list. Refer the person for relocation assistance by completing Form 1579, Referral for Relocation Services. Inform HHSC that the person is signing up for the STAR+PLUS HCBS program. PSU employees are responsible for completing the following activities 14 days after the STAR+PLUS HCBS program selection. PSU staff should document in HEART all attempts to contact the NF resident and any delays encountered. PSU staff: contact the NF resident if PSU employees have not received Form H1200; and discuss with the NF resident the importance of choosing an MCO if the individual has not selected one during the first contact, with the MCO conducting the assessment and developing the initial individual service plan (ISP) to facilitate a suitability determination for the STAR+PLUS HCBS program. If, during the 14-day follow-up contact, the NF resident declares that he or she, the AR or the NF has already filed a completed Form H1200, PSU staff check the Texas Integrated Eligibility Redesign System (TIERS) to verify Form H1200 has been filed. If the NF resident has not communicated Form H1200, or if has not submitted a record form H1200, the PSU informs the NF resident to immediately return Form H1200 to PSU staff because the application for SPW services is refused due to non-return of the Form H1200 H1200 45 days after the date on which the PSU sent the form to the NF resident. Upon receipt of the completed Form H1200, PSU staff make a referral to the MEPD specialist within two business days by completing Form H1746-A, MEPD Referral Cover Sheet, with the submission of the returned Medicaid application. If Form H1200 is not received within 45 days of the date psu employees sent Form H1200 to the NF resident, PSU employees will refuse to apply for the STAR+PLUS HCBS program: the documenting in HART Form H1200 was not received within 45 days; sending the NF resident Form H2065-D, Notification of Managed Care Program Services; and uploading Form H2065-D to TxMedCentral using the appropriate naming convention. Within two working days of the NF resident notifying the PSU orally or in writing of the MCO selection, or from the time the member defaults to an MCO, PSU staff must check SASO to determine whether the applicant has a current medical need and level of care (MN/LOC); Part A of Form H3676, Managed Care Pre-Enrollment Assessment Authorization, fill in whether the applicant has a current MN by entering the Resource Utilization Group (RUG) and expiration date in point 6; Upload Form H3676 to the MCO's XXXSPW folder on TxMedCentral using the appropriate naming convention; upload form H2067-MC, Managed Care Programs Communication, txMedCentral, noting whether or not the applicant is on an HHSC 1915(c) Medicaid waiver interest list; and ensure the correct items on Form H3676 are completed and faxed to the relocation specialist, as the NF resident requires assistance transitioning to the community due to lack of support, lack of housing or other barriers. The MCO initiates contact with the applicant to begin the assessment process within 14 days of receipt of Form H3676. Within 45 days of receipt of Form H3676, the MCO service coordinator shall assess the applicant for appropriate services and community institutions. The MCO completes the following activities The MCO completes the MN/LOC Assessment if there is no valid Minimum Data Set (MDS) or the ability to complete its own MN/LOC assessment instead of using the NF's MDS. If there is no valid MDS, the MCO completes the MN/LOC for an MN determination. The MCO should ask the NF for a courtesy copy of

the MDS assessment completed by the MDS. If the NF refuses, it is not mandatory for the MCO to have a copy. A rejected MN/LOC decision resulting from the MCO's assessment is not used to refuse a STAR+PLUS HCBS program applicant with a valid NF MDS. The NF MDS and Rug are for STAR+PLUS HCBS program eligibility provisions. An MN record must be in SAS so that ISP registration is not suspended. The SASO MN record must match the effective date of the ISP input and must have an active MN period for the entire ISP period. The MN/LOC end date should be adjusted to the end date, if necessary. If the applicant needs services through the STAR+PLUS HCBS program, the MCO completes Section B of Form H3676 and develops the ISP with Form H1700-1, Individual Service Plan (Pg. 1). If a referral for relocation services is not indicated in Part A of Form H3676 and the applicant needs these services, the MCO shall updating Form H3676, Section B, and forward form 1579 to the relocation specialist. If the applicant is not eligible for the STAR+PLUS HCBS program, the MCO must notify PSU employees by uploading Form H2067-MC to TxMedCentral. When the MCO has established that the applicant meets the functional eligibility requirements for the STAR+PLUS HCBS programme, the MCO shall coordinate with the relocation specialists to ensure that all that is necessary for community life is in place at the time of dismissal of the NF. The MCO must coordinate Transition Assistance Services (TAS) when the applicant needs it as part of the STAR+PLUS HCBS program. The MCO is not responsible for obtaining independent housing for the NF resident, but is responsible for identifying adult foster care (AFC) or alternatives to assisted living (AL) available in the network. When the applicant needs additional transition support (STS), relocation specialists must coordinate it through the MCO service coordinator. If necessary, PSU employees will work with stakeholders in the star+plus HCBS program to be eligible to help resolve issues and document any delays. PSU employees track all actions and communication in HEART until all STAR+PLUS HCBS program enrollment activities are complete. Within 45 days of receiving Form H3676 with Section A, the MCO uploads the following information to TxMedCentral: Form H1700-1; Form H3676 with Section B completed; and Form H2067-MC, informing PSU staff of the proposed discharge date of the NF. PSU employees will send an email to Managed Care Compliance & Operations (MCCO) if the MCO does not upload the above information within 45 days of the NF resident's request to return to the community. PSU staff will continue to check for receipt of the above forms. Within two business days of receiving this information, when Medicaid is pending, PSU staff fill out and send Form H1746-A, MEPD Referral Cover Sheet, to notify the MEPD specialist of the approved ISP and MN/LOC so that the MEPD specialist can complete the Medicaid eligibility provision. Upon completion of the evaluation for financial eligibility, the mepd specialist shall psu informed of the finding by sending an email to the relevant mailbox designated for the MEPD specialist to make announcements to PSU staff. Within five business days of receiving all MCO documentation required for STAR+PLUS HCBS program eligibility, as well as communication from the MEPD specialist of the applicant's Medicaid eligibility, PSU staff: confirm confirm HCBS program eligible based on: Medicaid eligibility for STAR + PLUS; an approved MN/LOC; an ISP with: at least one STAR+PLUS HCBS programme; a cost within the individual's expense; and send the original Form H2065-D to the member and upload a copy to TxMedCentral to notify the staff of the MCO PSU of this finding. The MCO is working with the relocation specialist, NF, NF resident and PSU staff to establish a proposed discharge date. Once the discharge date has been set, the MCO must notify PSU staff of the discharge date within two business days by uploading Form H2067-MC to TxMedCentral. If another entity contacts PSU personnel with a discharge date, PSU staff must notify the MCO within two business days by uploading Form H2067-MC to TxMedCentral to determine whether the date is acceptable. The MCO resolves this discrepancy and must confirm the scheduled discharge date by uploading Form H2067-MC to TxMedCentral within two business days of the upload date of PSU's Form H2067-MC. Within two business days of discharge from the NF, the MCO uploads form H2067-MC to TxMedCentral to communicate the discharge to PSU employees. Within one working day, PSU employees will complete the final Form H2065-D with the effective date of the service and: mail the original to the individual; upload it to TxMedCentral in the MCO's XXXSPW folder using the appropriate naming convention; Fax or email a copy and form H1746-A to the assigned MEPD specialist to generate a task in layers; and email form H2065-D to the E-mail resolution services (ERS) mailbox requesting registration with STAR+PLUS, if applicable. Within one business day of sending the final Form H2065-D, PSU personnel: verify that NF records in the SASO reflect the NF end date; contact HHSC Long Term Care (LTC) Provider Claims at 512-438-2200 and select option 1 to request closure of the NF service authorization in SAS if the NF end date that reflects the discharge has not been processed; update the CSIL so that the CSIL closing code(s) are accurately selected; and email Enrollment Resolution Services (ERS) with the request for enrollment in the first of the month in which the individual is fired, as required by Section 3510, Money Follows the Person and Managed Care. If star+plus HCBS program is eligible, PSU employees will complete Form H2065-D and email the original to the applicant; Upload form H2065-D on TxMedCentral in the MCO's XXXSPW folder using the appropriate naming convention; Upload H2065-D form to HART; closes the case in HEART; and csil close. If the chooses to leave the NF before being determined to be eligible for the STAR+PLUS HCBS program, PSU personnel deny the STAR +PLUS HCBS program and fax form H2065-D, along with Form H1746-A, to the MEPD specialist. Upon completion of all STAR+PLUS HCBS program actions, PSU employees close the case 3520 Money follows the Person Demonstration Revision 20-1; As of March 16, 2020 3521 Money follows the Person Demonstration Introduction Review 20-1; As of March 16, 2020 The Money Follows the Person Demonstration (MFPD) was implemented to eliminate barriers and enable Medicaid-eligible individuals to transition from nursing homes (NFs) to the community and receive necessary services and long-term support (LTSS) in the context of the individual's choice. Participation in MFPD does not affect the type or number of services received or the way services are provided. Individuals participating in MFPD will receive the same services provided to other participants in the STAR+PLUS Home and Community Based Services (HCBS) program. 3522 Screening Criteria for Money Follows the Person Demonstration Eligibility Revision 20-1; As of March 16, 2020, the Managed Care Organization (MCO) must apply the following screening criteria to determine whether a person may be eligible to participate in the Money Follows the Person Demonstration (MFPD). To qualify for MFPD, the individual must meet the current STAR+PLUS Home and Community Based Services (HCBS) program eligibility criteria. In addition, the individual must meet the MFPD eligibility criteria that require the individual to remain in a Medicaid-certified nursing home (NF) at least 90 days before the star+plus HCBS eligibility date; Medicaid eligibility under Title XIX of the Social Security Act; transition* from an NF to a qualified dwelling comprising: a dwelling owned or rented by the family member of the person or individual; an apartment with an individual lease with living, sleeping, bathing and cooking areas in which the individual or family member has a domain; Apartment (Assisted Living) (Service Code 19); Apartment Residential Care (Service Code 19A); and Adult Foster Care (AFC) at home (no more than four unrelated persons living in the house); and agree to participate in the MFPD by completing Form 1580, Texas Money follows the Person Demonstration Project Informed Consent for Participation, signed by the individual or authorized representative (AR) and MCO staff, after explanation of MFPD and prior to the provision of services. *The MCO should include the AR in the actual transition planning, if any. 3522.1 Screening for 90-day qualification institutional stay review 20-1; As of 16 March 2020 For the purposes of the Money Follows the Person Demonstration (MFPD), an institutional setting is defined as a nursing home (NF), intermediate care facility for persons with intellectual disabilities or (ICF/IID), hospital or state hospital. The 90-day institutional stay can be met by a continuous stay in a combination of institutions. See also Article 3525, 3525, 90-day qualification institution stay required for MFPD eligibility in the STAR+PLUS HCBS programme. Example: An MFPD person spent 30 days continuously in an NF, 60 days in a hospital and then went back to the NF for another 30 days. This would meet the 90-day institutional residency requirement for MFPD. The individual does not have to stay in the NF or any other institution for 90 days at the time they indicate a desire to transition to the community. The person meets the screening criteria if it appears likely that he will stay in an NF or other institution at least 90 days before the discharge date of the NF. 3522.2 Program Support Unit Staff Verification of 90-Day Qualifying Institutional Stay Revision 20-1; As of March 16, 2020 Program Support Unit Personnel (PSU) must verify the 90-day residency requirements for eligibility in the Money Follows the Person Demonstration (MFPD). For verification, PSU employees can: use Minimum Data Set (MDS) information available on the Texas Medicaid & Healthcare Partnership (TMHP) website; View service authorization system online (V-NF) records; contact the NF for admission dates; or as a last resort, to obtain confirmation from the individual. PSU employees communicate to Managed Care Organization (MCO) employees that the individual may be eligible for MFPD by completing the MFPD qualification and end dates in Section A, section 20, qualification dates, on Form H3676, Managed Care Pre-Enrollment Assessment Authorization. 3523 Registration in money follows the Person Demonstration Revision 20-1; As of March 16, 2020, persons who meet the eligibility requirements and choose to enroll in the Money Follows the Person Demonstration (MFPD) must be appointed by the staff of the Program Support Unit (PSU), according to star+plus program support unit operational procedures section 9480, MFPD for STAR + PLUS HCBS Applicant Program, in the Service Authorization System Online (SASO) , using the following procedures: Registration record — Registered with Field: Choose '12 — Money follows the person'. Service Authorizations: Force Box: Select the Force check box for each service authorization. Fund type - Choose 19MFP-Money Follows the Person. This code only applies to MFPD recipients. Force Comment — Enter 'MFP Demonstrator' and select 'Force'. Fund type 19MFP-Money Follows the Person should be selected for the first individual service plan (ISP) period of participation in MFPD. This fund type is removed after the MFPD legal period is over or if the person withdraws from MFPD. See Section 3524, Money Follows the Person Demonstration Entitlement Period PSU employees must keep a list of MFPD participants. This list must contain the following: the name of the individual; Medicaid identification (ID) number; and isp start and end date. The person can withdraw MFPD at any time by informing the managed care organization (MCO) service coordinator. To notify PSU employees of the withdrawal, the MCO service coordinator uploads Form H2067-MC, Managed Care Program Communications, to TXMedCentral, indicating withdrawal from MFPD. Although the eligibility of MFPD may end after MFPD is withdrawn, the individual will continue to receive star+plus home and community based services (HCBS) program services if all STAR+PLUS HCBS eligibility criteria are met. 3524 Money follows the Person Demonstration Entitlement Period Tracking Revision 20-1; From 16 March 2020, Money Follows the Person Demonstration (MFPD) is entitled to 365 days of participation in MFPD. Time spent in an institutional environment does not count for the period of 365 days rights; therefore, tracking is required to ensure that MFPD individuals receive the full 365-day period. The legal period begins on the date the MFPD person is enrolled in the STAR+PLUS Home and Community Based Services (HCBS) program. Example: The person chooses to participate in MFPD and is enrolled in the STAR+PLUS HCBS program, effective June 1, 2019, with an initial individual service plan (ISP) from June 1, 2019 through May 31, 2020. If there are no institutional residences during the first ISP period, the MFPD legal period ends when the ISP period ends on May 31, 2020. If the MFPD individual is institutionalized for 10 days in April 2020, the MFPD legal period will be suspended during the period of institutionalisation and resumed when he returns to the community until the end of the 365-day legal period. In this example, the MFPD legal period ends on June 10, 2020, which is after the ISP end date of May 31, 2020. If the MFPD person is authorized for a new MFPD service during the first ISP period and there are no institutional stays, the MFPD surcharge would still end on May 31, 2020. Tracking is required to ensure that MFPD individuals receive the full 365-day period unless the individual withdraws from MFPD. The MCO is responsible for keeping track of the MFPD legal period. Once the 365-day legal period has expired, the MCO will be responsible for uploading Form H2067-MC to TxMedCentral in the MCO folder to inform PSU employees about the date on which the person's legal period ended. It is essential that complete and accurate records are kept because MFPD tracking is subject to audit by the Centers for Medicare and Medicaid Services (CMS). 3525 Documentation of the 90-day institutional residence qualification required for MFPD eligibility in the STAR + PLUS HCBS Program Revision 20-1; With effect from 16 March 2020, the entry and the date of discharge from a hospital, nursing facility (NF) or other institutional institution included in the number of days the individual has been institutionalised for purposes of 90-day qualification setting stay required for the money follows the person Demonstration (MFPD). Program Support Unit (PSU) staff must check the Service Authorization System Online (SASO) to verify the stay in qualified institutional institutions. This may include stays in a combination of applicable settings, including: Service Group (SG) 1, Service Code (SC) 1, NF — Daily Care; SG 5, SC 1, state-operated intermediary care facility for persons with intellectual disabilities or related conditions (ICF/IID); SG 6, SC 1, non-state ICF/IID; and SG 4, SC 1, State Supported Living Centers. PSU employees must send Form H2067-MC, Managed Care Programs Communication, to the managed care organization (MCO), documenting MFPD 90-day qualification start and end dates. Institutional stays for the 90 days prior to the eligibility date should be documented, even if it is found that the person does not meet the criteria. If the person is currently in a qualified institutional setting at the time form H2067-MC is sent to the MCO, enter the start date of the cover and continuously use it as an end date. SASO records do not include possible hospitalizations, which also count towards the 90-day requirement. The MCO will determine if the person was in a hospital immediately before the start date on Form H2067-MC. The MCO will also determine whether the 90-day residency requirement for MFPD eligibility is met once the NF's discharge date is known. Similarly, if the individual has a gap in institutional residency, the MCO will evaluate MFPD eligibility by checking for possible hospitalizations prior to the NF stay or during the hiatus period, as well as taking into account the discharge date of the NF. 3530 Members with high/complex needs review 18-2; With effect from 3 September 2018 3531 Designation of Members with High Needs Review 18-2; As of September 3, 2018, the Uniform Managed Care Contract (UMCC), Attachments A and B-1, Section 8.1.12, the Managed Care Organization (MCO) should develop and maintain a system and procedures for identifying members with special care needs (MSHCN), including people with disabilities or chronic or complex medical and behavioral health conditions and children with special health needs (CSHCN). The MCO should contact members who have been pre-screened by the Contractor of the Texas Health and Human Services Commission (HHSC) Administrative Services as MSHCN to determine whether they meet the MCO's MSHCN assessment criteria and to determine whether the member needs special services. The MCO must provide information to the HHSC Administrative Services identify members that the MCO has assessed as MSHCN, including all members pre-screened by the HHSC Administrative Services contractor and confirmed by the MCO as an MSHCN. The information must be provided in a format and on a timeline that is by HHSC in the Uniform Managed Care Manual (UMCM), and updated with newly identified MSHCN by the 10th day of each month. In the event that an MSHCN changes MCOs, the MCO must provide the receiving contractor with information on the results of the identification and assessment of the MCO's needs in order to avoid duplication of those activities. CSHCN: a child (or children) that: age ranges from birth to 19 years; has a serious persistent illness, complex chronic condition or disability that has lasted or is expected to last at least 12 consecutive months or more; has a disease, condition or disability that leads (or would result without treatment) in limitation of function, activities or social roles compared to accepted pediatric age-related milestones in the general areas of physical, cognitive, emotional and/or social growth and/or development; requires regular, continuous therapeutic intervention and evaluation by well-trained healthcare personnel; and needs health and/or health-related services at a level significantly higher than usual for the child's age. MSHCN includes a CSHCN and any adult member who: has a serious persistent illness, a chronic or complex condition, or a disability that has lasted or is expected to last a significant period; and requires regular, continuous therapeutic intervention and evaluation by appropriately trained healthcare personnel. 3532 Fixing the status of high needs for current members review 19-1; As of June 3, 2019 If the managed care organization (MCO) determines during the period of the individual service plan (ISP) that the member's next ISP may exceed the cost limit, that member is deemed to have a high needs status. Once the MCO is designated as a high-needs status, it must initiate plans to bring the ISP to/or below the cost limit in the ninth month of the ISP period. If the subsequent ISP is found to exceed the cost limit and efforts to explore other health and safety protection alternatives are unsuccessful, the MCO initiates a request for staff employment with the Texas Health and Human Services Commission (HHSC) to determine whether a request for the use of General Income (GR) funds is appropriate. 3600 Continuous review of the coordination of services 19-1; As of June 3, 2019, the existing responsibilities of the managed care organization (MCO) of the ongoing service coordination (ISP) may consist of: reviewing the individual service plan (ISP) if necessary to meet the member's needs, responding to requests for change of the service plan and the to requests for additional services such as adaptive devices, emergency services, respite or requests for suspension of the service; coordinate and consult with MCO-contracted providers with regard to services; remember to complete the member and return Medicaid renewal eligibility documents sent by Program Support Unit (PSU) staff or the Medicaid for the elderly and people with disabilities (MEPD) specialist; monitoring services provided to members, evaluating the suitability and suitability of the STAR+PLUS HCBS programme and the non-STAR+PLUS HCBS programme and documenting monitoring activities; assist the member in accessing and using community, Medicare, family and other external resources (TPR); assisting in crisis intervention; and respond to situations of possible denial of an active member whose ISP costs exceed the individual's estimated cost limit, including requesting a re-evaluation of the need, meeting the interdisciplinary team and administrative staff, and coordinating other services before termination of the STAR+PLUS HCBS program. 3610 Review of the review plan for individual services 18-2; As of September 3, 2018, it may be necessary to review the individual service plan (ISP) within the ISP period due to changes in the member's needs or changes to the services offered or emergencies. The managed care organization (MCO) documents revision of the ISP on form H1700-1, Individual Service Plan (Pg. 1). A revised ISP is not submitted to the Program Support Unit (PSU) via TxMedCentral, but is kept in the member's file. 3611 MCO required notifications from the provider revision 18-2; As of September 3, 2017, the provider must notify the managed care organization (MCO) when one or more of the following circumstances arise: the member leaves the service area for more than 30 days; the member is legally locked up in an institutional environment. An institution includes legal incarceration, an acute care hospital, a hospital, a rehabilitation hospital, a state-supported residential centre, nursing home or intermediate care for persons with intellectual disabilities or related conditions (ICF/IID); the member is not financially eligible for Medicaid benefits; providers have refused to serve the member on the basis of a reasonable expectation that the medical and nursing needs of the member cannot be adequately met in the member's place of residence; the member or a member at the home refuses to comply with the mandatory programme requirements, including the determination of the suitability and/or supervision of the service; the member does not pay his or his qualified income trust (QIT) copayment; the situation, the member or someone in the member's house is dangerous to the health and safety of the service provider, but there is no immediate threat to the and safety of the provider; the member or someone in the member's house openly uses illegal drugs or has illegal drugs that are readily available in front of the service provider; or the member asks that the services be terminated. 3611.1 Immediate suspension of Revision 20-1; With effect from 16 March 2020 If the member or person in the member's place of residence exhibits behaviour leading to an immediate risk to the health and safety of service providers or others, the provider must orally inform the managed care organisation (MCO) by the following working day and follow up the MCO within two working days of oral notification. The written notification must contain a detailed description of the member's conduct and how it has impaired the provider's ability to provide secure services to the member. Upon notification of suspected abuse, neglect or exploitation, the MCO must ensure that an immediate notification is made to the Texas Department of Family and Protective Services (DFPS) and can notify the police and immediately suspend the services if necessary. The MCO must notify the member in writing of suspension of the service, as stated in Chapter 3.21 of the Uniform Managed Care Manual (UMCM), explaining the member's right to apply for an MCO Internal Appeal. The MCO should only let members know that they are entitled to access the fair hearing process of the state after the MCO Internal Appeal System has been exhausted. The written notification should also state the reason for the suspension, the effective date and the regulatory reference, such as 1 Texas Administrative Code (TAC), Section 353.203(1)(D)(iv), concerning the member account and the responsibility to treat providers and staff with respect. The MCO should make efforts to resolve the situation, as appropriate, and document such efforts. The MCO must document whether the behaviour is related to a developmental, intellectual or physical disability or behavioural status. If the suspension of services threatens the health and safety of the individual, Community alternatives or placement in an institutional environment should be offered and facilitated by the MCO. With the prior consent of the MCO, the provider can continue to provide services to assist in resolving the situation. If it is not resolved satisfactorily, the MCO must follow the established procedures for denial of services in CHAPTER 3.21 UMCM or end up in managed care, located in UMCM Chapter 11.5. Services will not be continued during the appeal suit. 3611.2 Required notice of service denial of the Overhaul of the Managed Care Organization 19-1; As of June 3, 2019 If the Managed Care Organization (MCO) determines that documentation supports the initiation of denial, the MCO will provide the member with a written notice of denial within five business days. The MCO's declaration of refusal should be for denial, the effective date of denial, specify the regulatory referral and provide written notification of the right of appeal. The MCO sends a copy of the notify the provider within two working days. If the member appeals against the notice of refusal within the 10-day adverse action period, the MCO must continue the STAR+PLUS Home and Community Based Services (HCBS) program until the decision is notified by the state fair hearings officer. The MCO may not reduce the STAR+PLUS HCBS program until the outcome of the state's fair hearing is known. 3620 Review of the reassessment 18-2; With effect from 3 September 2018 3621 Review 19-1 reassessment procedures; As of June 3, 2019, Program Support Unit (PSU) employees must ensure that the member's individual service plan (ISP) is entered annually in the Service Authorization System Online (SASO). PSU employees: Check TxMedCentral to determine whether the managed care organization (MCO) has submitted Form H1700-1, Individual Service Plan (Pg. 1) before the ISP's end date; check that the SASO file has an approved medical need and level of care (MN/LOC) (both must have the same end date as the ISP being registered; if not, extend the MN/LOC registration until the end of the registered ISP); confirm ongoing Medicaid eligibility; check that the registration in SASO reflects any change to the plan; check that the ISP falls within the cost limit; determine whether the ISP was submitted on time and whether: on time, the service group (SG) enters 19 service code (SC) 12 on time; not on time, SG 19 SC 13 enters for the month(s) for which the ISP was late and SG 19 SC 12 for the remaining ISP period; and enter the current ISP in SASO within five working days of receipt, so as not to exceed the ISP end date. The Supplemental Security Income (SSI)-denied Medicaid program types referred to in Section 3330, STAR+ PLUS members requesting an upgrade to the STAR+ PLUS Home and Community Based Services (HCBS) Program, do not change to the Texas Integrated Eligibility Redesign System (TIERS) either during the first or annual assessment by the Medicaid for the elderly and people with disabilities (MEPD) specialist. As part of reassessment procedures, PSU staff will remain responsible for confirming ongoing Medicaid eligibility, but it is not required to request a person's MEPD test for the additional criteria, or to request a change to the Medicaid program type. If the ISP reassessment is submitted as a result of the participant's timely appeal of a STAR + PLUS HCBS program denial, PSU staff enter the information of the old ISP, extending the end date an additional four months. Services will continue to use this ISP until a decision has been received from the hearing officer. At that time, changes will be made, if necessary, to comply with decision of the hearing officer. 3621.1 Review of the expiring report of the individual service plan 20-2; As of October 1, 2020, employees and managed care organizations (PSU's) will review the individual service plan (ISP) expiration report for the STAR+PLUS Home and Community Based Services (HCBS). Assess. on a monthly basis to ensure that the annual reassessments are carried out in a timely manner. The ISP expiration report includes members of the STAR+PLUS HCBS program with ISPs expiring within 90 days of the date of the report. PSU employees must email the ISP expiring report to the MCOs five business days prior to the monthly conference call with PSU employees. The MCOs must provide a written status update for all STAR+PLUS HCBS program members who have ISPs that expire within 45 days. The MCOs must return the status update to PSU employees within two business days of the monthly conference call. Although the report shows that all ISPs that expire within 90 days, only the ISPs that expire within 45 days require a status update. 3622 Notification requirements revision 19-1; As of June 3, 2019 If the member continues to meet the requirements of the STAR+PLUS Home and Community Based Services (HCBS) program, it is not necessary to reassess Form H2065-D, Notification of Managed Care Program Services, as reporting continuing services. If the member does not meet the requirements of the STAR+PLUS HCBS program, the program support unit (PSU) staff must send form H2065-D to the member indicating why the application is terminated within two working days of notification; Upload a copy of Form H2065-D in TxMedCentral to the XXXSPW folder using the appropriate naming convention; and after the effective date of the action on Form H2065-D, send a copy of Form H2065-D to Enrollment Resolution Services (ERS), if applicable. If no appeal is brought, ERS will roll out the STAR+PLUS member from the date of the action on Form H2065-D. If the member lodges an appeal within two working days of notification, PSU staff will send the Form H1746-A, MEPD Referral Cover Sheet, for business in the central representation unit, which forwards the information to the appropriate Medicaid for the Elderly and People with Disabilities (MEPD) specialist; upload form H2067-MC, Managed Care Programs Communication, in TxMedCentral to the XXXSPW folder, using the appropriate naming convention, informing the MCO to continue services due to the timely profession (if the services have already been terminated, the MCO immediately re-initiates services); extend the end date of the current ISP by four months; and send an email to ERS about medical assistance only (MAO) cases as notification that a timely appeal has been filed and registration must remain open. ERS implements the decision within 10 days of receipt of the decision of the Fair Counsel. See section 4234, hearing decision. 3623 STAR+PLUS Home and Community Based Services Program Eligible on Form H2065-D Revision 18-2; As of September 3, 2018, Program Support Unit (PSU) employees must adhere to the following policy when setting the eligibility date for STAR+PLUS Home and Community Based Services (HCBS) program matters on Form H2065-D, Managed Notification Program services. The effective date varies. The possible scenarios are: upgrades and interest rate list releases; members who switch from children's programmes; and transfers from a nursing home (NF) using Money Follows the Person (MFP). 3623.1 Upgrades and interest list releases revision 19-1; As of June 3, 2019 The start of the care (SOC) date for a STAR + PLUS Home and Community Based Services (HCBS) program applicant will be released from the interest list or a member asks/is processed for an upgrade is based on the: Medicaid eligibility effective date; date the approved and valid medical necessity and level of care (MN/LOC) was filed through the Texas Medicaid & Healthcare Partnership (TMHP) Long-Term Care Online Portal; andNote: A valid MN no more than 120 days after the date of Texas Medicaid and Healthcare Partnership (TMHP) approval. If MN exceeds more than 120 days after the date of TMHP approval, PSU staff must complete Form H2067-MC, Managed Care Programs Communication, advising the MCO, and requesting the MCO process a significant change in condition to the MN. PSU employees must upload Form H2067-MC to TxMedCentral in the MCO's SPW folder. the date the member's individual service plan (ISP) was uploaded to TxMedCentral. Employees of the Program Support Unit (PSU) determine the suitability and effective date based on the later dates. If the date falls on the first day of the month, the date on which the ISP and the effective date of the ISP on Form H2065-D, Notice of Managed Care Program Services, are the first day of that month. If the date falls between the second and last day of the month, the date on which the qualifying and ISP effective date is the first date of the following month. 3623.2 Members transition from children's programmes Review 19-1; With effect from 3 June 2019 The eligibility and individual service plan (ISP) effective date on Form H2065-D, Notice of Managed Care Program Services, for members transitioning from the following programs is the 1st of the month after their 21st birthday: Medically Dependent Children Program (MDCP) The Texas Health Steps Comprehensive Care Program (CCP) /Private Duty Nursing or Prescribed Pediatric Extended Care Center Note: Depending on eligibility requirements, some members may continue to receive services except MDCP, through STAR Health up to the age of 22. In this scenario, the date of suitability and ISP entry is the 1st of the month after their 22nd birthday. 3623.3 Money Follows the Person Nursing Facility Releases Revision 19-1; As of June 3, 2019 The effective date of the individual service plan (ISP) on Form H2065-D, Notification of Managed Care Program Services, for members who move from nursing homes (NFs) to the Home and Community Based Services (HCBS) program through the Money Follows the Person (MFP) process is the date of dismissal. STAR+PLUS eligibility date on form for members who move from NFs to the STAR+PLUS HCBS program through the MFP process, the date used on the original form H2065-D. The registration of the Service Authorization System Online (SASO) for MFP releases of NFs should be as follows: NF service group 1 SAS registrations must be closed the day before discharge. STAR+PLUS HCBS program Service Group 19 SAS ISP period. The effective date on Form H2065-D is the date of discharge. 3630 Review or termination procedures 19-1; As of June 3, 2019, this section contains information, procedures and references regarding the refusal or termination of the STAR+PLUS Home and Community Based Services (HCBS) program for active members, along with sufficient notification of members' rights and capabilities to go through due process. The following quote from the Code of Federal Regulations (CFR) specifies situations where an unfavorable action period is not required: CFR §431.213, Advance Exceptions. The Agency may send a notice by the date of appeal if — (a) the Agency has factual information confirming the death of a consignee; (b) The Agency shall receive a clear written declaration signed by a recipient that – 1) He no longer wishes services; or (2) provide information requiring termination or reduction of services and indicates that he understands that this must be the result of the provision of that information; (c) the beneficiary has been admitted to an institution where he is not eligible for the plan for further services; (d) The place of residence of the consignee is unknown and the post office shall return the post office addressed to him or him indicating no forwarding address (see §431.231(d) of this procedure sub-part if the recipient's whereabouts become known); (e) The Agency notes that the recipient has been accepted for Medicaid services by another local jurisdiction, state, territory or commonwealth; (f) A change in the level of medical care is prescribed by the recipient's physician.... The quote for the following line, which appears in Texas Administrative Code, Title I, Part 15, Chapter 353, Subs chapter G, §353,607, appears on Form H2065-D, Notice of Managed Care Program Services. It is the basis for all STAR+PLUS case action. The STAR+PLUS Handbook sets out policies and procedures to be used by all health and human services agencies and their contractors and providers to provide STAR+PLUS program services to eligible members. The STAR+PLUS Handbook can be found on the Texas Health and Human Services Commission website. 3631 Review of the notification of action 10 days 19-1; As of June 3, 2019, the Code of Federal Regulations (CFR) requires the Health and Human Services Commission (HHSC) to notify the member at least 10 days before the effective date of the action. The member must be given the full unfavourable action period of 10 days in order to time to appeal. CFR, Subpart E, Sec. 431,230, Maintenance of services. (a) If the Agency is the member of the Commission. 431,211 or sec. 431.214 of this subpart sends an e-mail and the member requests a hearing before the date of action, the Agency may not terminate or reduce the services until a decision is taken after the hearing, unless — 1) at the hearing it is determined that the only issue is one of federal or state law or order; and (2) The Agency shall inform the member without delay in writing that the services should be terminated or reduced pending the hearing decision. (b) If the agency's action is continued by the Framework Decision, the Office may initiate recovery proceedings against the applicant or member in order to recover the costs of the services provided by the consignee, provided that they are carried out solely on the basis of that section. Period calculation instructions are set out in Section 311.014 of the Code Construction Act. It stipulates that: when calculating a period of days, the first day is excluded and the last day is included; and if the last day of a period is a Saturday, Sunday or public holiday, the period is extended by the following day that is not a Saturday, Sunday or public holiday. The 10-day period for adverse action is extended on the basis of whether the 10th day of the period is a Saturday, Sunday or public holiday. A statutory holiday that falls in the middle of the 10-day unfavorable action period does not require the period to be extended. Legal holidays do not include holidays when HHSC offices are officially open, even with limited workforce. The entire unfavourable action period may be lifted if the member signs a declaration to suspend the unfavourable action period. 3631.1 Denial of medical necessity, level of care assessment or individual service plan (MN/LOC/ISP) Review 19-1; As of June 3, 2019 Date informed eligibility lost date form H2065-D sent current individual service plan (ISP) end date 10-day Unfavorable action expiration date form H2065-D Termination Date Service Authorization System Online (SASO) Action April 10 12 May 31 April 22 May 31 No 20 May 21 May 31 May 31 May 31 May 31 No 20 May 22 May 31 June 1 June 30 ISP should be extended until 30 June. June 5, May 7, June 31, June 17, 30 ISP should be extended until June 30. June 22, 24 May 31 July 4 July 31 ISP should be extended until July 31. 3631.2 Denial of Medicaid Eligibility Revision 19-1; As of June 3, 2019 When a member is denied star +PLUS Home and Community Based Services (HCBS) program services because he or she does not meet Medicaid eligibility, the following chart shows a of the data Program Support Unit (PSU) staff when completing case actions. Actual Date of Medicaid Eligibility Denial Date Informed Eligibility Lost Current Individual Service Plan (ISP) End Date Form H2065-D Sent Form H2065-D Termination Date Service Authorization Authorization Online (SASO) Action 31 December 31 May 31 January 31 January 2 December 31 ISP and medical necessity and care level (MN/LOC) should be corrected to 31 December. October 31, 31, November 2, 31 ISP and MN/LOC must be corrected until December 31. 31 February 5 May 31 February 7 December 31 ISP and MN/LOC should be corrected until 31 December. Notes: If eligibility for Medicaid has been restored with a gap of more than four months, this should be treated as an interest rate release and the individual should go back on the interest list. If eligibility for Medicaid is restored with a gap of four months or less, the existing ISP and MN/LOC are still valid. If the ISP and MN/LOC have expired, the MCO may reassess without penalty. 3631.3 Members who are no longer taking part in the review of the area of services 19-1; As of June 3, 2019 When a member is denied star +PLUS Home and Community Based Services (HCBS) program services because he or she is no longer in the service area, the following chart shows an example of the data Program Support Unit (PSU) staff using when completing case actions. For members who switch to another service area with and without prior knowledge, see section 3410, Transfer Scenarios. Actual Date of Removal Date Health and Human Services Commission (HHSC) Informed Current Individual Service Plan (ISP) End Date Form H2065-D Sent Form H2065-D Termination Date Service Authorization System Online (SASO) Action December 31, May 31, January 31, January 2, 31 ISP and Medical Necessity and Care Level (MN/LOC) must be corrected to January 31. December 31, 31 May 31 January 2 January 31 ISP and MN/LOC should be corrected to 31 January. 22 June 9 May 31 June 11 June 30 ISP and MN/LOC should be corrected until 30 June. May 22, May 31, June 24, 30* ISP and MN/LOC must be corrected until June 30. 30 June 9 May 31 June 11 June 30 Managed care organisation should have submitted an ISP and MN/LOC by 1 June. If these forms are not submitted, enter service group 19/service code 13 for June 1 through June 30. *The unfavorable 10-day action period expires after the end of the month. 3631.4 Cannot locate Revision 19-1; Starting June 3, 2019 When a member is denied star +PLUS Home and Community Based Services (HCBS) program services because he or she cannot be located, the following chart shows an example of the data Program Support Unit (PSU) staff using when completing case actions. Date HHSC Informed Current Individual Service Plan (ISP) End Date Form H2065-D Sent Form H2065-D Termination Date Service Authorization System Online (SASO) Action December 31, May 31, January 2, 31 ISP and Medical Necessity and Care Level (MN/LOC) 31 January. 3 May 31 May 5 May 31 No 5 May 31 May 27 June 30* ISP and MN/LOC must be corrected until 30 June. 9 May 31 June 11 11 30 Managed care organisation should have submitted an ISP and MN/LOC by 1 June. If these forms are not submitted, enter service group 19/service code 13 for June 1 through June 30. *The unfavorable 10-day action period expires after the end of the month. 3631.5 Unable to obtain Doctor's Signature Revision 20-1; As of March 16, 2020, the Managed Care Organization (MCO) has 45 days to complete the assessment process for the STAR+PLUS Home and Community Based Services (HCBS) program, including obtaining a doctor's signature for the Medical Necessity and Level of Care (MN/LOC) Assessment. If, within five working days of the first request to the applicant's doctor, the MCO does not receive a signed copy of the doctor's signature page, the MCO must make at least three additional attempts to obtain the signature. If this fails, the MCO must contact the applicant or member for assistance in obtaining the required signature. If the MCO needs more time after 45 days to make the required contacts to obtain the doctor's signature, the MCO should notify the Program Support Staff (PSU) staff by uploading Form H2067-MC, Managed Care Programs Communication, to TxMedCentral, as described in Section 5110, TxMedCentral Naming Convention and File Maintenance. If the MCO is unable to obtain the doctor's signature, the MCO must upload the correct form to TxMedCentral to request PSU employees not to be eligible for the STAR+PLUS HCBS program because the MCO is unable to obtain a doctor's signature. Use Form H3676, Managed Care Pre-Enrollment Assessment Authorization, Section B for The Release of Interest List. Use Form H2067-MC for upgrades. 3632 Program Support Unit Initiated Denials or Terminations Review 19-1; As of June 3, 2019, the following sections include policy citations to be included on Form H2065-D, Notified of Managed Care Program Services, when the denial or termination action is initiated by Program Support Unit (PSU) employees. 3632.1 Denial or termination as a result of the review of death 19-1; As of June 3, 2019 After the death of a member, program support unit (PSU) employees must send to the managed care organization (MCO) within two business days of verification: Form H1746-A must be sent to the Medicaid for the elderly and people with disabilities (MEPD) within two business days of verification, if PSU has not received a notification from MEPD. Do not send a message to the member's address or family. The effective date is the date of death. If the member has received additional security income (SSI) and the SSI has been refused, PSU personnel must use the same date of denial as the SSI refusal date. If the eligibility data indicates that SSI is still active, it is the responsibility of the member's family to notify the Social Security Administration (SSA) of the member's death. If the Qualifying has been denied due to death in the Texas Integrated Eligibility Redesign System (TIERS), the correct entries must be made to terminate enrollment in the Service Authorization System Online (SASO). Services must be refused or terminated as soon as the member's death has been confirmed by PSU staff through: TIERS; obituaries in the local newspaper; contact with family or friends; notification from the MCO; other reliable sources. A 10-day adverse action period is not required for death denials. 3632.2 Denial or termination due to stay in a nursing home Review 19-1; As of June 3, 2019 After the 90th day a member does not return to the community when a member spends 90 days or more in a nursing facility (NF), the Managed Care Organization (MCO) or Medicare-Medicaid Plan (MMP) shall notify the Program Support Unit (PSU) within 14 days. The MCO sends this message to PSU employees by uploading Form H2067-MC, Managed Care Programs Communication, into TxMedCentral. PSU employees will reject the STAR+PLUS Home and Community Based Services (HCBS) program by the end of the month in which the 90th day occurred by: sending the H2065-D member form, Notice of Managed Care Program Services; uploading the form to TxMedCentral in the MCO's SPW folder or MMP, following the instructions in Section 5110, TxMedCentral

Naming Convention and File Maintenance; send to Medicaid for the Elderly and People with Disabilities (MEPD) Form H1746-A, MEPD Referral Cover Sheet, and a copy of Form 2065-D, for medical assistance only (MAO) STAR + PLUS HCBS program members; and uploading Form H2065-D and Form H1746-A to the Texas Health and Human Services (HHS) Enterprise Administrative Report and Tracking System (HEART). 3632.3 Refusal or termination as a result of the request of the member review 19-1; As of June 3, 2019 When Program Support Unit (PSU) employees have been notified, a member no longer wishes to provide STAR+PLUS HCBS program services within two business days of notification: mail member Form H2065-D, Notice of Managed Care Program Services; and upload Form H2065-D to TxMedCentral in the SPW folder (MCOs) OF the managed care organization (3632.4 Refusal or termination of the review of financial eligibility 19-1; As of June 3, 2019, a member's continued receipt of STAR+PLUS services depends on the financial suitability determined by the requirements for additional security revenue (SSI) or only medical assistance (MAO). The member shall be informed of the refusal of financial eligibility by either Social Security Administration (SSA) staff for SSI or the Medicaid for the elderly and with a disability (MEPD) specialist for MAO. The member may appeal against the financial refusal by means of SSA or MEPD processes, as appropriate. Within two business days of notification, employees of the Program Support Unit (PSU): mail the member Form H2065-D, Notification managed care program care program and upload form H2065-D to TxMedCentral in the SPW folder (MCOs) OF the managed care organization (Notification may come from: monthly reports; Registration Resolution Services (ERS); a managed care organisation (MCO); other reliable sources. The chart below describes how to proceed if financial suitability is denied. When the individual is denied SSI: When the individual is denied MAO: deregistration of the STAR+ PLUS program will take place as of the last date of Medicaid eligibility, which is usually the last day of current or next month. the right to appeal to SSA is available to the individual. the individual may contact the local Texas Health and Human Services Commission (HHSC) office to request other long-term services and support (LTSS) (for example, Community Attendant Services, Family Care, Title XX programs or state-funded programs). depending on the availability of local services, the person may be placed on the interest list if Medicaid eligibility cannot be determined based on the date of the request. the deregistration of the STAR+PLUS program will take place as of the last date on which Medicaid is eligible, which is usually the last day of the current or next month. the right to call on the MEPD specialist is available to the individual. the person can contact the local HHSC office to request other LTSS (for example, Community Attendant Services, Family Care, Title XX programs, or state-funded programs). depending on the availability of local services, the person may be placed on the interest list if Medicaid eligibility cannot be determined based on the date of the request. For SSI members, the termination date must correspond to the SSA's termination date. For MAO members, the termination date must correspond to the date of the MEPD MAO Denial Date. This is true even if the MAO denial date is in the past when PSU staff become aware of the denial. 3632.5 Refusal or termination of MN/LOC Revision 19-1; As of June 3, 2019, the STAR+PLUS Home and Community Based Services (HCBS) program must be rejected or terminated if the member's Medical Necessity and Level of Care (MN/LOC) Assessment is rejected. Program Support Unit (PSU) employees must submit Form H2065-D, notified by Managed Care Services, within two business days of notification. Notification may come from: the monthly ISP expiration report; Registration Resolution Services (ERS); a managed care organisation; other reliable sources. MN/LOC Assessment status of MN Denied in the Texas Medicaid & Healthcare Partnership (TMHP) Long-term Care (LTC) Online Portal is the period in which the STAR+PLUS HCBS program requires applicant or physician 14 business days to submit additional information. Once an MN/LOC rating is in MN Denied status, several actions can occur: MN Approved: The status changes to MN Approved if the TMHP doctor overturns the denial because information is received. Omturn Doctor Review Expired: The status changes to Omturn Doctor Review Expire when the 14 business day period for the TMHP doctor to overturn the denied MN has expired and no additional information was submitted for the doctor review or the additional information that was submitted was not enough to undo the denial. The rejected MN will remain in the status of Overturn Doctor Review Unless a fair hearing is requested. PSU personnel may not email Form H2065-D to deny the STAR+PLUS HCBS program case until after 14 business days from the date the MN Denied status appears in the TMHP LTC Online Portal. After the 14 business day period has elapsed, PSU staff may not send Form H2065-D to refuse services unless the TMHP LTC Online Portal Status Review Doctor Review is Expired. PSU staff must meet the initial certification and annual review time, unless the deadlines cannot be met due to the pending MN status. All delays must be documented. 3632.6 Refusal or termination on the grounds of inability to locate the revision of paragraph 19-1; As of June 3, 2019, the STAR+PLUS Home and Community Based Services (HCBS) program must be rejected/terminated when Program Support Unit (PSU) employees are notified that a member cannot be found. Within two business days of notification, PSU employees must: mail member Form H2065-D, Notice of Managed Care Program Services; and upload form H2065-D to TxMedCentral in the SPW folder (MCOs) OF the managed care organization (Notification may come from: monthly reports; Registration Resolution Services (ERS); a managed care organisation (MCO); other reliable sources. 3632.7 Denial or termination for non-compliance with other STAR+PLUS HCBS programme-enhancing vision 19-1; As of June 3, 2019 Use this refusal citation if the applicant does not comply with a STAR+PLUS Home and Community Based Services (HCBS) program requirement listed in Section 3632.1 through Section 3632.6. For example, this citation is used if the applicant requesting services does not require at least one STAR+PLUS HCBS program service. Within two business days of notification, program support unit (PSU) employees must: mail the Member Form H2065-D, Notice of Managed Care Program Services; and upload form H2065-D to TxMedCentral in the SPW folder (MCOs) OF the managed care organization (Notification may come from: monthly reports; Registration Resolution Services (ERS); a managed care organisation (MCO); other reliable sources. 3632.8 Refusal or termination for other reasons revision 19-1; As of 3 2019 Use this citation if you initiate refusal or termination for a reason not covered by Section 3632.1 to Section 3632.7. Within two business days of notification, program support unit (PSU) employees must: mail the Member Form H2065-D, Notice of Managed Care Program Services; upload and upload H2065-D to TxMedCentral in the SPW folder (MCOs) OF the managed care organization. Notification may come from: monthly reports; Registration Resolution Services (ERS); a managed care organisation (MCO); other reliable sources. 3633 Denial/termination initiated by the Overhaul of the Managed Care Organization 19-1; As of June 3, 2019, Articles 3633.1 through Article 3633.7 contain policy citations to be included in denial notices when the action is initiated by Managed Care Organization (MCO) employees. Within two business days of notification by the MCO, employees of the Program Support Unit (PSU) must: mail member Form H2065-D, Report managed care program services; and upload Form H2065-D to TxMedCentral in the SPW folder (MCOs) OF the managed care organization (3633.1 Denial or termination due to threats to the review of health and safety 19-1; As of June 3, 2019, the managed care organization (MCO) and the provider's staff should take special precautions when the comments or behavior of an applicant or member appear to be threatening, hostile or of a nature that would ensure the safety of the applicant or member, a provider contracted by MCO or an MCO employee. If an applicant exhibits such behaviour, the staff member must inform his or his manager immediately. The Texas Health and Human Services Commission (HHSC) assesses these situations on a case-by-case basis and determines the most appropriate action to be taken. If the safety of the applicant or member may be at risk, the MCO must follow the current policy regarding notification to the Department of Family and Protective Services (DFPS). If the staff member considers that there is a potential threat to others, HHSC management should determine the best method for reporting the MCO and/or the contracted provider and addressing the needs of the applicant or member without jeopardizing an MCO staff or contracted provider. Within two business days of notification by the MCO, employees of the Program Support Unit (PSU) must: mail member Form H2065-D, Report managed care program services; and upload Form H2065-D to TxMedCentral in the SPW folder (MCOs) OF the managed care organization (The 10-day reporting period does not apply in this situation. 3633.2 Denial or termination due to dangerous circumstances or reckless conduct Revision 19-1; As from 3 June 2019 Where there is no immediate threat to the health or safety of the service provider, but the situation, member or person in the member's home is dangerous to the health and safety of the service provider, documentation of denial essential. For example, a situation where the member has a large dog that can bite as loose can be resolved if the member or a neighbor or family member will agree to limit the dog in times of service delivery. However, if the provider appears on several occasions on the time and the dog is loose and the provider has documented a significant pattern of not being able to deliver services as a result of this, services may be terminated. Similarly, if there are illegal drugs in the member's house used by the member or others, the service provider may not be in immediate danger, but the situation still poses a threat. It is imperative that all available interventions be presented and the opportunity is provided for the member to get rid of the illegal drugs and/or users, and agree to abstain and not allow the illegal drug use to resume. The managed care organisations (MCO) must convene an interdisiplinary team (IDT) meeting if illicit drug use occurs again, and the member should be warned in writing of the potential loss of services to allow this activity to continue. Within two business days of notification by the MCO, employees of the Program Support Unit (PSU) must: mail member Form H2065-D, Report managed care program services; and upload Form H2065-D to TxMedCentral in the SPW folder (MCOs) OF the managed care organization (The 10-day reporting period does not apply in this situation. 3633.3 Refusal or termination due to harassment, abuse or discrimination review 19-1; From 3 June 2019, a substantially demonstrated pattern of verbal abuse or discrimination must be clearly established and documented by the Managed Care Organisation (MCO) before services can be denied for any of these reasons. This means multiple instances of inappropriate behavior, which have been followed with personal conversations with the member and/or family or authorized representative (AR), explaining that the MCO does not condone discrimination, harassment and/or verbal abuse. Appropriate interventions should be sought. This may include counseling, referral to other case management agencies and any changes to the individual service plan (ISP), such as attending Day Activity and Health Services (DAHS) for nursing. There should be meetings of the Texas Health and Human Services Commission (HHSC) staff that provide external agencies, if applicable, such as the Department of Family and Protective Services' (DFPS) Adult Protective Services (APS). The results should be documented in letters sent to the member that provide the ability to stop the behavior, with clear indication that failure can lead to loss of service. Copies of written alerts must be sent to anyone attending the meetings and a copy must be kept in the MCO's member file. If the situation persists and results in an inability to provide services, the MCO may be able to hhsc, as described in the Uniform Managed Care Manual Chapter (UMCM) 11.5. After HHSC has approved the unsubsc, HHSC will notify the program support unit (PSU) by email. PSU Staff Send Form H1746-A, MEPD Referral Cover Sheet, to the Medicaid Medicaid elderly and disabled people (MEPD). Within two business days of notifying HHSC personnel, PSU employees must: mail member Form H2065-D, Notice of Managed Care Program Services; and upload Form H2065-D to TxMedCentral in the SPW folder (MCOs) OF the managed care organization (The 10-day notification period does not apply in this situation. If the refusal or termination is considered as a result of verbal abuse or harassment by the service provider, HHSC must determine whether this conduct is directly related to the member's disability. If the member produces a letter from her or his doctor indicating the behaviour arising from the member's disability, the services cannot be refused for this reason. Appropriate measures still need to be taken to ensure the provision of services, as mentioned above. 3633.4 Denial as a result of exceeding the revision of the cost limit 19-1; As of June 3, 2019, the Managed Care Organization (MCO) must take into account all available support systems to determine whether the STAR+PLUS Home and Community Based Services (HCBS) program is a viable alternative that ensures that the applicant's needs are adequately met. If the STAR+PLUS HCBS program is not a viable alternative, the MCO must notify the Program Support Unit (PSU) personnel of the denial and keep the appropriate documentation to support the denial. The MCO's documentation of this type of denial is based on the inadequacy of the care plan (POC), including both the STAR+ PLUS HCBS program and non-STAR+PLUS HCBS program services, to meet the member's needs within the cost limit. If Form H1700-1, Individual Service Plan (Pg. 1), exceeds the cost limit within two business days of receiving Form H1700-1, PSU personnel must: mail the H2065-D member form, Notice of Managed Care Program Services; and upload Form H2065-D to TxMedCentral in the SPW folder (MCOs) OF the managed care organization (3633.5 Refusal or termination due to non-compliance with mandatory program requirements and service delivery provisions Revision 19-1; As of June 3, 2019 If the member repeatedly and directly, or knowingly and passively, condones the conduct of someone in her or his home and thus refuses to comply with the service's terms of delivery more than three times, services may be refused or terminated. Refusal to comply with the provisions of the service includes actions of the member or someone in the member's house that prevent the determination of suitability, the execution of the service plan or the supervision of services. Within two business days of notification, program support unit (PSU) staff must: mail the Member Form H2065-D, managed care program services; and upload Form H2065-D to TxMedCentral in the SPW folder (MCOs) OF the managed care organization (3633.6 Refusal or termination for non-payment of room and board/Copay/Qualified Income Trust Revision 19-1; 19-1; June 3, 2019 If the member refuses to pay a required copayment, room and board (R&B) payment or qualified income trust (QIT) payment, the STAR+PLUS Home and Community Based Services (HCBS) program must be refused. Within two business days of notification, the staff of the Program Support Unit (PSU): mail the member Form H2065-D, Notification of Managed Care Program Services; and upload Form H2065-D to TxMedCentral in the SPW folder (MCOs) OF the managed care organization (3633.7 Refusal or termination due to other reasons revision 19-1; As of June 3, 2019 Use this refusal or termination certification as initiating denial for a reason not covered above. Upon notification by the Managed Care Organization (MCO), the staff of the Program Support Unit (PSU) must, within two business days of notification: mail member Form H2065-D, Report Managed Care Program Services; and upload Form H2065-D to TxMedCentral in the SPW folder (MCOs) OF the managed care organization (3640 Review of the policy for withdrawal requests 19-1; As of June 3, 2019, mandatory STAR+PLUS members can request an assessment of the STAR+PLUS unsubscribing application. The deregistration of a compulsory member is only approved if it is determined that a member would be better served under fee-for-service (FFS) than participation in managed care. Members who request to opt out of STAR+PLUS submit a written request with supporting documentation on medical conditions and extenuating circumstances. This written request must be submitted to the Texas Health and Human Services Commission (HHSC) at the following address: Texas Health and Human Services Commission Managed Care POST 149030, Mail Code W-516 Austin, TX 78714-9030 HHSC conducts a case review and makes a final determination. The staff of the Member and Program Support Unit (PSU) will be informed in writing of the decision and any available alternatives. If the member is deregistered, HHSC will make the necessary adjustments to the Service Authorization System Online (SASO) and notify the relevant managed care organization (MCO) and HHSC enrollment broker. The member can only re-join the STAR+PLUS system and the STAR+PLUS HCBS program using Money Follows the Person (MFP) procedures. For more information, see Section 3510, Money Follows the Person and Managed Care. 3641 Services for Members Disenrolled from STAR+PLUS Revision 18-2; From September 3, 2018, a STAR+PLUS member or her or his managed care organization (MCO) can request and receive the member from managed care. Whether the deregistration is voluntary or involuntary, deregistered members may receive available services from the Texas Health and Human Services Commission (HHSC) and Social Services (MSS) Division, if determined to qualify. For more information, see Section 3640, Unrollion Request Policy. Section 4000, 4000, Internal MCO appeal and state fair hearings Review 19-3; As of December 2, 2019 4100 Managed Care Organization Procedures Revision 11-4; As of December 1, 2011 The Managed Care Organization (MCO) must develop, implement and maintain a member complaint and appeal system that complies with the requirements in applicable federal and state laws and regulations, including Code of Federal Regulations 42, §431,200, 42 CFR Part 438, Subpart F, Grievance System, and the provisions of Texas Administrative Code 1 , Chapter 357, relating to Medicaid managed health care organizations. The MCO's complaints and professional systems should include: a complaints procedure; an appeal procedure; and access to the fair hearing process of the Health and Human Services Commission. 4110 MCO Complaints Procedures review 14-1; As of March 3, 2014, the Health and Human Services Commission (HHSC) Uniform Managed Care Contract Terms and Conditions, Attachment A, defines a complaint as an expression of dissatisfaction expressed by a complainant orally or in writing to the managed care organization (MCO) on all matters related to the MCO, except for an action. As determined by 43 CFR §438,400, possible topics for complaints include, but are not limited to, the quality of care of the services provided, and aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the rights of the Medicaid member. The complaints procedure does not apply to situations described in AppealProcedures. If a member of the Managed Care Organization (MCO) wishes to file a complaint, he or she must first contact the MCO, according to the procedures specified in the MCO's member handbook. The MCO must be a designated member attorney to assist the member in using the complaint system. The lawyer must assist members in writing or filing a complaint, and oversee the complaint throughout the process until the issue is resolved. If the member is not satisfied with the outcome of the MCO complaints procedure, he or she will send a written request to HHSC to investigate the complaint. The request is sent to: Texas Health and Human Services Commission Managed Care Operations – STAR+PLUS Mail Code H-320 P. O. Box 13247 Austin, TX 78711 If a STAR+PLUS member contacts an HHSC employee with a complaint about an agency licensed by HHSC, the member is referred to 1-800-458-9858 to file a regulatory complaint. Members can also call the Medicaid hotline at 1-800-252-8263 to file a complaint unrelated to licensing issues. 4120 MCO Appeals Review 14-1; As of March 3, 2014, the Uniform Managed Care Terms and Conditions of the Health and Human Services Commission, Annex A, an appeal as the formal process by which a member or his or her representative requests a review of the action of the managed care organization (MCO). An action is: denial or limited of a requested Medicaid service, including the type or level of service; the reduction, suspension or termination of a previously recognised service not caused by loss of eligibility; denial in whole or in part of the payment for the service; the failure to provide services in a timely manner; the non-occurrence of an MCO within the time limit set out in the contract and 42 Code of Federal Regulations (CFR) §438.408(b); or for a resident of a rural area with only one MCO, the denial of a Medicaid member's request to obtain services outside the network. The member may appeal by contacting the MCO in accordance with the procedures specified in the mco member's manual. The MCO is contractually obliged to consider any oral or written expression of dissatisfaction or dissent as a request for appeal. The MCO must be a designated member's attorney to assist the member in filing an appeal. The lawyer must also assist members by reviewing the appeal throughout the process until the matter is resolved. During the appeal procedure, the MCO must provide the member with a reasonable opportunity to present evidence and all allegations of fact or law in person and in writing. The MCO should inform the member of the time available to provide this information and that in the event of an accelerated solution, limited time will be available. The MCO should allow the member and his representative, before and during the appeal proceedings, to examine the member's file, including medical records and any other documents taken into account during the appeal procedure. As required by 42 CFR §438,420, the MCO must continue the benefits of the person concerned pending the outcome of the appeal if all the following criteria are met: an appeal is lodged at the effective date of the action; the appeal shall include termination, suspension or reduction of a treatment course previously authorised; services were ordered by a licensed provider; and the original period covered by the authorisation has not expired. 4121 Accelerated MCO professional review 11-4; With effect from 1 December 2011 in accordance with 42 Code of Federal Regulations §438,410, and Uniform Managed Care Contract (UMCC) Annex B-1, Section 8.2.7.3, the Managed Care Organization (MCO) must set up and maintain an accelerated assessment process for service-related occupations when the MCO determines (at the request of a member) or the provider (by making the request on behalf of the member or supporting the member's request) that taking the time for a standard solution indicates the life of the member may be seriously endangered or The MCO must comply with all professional requirements for standard part-script professionals as set out in UMCC Annex B-1, section 8.2.7.2, unless specific differences are identified. The MCO must accept oral or written requests for expedited appeals. After the MCO made a request for a the MCO must inform the member within three working days of the outcome of the accelerated appeal. However, the MCO must complete an examination and resolution of an appeal relating to an ongoing emergency or refusal of continuous hospitalisation: in accordance with the medical or dental immediacy of the case; and no later than one working day after receipt of the member's request for an expedited appeal. Members must exhaust the MCO's expedited appeals process before applying for an expedited state's motion. With the exception of an appeal relating to an ongoing emergency or refusal of continued hospitalisation, the time limit for notifying the member of the outcome of the expedited appeal may be extended to 14 calendar days if the member applies for an extension or the MCO (to the satisfaction of the Health and Human Services Commission (HHSC), at HHSC's request) that additional information is needed and how the delay is in the member's interest. If the time limit is extended, the MCO must inform the member in writing of the reason for the delay if the member has not requested the delay. If the decision is detrimental to the member, the MCO shall follow the procedures in respect of the notice in UMC Annex B-1, point 8.2.7.5. The MCO is responsible for informing the member of his/her right to access an expedited fair hearing of HHSC. The MCO is responsible for providing documentation to the state and the member, indicating how the decision was made, prior to HHSC's expedited fair hearing. The MCO is prohibited from discriminating against or penalising a member or his representative for applying for an expedited appeal. The MCO must ensure that no punitive measures are taken against a provider requesting an accelerated solution or supports a member's request. If the MCO denies a request for expedited settlement of an appeal, the MCO must: transfer the appeal to the time frame for standard ly settling; and make a reasonable effort to give the member prompt oral notification of denial, and follow up within two calendar days with a written notification. 4200 Appeal procedures for the review of programme support staff 14-1; As of March 3, 2014 4210 PSU Specialist Procedures Review 19-3; As of December 2, 2019 When a request for a fair trial is received from an applicant or member, orally or in writing, the staff of the Program Support Unit (PSU) must refer the request to the hearing officer within five calendar days of the date of the request. Upon receipt of the request for a fair trial, the PSU specialist fills out the Fair Hearing Request Summary, in. The PSU specialist shall send the form to the regional data entry representative (DER) and the supervisor within three calendar days of the hearing. The three-day time frame allows the DER two days to enter the information into the Texas Integrated Integrated Redesign System. When PSU employees complete Form 4800-D, all questions in Section 3, Appellant details programs, must be answered. In Subsection D, Summary of Agency Action and Citation, staff should always answer No to the question, Is there a good reason for not being timely? if this question applies only to Texas Works programs. PSU employees must disclose the individual service plan (ISP) or Individual Care Plan (IPC) that, if applicable, in Section 3.D., summary of the Agency's action and citation. The start and end dates should also be disclosed during the fair hearing, so that the hearing officer is aware of when the ISP or IPC year ends when making a decision for STAR +PLUS Waiver. The Form 4800-D format follows the data entry screens. See the Form 4800-D instructions for more specific directions for completion and transfer. 4211 Designated REVIEW OF PROCEDURES 19-3; As of December 2, 2019, the Data Entry Representative (DER) will conduct the information in the Fair Hearing and Appeals system in the Texas Integrated Eligibility Redesign System. When all information is complete, the system assigns the Appeal Identification (ID) number. The DER writes down the appeal ID number at the bottom of the form and in the designated room on the front of the form and sends a copy back to the PSU specialist and his supervisor. When an applicant or member requests a fair trial, the burden of proof to uphold the PSU decision lies with the PSU. The hearing officer is a neutral party and is limited by law to the presentation of the agency's case. It is crucial that staff prepare and organise all packages for fair hearing to support the agency's decision. 4212 Fair Hearings and Appeals Procedures Revision 14-1; As of March 3, 2014 the Texas Integrated Eligibility Redesign System generates a hearing package, including: The Program Support Unit (PSU) coordinator and his/her supervisor received a copy of Form H4800 and Form H4803, identifying the fair hearing officer assigned to the appeal and the date, time and location of the hearing. PSU employees are not expected or required to attend fair hearings. 4213 Hearing packet revision 19-3; As of December 2, 2019 Use Form H4800-A, Fair Hearing Summary Request (Addendum), to submit all supporting documentation to the fair hearing officer. Make sure that the documentation on the form clearly states that this is a STAR+PLUS program attraction. The identification number for appeals assigned by the Texas Integrated Eligibility and Redesign System must be on top of Form H4800-A. Use Form 4800-D, Fair Hearing Request Summary, to provide the names, titles, addresses and phone numbers of all persons, or their persons, who attend the hearing. For professional issues related to service delivery, enter the names of the staff of the care organisation (MCO) and the designated backup. The staff of the Program Support Unit (PSU) should contact the MCO if there is any doubt as to who should be listed on Form 4800-D. Depending on the issue of appeals, the following employees must be present: MCO and Texas Medicaid & Healthcare Partnership (TMHP) (for medical necessity/level of care (MN/LOC) denials); MCO (for refusals of individual service plans (ISPs) above the cost ceiling); and Medicaid for the elderly and people with disabilities (MEPD) (for financial denials). All related documentation necessary to support the decision taken on a star+plus waiver (SPW) case (Home and Community) case must be sent to the fair hearings officer within 10 business days before the hearing. Each entity involved in due process shall be responsible for preparing its package and forwarding it to both the counsel identified on Form H4803, notice of hearing as the appellant. Make sure the documentation on the form clearly states that this is a STAR+ PLUS Waiver Program appeal. All documentation must be neatly and logically organized and all pages are numbered. Examples of additional information and who is responsible for submitting that information to the state fair hearings office are, but are not limited to, to: MCO: MCO policy handbook, STAR+PLUS Handbook and/or Uniform Managed Care Contract/Uniform Managed Care Manual; summary of events; other documentation supporting the decision, such as documentation of telephone calls, visit summaries, etc.; and copies of the signed Form H1700-1, Individual Service Plan — SPW (Pg. 1) and Form H1700-2, Individual Service Plan — SPW (Pg. 2), Individual Service Plan and all relevant Annexes; Spd: documentation in support of the financial decision, including official documentation forms, telephone calls, etc.; and a copy of the original signed refusal form; TMHP: a copy of the MN/LOC; and other documentation in support of the decision; and PSU — a copy of the original signed Form H2065-D, Notice of Managed Care Program Services (if available, use the signed copy of the form returned by the applicant/member when the appeal was filed). After the Data Entry Representative (DER) has added information from Form 4800-D to the Texas Integrated Eligibility Redesign System (TIERS), PSU may learn more about subsequent changes, such as address changes, revocation forms, or additional supporting documents necessary for due process. When this happens, psu employees form H4800-A with the updated information and submit it to the designated DER which monitors TIERS to determine whether a fair hearing officer has been assigned to the case. In the event that the participant's updates need to be communicated to the fair hearings officer, fill out PSU staff and forward Form 4800-D to the DER. If a fair council officer has not yet been assigned, the DER must wait for a to send the additional information. When sending information, the DER carries out the following activities based on the situation: When PSU employees submit Form H4800-A or Form H4800-D to the DER, the DER sends the form(s) directly to the email address of the counsel audit with the professional ID number in the subject line. If the PSU staff submitted to the DER contains additional supporting documentation for an appeal, the DER not only sends Form H4800 to the assigned hearing officer, but also uploads the supporting documentation directly to TIERS. The email sent by the DER must include the professional ID number in the subject line, as mentioned above, and notify the hearing officer that the supporting documentation in Section 2 of Form H4800-A has been uploaded to TIERS. PSU employees and the DER should follow current deadlines and procedures to ensure that supporting documentation is uploaded to TIERS no later than 10 calendar days before the trading date. 4220 special procedures for matters of member of the European Parliament or TW, adopted on the revision of financial eligibility 14-1; As of March 3, 2014 4221 Centralized Representation Unit Revision 14-1; As of March 3, 2014, the Health and Human Services Commission (HHSC) Office of Eligibility Services (OES) has a Centralized Representation Unit (CRU) to provide all hearings for Medicaid for the Elderly and People with Disabilities (MEPD) and Texas Works (TW) staff. CRU replaces the MEPD specialist in specific steps related to the denial of MEPD applications and pending cases. CRU: represents HHSC OES in fair hearings, including both TW and MEPD; completes and implements all TW/MEPD case actions based on fair hearing decisions; and coordinates the required actions with the regional TW/MEPD staff and the staff of the Program Support Unit (PSU). PSU staff must coordinate all occupations related to TW/MEPD-related suitability with CRU. This includes HCBS STAR+PLUS Waiver (SPW) cases. The procedures laid down in Article 4222, central representation unit procedures, should be used to coordinate appeals with CRU in cases where EU Parliament staff determine financial eligibility. Staff should remember that CRU replaces the local TW/MEPD specialist in the next steps and that notices may not be sent to the local MEPD specialist, except as specified. All correspondence on appeal goes to the CRU supervisor and the CRU administrative officer. 4222 Centralised review of the procedures of the Representative Unit 19-3; From 2 December 2019, appeal against a decision orally, in person or in writing. The program support unit (PSU) staff is responsible for completing Form 4800-D, Summary of Fair Hearing Request, to file the appeal through the Texas Integrated Eligibility Redesign System (TIERS) when an applicant/member requests due process. The method in which the form is completed depends on the action to which an appeal is lodged. Staff must determine whether the action is: a waiver/service denial (exclude denials based on Texas Works/Medicaid for elderly and people with disabilities (TW/MEPD) denials); or a financial denial of TW/MEPD (denials based on a TW/MEPD denial action). If the action is related to a waiver/service denial, PSU employees will complete Form 4800-D and contact the managed care organization as a representative of the Agency. In the field of other participants, PSU employees join the Centralized Representation Unit (CRU) supervisor and CRU administrative assistant. The names of the CRU supervisor and assistant must be entered using the Office Resources (MOR) Model search function. This will ensure that all correct information is filled in in the Texas Integrated Eligibility Redesign System (TIERS) and CRU staff will receive the notice of the appeal. Additional Security Income recipient appeals are not handled by CRU. If the appeal suit is a financial refusal of TW/MEPD, the staff shall complete Form 4800-D and enter the name of the CRU supervisor as a representative of the Agency. This information must be entered through the MOR Search function for CRU in order to receive the hearing information. Please include the name and title of the PSU staff in the Other Participants section. The name of the local TW/MEPD specialist is not entered by the staff on form 4800-D for TW/MEPD financial professions. PSU staff should include the title of staff, such as PSU specialist or supervisor. Enter the staff email address and add the CRU administrative assistant to other participants. Its data must be entered via the mor search function. If this is a TW/MEPD-related appeal, select Yes to the question in Section 6 that asks: Are you an OES Texas Works or MEPD employee? You are actually responding to this question on behalf of Kristi Rojas, so Yes is the right answer. On the Agency Representative page, select Yes from the drop-down menu. If you do not reply to Yes to this article, CRU will not be notified of the hearing. This paragraph applies only to financial denials of TW/MEPD. When Form 4800-D is sent to the designated data entry representative, PSU employees will send an email notification about the request for an appeal to CRU. PSU employees send the email to the HHSC Office of Eligibility Services (OES) Fair Hearings inbox, which can be found in the Outlook Global Address List search box by typing HHSC OES Fair Hearings. Please include the following: Request for Continued Benefits-MEPD Appeal ID-XXXXXXX in the subject line of the email. In an attachment to the e-mail, staff must also provide a copy of the sent to the applicant or member. The e-mail must contain the name of the applicant/member; Medicaid number (if available); type of service (HCBS STAR+PLUS Waiver (SPW)); and specific information requesting the TW/MEPD financial case, remain active/open during the appeal, if the member has appealed in good time and lasting benefits. For example, the financial case may be required to remain open pending an appeal decision regarding medical or functional suitability. PSU employees must notify CRU to keep the TW/MEPD case open pending the decision on the fair hearing. Upon receipt of the notification of an appeal, CRU shall request the TW/MEPD package of evidence from the local TW/MEPD specialist and complete the necessary actions necessary during the appeal procedure. The CRU supervisor assigns CRU staff to represent TW/MEPD at the hearing, if necessary, and shall take steps to ensure that the appropriate financial affairs of TW/MEPD are taken once the decision of a fair counsel has been taken. When the fair hearing officer issues a decision on the fair hearing, the PSU staff registered as an Agency representative shall be informed of the decision by the fair hearing officer by e-mail. Based on the hearing decision, PSU employees determine the appropriate action for the waiver/services based on programme-specific deadlines. For more information, please refer to Article 4500, hearing decision actions. PSU employees may need to coordinate the entrance dates of the reintroduction with CRU and email the CRU supervisor (with a copy to the cru administrative officer) for coordination. PSU employees report the implementation of the hearing decision via TIERS on Form 4807-D, action subject to the hearing decision, in accordance with current procedures. The local TW/MEPD specialist shall inform PSU employees when tw/mepd lodges an appeal in relation to a decision of financial suitability, and refers the TW/MEPD case to CRU to be dealt with during the appeal suit. Once the decision on appeal in relation to the Financial Case of the European Parliament has been made by the Hearing Officer, CRU must inform PSU staff by e-mail of the hearing decision, including decisions that are continued, reversed or withdrawn. On the basis of the hearing decision, staff shall determine the appropriate measures for the exemption/service. The e-mail sent by CRU shall contain: the name of the applicant/member; Medicaid number; a copy of the decision to be heard; and the effective or denial date of Medicaid eligibility. Staff may not return an applicant/member to waiver/service-specific interest lists while a TW/MEPD denial is in the appeal suit. PSU staff should take appropriate measures to certify or refuse the case, or resume services once the TW/MEPD hearing decision has been taken. The person can choose to return added to the waiver/service-specific interest list once the staff deny the waiver/service. 4230 review of regional responsibilities 14-1; As of March 3, 2014, 4231 Uploading the Appeals Evidence Packet in the TIERS Application Revision 14-1; As of March 3, 2014, all evidence packages must be scanned in the Texas Integrated Eligibility Redesign System (TIERS) Appeals application using the process described below. The Regional Data Entry Representative (DER) uses Form H4800-A, Fair Request Request Request (Addendum), to submit all evidence (also called the professional package) to the fair hearings officer. The identification number for appeal assigned by TIERS shall be written at the top of Form H4800-A. At least 12 working days before the trading date, the case manager or Program Support Unit (PSU) specialist must: go to the multifunctional office Workcenter and scan the documentation; save the document by allowing the default document name or entering a name of the user's choice; retrieve the scanned document and add it to an email; and send the document to the regional DER. Within two working days of receipt, the DER shall: store the annex to the correct network station as assigned by the regional management; go to the TIERS portal and select the Objections tab, without starting TIERS; ensure that the appeal is lodged in TIERS (this requirement must be met before the next step can be completed); select Uploading proof packages for hearing documents and enter the professional ID; Select Document Type: Instance Evidence Pack (items entered in another selection are not included in the evidence pack); Select Validate; check the data to make sure the right person is selected; search for the document; and select Upload. Users who make mistakes they can't reverse can contact the state office document manager to help correct the error and upload the correct information. 4232 Presentation of the hearing packet revision 14-1; As of March 3, 2014, the Texas Integrated Eligibility Redesign System will generate a hearing kit with Form H4803, Notice of Hearing and Form H4800, Fair Hearing Request Summary. The specialist of the Program Support Unit (PSU) and his/her supervisor will receive a copy of Form H4800 and Form H4803, which identifies the assigned counsel and the date, time and location of the hearing. PSU employees are not expected or required to attend fair hearings. 4233 Presentation of the revision of the evidence 14-1; As of March 3, 2014 Documentation in the scholarship hearing package will not be taken into account in the case unless the package is offered as evidence. In order to meet this requirement, the agency's representative must present the package, request that it be submitted as evidence and summarize what the package contains. Example: I would like to offer the following package as evidence in the appeal lodged on behalf of Ned Vlaanderen. Page 1-10 contains information about filling out form H2060, Needs Assessment Questionnaire and Task/Hour Guide. Pages 11-15 contain policies from the STAR+PLUS Handbook that relates to the problem in question. Page 16-20 contains documents signed by the applicant regarding individual rights. Page 21 contains Form H2065-D, Notice of Managed Care Program Services, which was emailed to the applicant on March 2, 2011. The stock exchange officer then asks for objections and admits the documents as evidence. If no documents are allowed, the honest counsel will explain the reasons for excluding the material. All documents admitted by the fair counsel officer shall be taken into account when a decision is taken. 4234 Review of the Hearing Decision 14-1; As of March 3, 2014, the fair hearings officer will send a letter of decision to the appellant and copies to the specialist of the Program Support Unit (PSU) and his/her promoter. If the decision is upheld, the PSU specialist will take the appropriate measures. If the member has requested continuing services during the appeal period, follow the procedures as described in Article 4500, hearing decision claims. If the action is reversed, the fair hearings officer will also send form H4807, Action Taken on Hearing Decision. The fair hearings officer specifies the corrective measures and a time limit of 10 days for the completion of the action. The PSU specialized actions required by the hearing officer must be reported back through the Texas Integrated Eligibility Redesign System within the 10-day time frame designated by the hearing officer. 4300 Review of treatment actions 14-1 afterwards; with effect from 3 March 2014 4310 Measures taken in the Framework Decision review 19-3; As of December 2, 2019, the Program Support Unit (PSU) specialist will complete Form 4807-D, take action in the field of hearing decisions, record the cases taken and send them to his/her supervisor and the designated data entry representative (DER). The PSU specialist must send Form 4807-D within the time frame so that the DER can enter the information into the system for at least two days. If the action cannot be taken within the time limit set by the hearing officer, Form 4807-D shall be completed and sent to the supervisor and DER, provided that the delay is justified. Acceptable reasons shall be given on the form; the initial delays and the end delay date should be included. For detailed information on filling out the form, see the instructions for Form 4807-D. 4400 Continuation of the review of services 14-1; As of March 3, 2014 4410 Continuation of STAR +PLUS Waiver Services During a review of the appeal 15-1; With effect from 1 September 2015, HCBS STAR+PLUS Waiver (SPW) services should continue until the hearing officer decides on the appeal of an active SPW member, if the appeal is brought at the effective date of the claim pending the appeal. If an appeal has been requested on the effective date of the action, the of the Program Support Unit (PSU) to immediately inform the managed care organisation (MCO). SPW services must be provided until the hearing officer makes a decision by posting on

TxMedCentral Form H2067-MC, Managed Care Programs Communication. If the auditor's decision is taken only after the expiry date of the individual service plan (ISP), the current ISP by four calendar months or until the outcome of the appeal is determined. PSU does not expand the medical necessity/level of care records in the Service Authorization System (SAS). Do not send Form H2065-D, Notice of Managed Care Program Services, to the member with the notice of continued suitability in connection with the reassessment action taken to continue services until the decision is appealed. If an appeal is initially rejected and subsequently reopened, the Health and Human Services Commission (HHSC) will continue with/restart services pending the outcome of the appeal, if the member requests continued services. When the hearing officer sets a date for a new hearing, he/she effectively voids the prior decision. As the services continue until a decision is given and the hearing officer declares that a hearing is yet to be held, HHSC will continue/restart the services. 4420 Discontinuation of HCBS STAR+PLUS Waiver Services during a review of the appeal 14-1; As of March 3, 2014 If the appeal is not filed at the effective date of the action, HCBS STAR + PLUS Waiver (SPW) services remain until the effective date of denial noted on Form H2065-D, Notice of Managed Care Program Services, which is usually the expiration date of the current individual service plan (ISP). If an appeal is not requested at the effective date of the action, the Program Support Unit must complete Form H2067-MC, Managed Care Programs Communication. For Medical Assistance Only (MAO) members, Form H2067-MC is: posted on TxMedCentral to the managed care organization (MCO) SPW services must remain until the end of the ISP period or the Medicaid denial date, as noted on Form H2065-D; and emailed to Operations Coordination to opt out of STAR+PLUS after the rollout policy that is in effect immediately after the ISP's expiration date. For additional members of security income income (SSI), Form H2067-MC should be placed with TxMedCentral to inform the MCO that SPW services should continue until the end of the ISP period. SSI members are still enrolled in STAR+PLUS services and are still eligible for State Plan services, including acute care and long-term services and support, such as primary care and day care and health services. 4500 Review of the treatment decision procedures 14-1; As of March 3, 2014 4510 Persistent appeals review 14-1; As of March 3, 2014, when the auditor's decision supports the denial of HCBS Star+Plus Waiver (SPW) services, the staff of the Program Support Unit inform the member by telephone or by letter (if the person concerned does not have a telephone) of the hearing officer's decision and the date of effectiveing of the dismissal; inform the managed care organisation of services via form H2067-MC, Managed Care Programs Communication, via the SPW end date continued during the appeal procedure; end spw services (service group 19) in the Service Authorization System as of the SPW termination date (see Article 4511 below); the Medicaid for the elderly and people with disabilities (MEPD) specialist the decision of the hearing officer and the termination of the effective date for non-supplemental security income (SSI) recipients. MEPD ends Medicaid eligibility for non-SSI recipients; and inform the managed care operations of the auditor's decision and the date of termination of termination for non-SSI recipients. Managed Care Operations rolls out non-SSI receivers from STAR+PLUS. PSU may not send another Form H2065-D, Notice of Managed Care Program Services, to notify the member of the persistent denial. 4511 Sustainable Decisions – Termination dates Revision 12-3; With effect from 1 October 2012 when services are terminated by reassessment because the member does not meet the eligibility criteria and the services are continued until the decision is known on appeal, the effective date of termination of the HCBS STAR+PLUS Waiver (SPW) depends on the circumstances: In cases where the auditor's decision is 30 calendar days or more before the end of the individual service plan (ISP) in force when the appeal was filed, the termination of SPW is in force at the end of the ISP that was in force at the time the appeal was filed. See Example 1. Where the decision date of the hearing officer is less than 30 calendar days before the end of the ISP which is in force when the appeal was lodged, the date of termination of the month which is 30 calendar days from the decision date of the hearing officer (the date on which the order was signed as registered on page 1 of Form H4807, action under hearing decision). See Example 2. Where the auditor's decision date is in force after the end of the ISP when the appeal was lodged, and a new ISP is developed to continue services beyond the ISP's end date until the appeal decision, the date of termination of the date is the end of the month which is 30 calendar days from the decision date of the hearing officer (as set out on page 1 of Form H4807). See Example 3. If the Hearing Officer assigns a specific expiry date for medical necessity (MN)/ISP which is not equal to the last day of the month, but after the end of the ISP that was in force when the appeal was lodged, the effective date for termination shall be the end of the month in which the hearing officer is designated as the expiration date. See Example 4. When the hearing officer has a specific of MN/ISP equal to the last day of the month, and this date is equal to or after the end of the ISP in force when the appeal was lodged, the effective date for the termination is the end of that ISP period. See Example 5. If the Hearing Officer assigns a specific mn/ISP expiration date that is in effect before the end of the MN/ISP, the appeal was filed, the termination effective date is the end of the month of the original MN/ISP expiration date. See Example 6. Examples Sample Conditions Original MN/ISP expiration date New expiration date Court Date Final MN/ISP Expiration date 1 hearing officer decision is more than 30 days after the original expiration date. 1/31/10 5/31/10 11/30/09 1/31/10 2 hearing officer decision is less than 30 days after the original expiration date. 1/31/10 5/31/10 1/15/10 2/28/10 3 sitting officer decision is greater than the original ISP expiration date and less than the new expiry date. 1/31/10 5/31/10 2/15/10 3/31/10 4 hearings officer decision assigns a specific expiration date. 1/31/10 5/31/10 hearings officer decision was for MN/ISP to expire on 2/15/10. 2/28/10 5 hearing officer decision assigns a specific expiry date that occurs in the future. 1/31/10 5/31/10 hearings officer decision was for MN/ISP to expire on 2/28/10. 2/28/10 6 hearing officer decision indicates a specific expiry date that has occurred in the past. 1/31/10 5/31/10 hearings officer decision was for MN/ISP to expire on 12/31/09. 1/31/10 4520 Reversed Appeal Decisions Revision 14-1; As of 3 March 2014 When the decision of the hearing member reverses the denial of an HCBS STAR+PLUS Waiver (SPW) applicant or member, the Programme Support Unit: The Managed Care Organization (MCO) via Form H2067-MC, Managed Care Programs Communication, must inform the staff that SPW services should continue as indicated in the decision and to apply for Form H1700-1, Individual Service Plan — SPW (1); send Form H2065-D, Notice of Managed Care Program Services, within two business days to the: SPW member that was terminated upon reassessment to notify him the denial decision was reversed and he is eligible for SPW services for the new individual service plan (ISP) year; SPW applicant who, on request, refused to inform him of the suitability for SPW services; MCO with regard to applicants and the effective date of the SPW; and managed care operations personnel with respect to applicants and the SPW effective date and registration date; ensure that the ISP is registered or updated in the service authorisation system with the correct entry dates; and inform Medicaid for the elderly and people with disabilities, if any, to remain Medicaid eligible. 4521 Reverse decisions – Revision of the entry dates 19-3; As of 2 December 2019 When the decision of the hearing advisor audit qualifies the refusal of HCBS STAR+PLUS Waiver (SPW), the SPW effective date for: reassessment shall be initiated one day after the end of the individual service plan when it is was submitted; and SPW refused on request is the first of the month after the decision of the hearing officer included on form H4807, Action taken on hearing decision. When a Fair Hearing Decides a Program Support Unit Unit measures, but PSU staff cannot implement the fair hearing decision within the time limit set, PSU personnel must complete Section C, implementation delays, on Form 4807-D, action in the field of the hearing decision. Form 4807-D must be submitted within the required time limit. 4522 New review required when reviewing the revised 19-3 decision of the Fair Hearing Decision; As of December 2, 2019 If the auditor orders the final decision to complete a new Form H2060, Needs Assessment Questionnaire and Task/Hour Guide, or Medical Necessity and Level of Care (MN/LOC) Assessment, the hearing will be closed as a result of this ruling. The staff of the Program Support Unit (PSU) must inform the member of the results of the new assessment on Form H2065-D, Notification managed care program services. The member may appeal against the results of the review. If the member chooses to appeal, psu staff shall indicate in Section 3.D. in Section 3.D. summary of the Agency's action and citation, Form 4800-D, summary of the request for due hearing and also during the hearing hearing that the new assessment was ordered from an earlier decision on a fair trial. If the member appeals against the re-assessment and the services continue, the managed care organisation (MCO) services will remain until the second fair hearing decision is implemented. For example, a STAR+PLUS Waiver (SPW) member is refused at an annual reassessment of medical necessity (MN) and requests for a fair hearing and services to continue. The MCO would continue the services at the level received by the member prior to the MN denial. The hearing officer then recommends a new MN/LOC Assessment that results in another MN denial. PSU staff sends a message to the member informing him of the MN denial. The member then requests another fair hearing and services be continued pending the second fair hearing decision. The MCO would continue the services at the same level before the first fair hearing. If the new assessment results in MN approval, but a lower level of the Resource Utilization Group (RUG) and the member requests a fair hearing due to the lower RUG level, the MCO would continue the services at the same level before the first fair hearing was continued. 4523 Request to withdraw a review 14-1; With effect from 3 March 2014, the appellant or appellant may request that his appeal be withdrawn orally by calling the office for the hearing. An oral request for withdrawal may be accepted by the administrative of the hearing officer or the hearing officer. The staff of the Programme Support Unit (PSU) shall advise the appellant or the appellant representative to speak directly to the administrative staff or hearing officer. If the appellant or the appellant representative contacts the staff of the PSU with regard to the withdrawal, psu staff shall contact the appellant's or appellant's office by telephone, so that the appellant or the appellant or the representative may inform the hearing office of the withdrawal. If the appellant or appellant submits a written request for withdrawal to PSU staff, psu staff shall send this written request to the Office for the hearings. A fair trial will not be rejected on the basis of a PSU decision to amend the negative action. All requests for the hearing to be withdrawn must come from the appellant or the appellant representative. If the appellant or appellant requests to withdraw his appeal within 14 calendar days of the day of the hearing, the hearing officer will inform the PSU by telephone or by e-mail and open the conference line to inform the participants of the cancellation. If the appellant or appellant representative requests to withdraw his appeal more than 14 calendar days before the day of the fair hearing, the hearing officer will indicate the withdrawal in the Texas Integrated Eligibility Redesign System and a written notification will be sent to the participants who inform them of the cancellation of the fair hearing. 4600 Roles and Responsibilities of HHSC Fair Hearings Officers Review 19-3; As of December 2, 2019 the Health and Human Services Commission fair hearings officer: warns all persons listed on Form 4800-D, Fair Hearing Request Summary, of the date, time and location of the hearing; prepares a final decision to remove a case by withdrawal and sends copies of this Decision to the appellant and programme support unit (PSU) after written notification from the appellant to withdraw an appeal; the hearing; uses the Texas Medicaid & Healthcare Partnership (TMHP) nurse to determine whether new medical information introduced at the hearing meets the medical necessity (MN) criteria for nursing care; reserves the right to keep a case open after a hearing pending medical examination by TMHP doctors; submit a written request for medical examination to TMHP for any new medical information presented at a hearing in situations where the TMHP nurse finds that the new medical information does not meet the MN criteria; take a decision; and send a written copy of all hearing decisions to the member/applicant, TMHP and PSU staff within five days of taking the decision. The appellant (applicant/member) must initiate an administrative review of the decision of the hearing officer. Programme staff cannot agree with the decision; however, the decision of the hearing officer is final. on policy or legal issues may be submitted by program staff to the regional lawyer. 4700 fair hearings for MCO decisions review 14-1; As of March 3, 2014 If an applicant is eligible for due process with the State of Texas regarding an HCBS STAR + PLUS Waiver (SPW) eligibility, he or she must contact the Program Support Unit (PSU) as instructed in the denial notice. In addition to relying on a negative negative ineligible, the SPW member can also request a fair hearing by contacting PSU. Section 5000, Automation and Payment Problems in STAR+PLUS Revision 20-1; As of March 16, 2020 5100 TxMedCentral Revision 18-2; As of September 3, 2018 5110 TxMedCentral Naming Convention and Review of File Maintenance 19-1; As of June 3, 2019, TxMedCentral is a secure Internet prick board that the Texas Health and Human Services Commission (HHSC) and managed care organizations (MCOs) use to share information. TxMedCentral uses specific naming conventions only for the documents below. HHSC and MCO employees must follow these naming conventions when one of the following documents is submitted in TxMedCentral. Form H1700-1, Individual ServicePlan (Pg. 1) The following forms may, if applicable, be used in the development of the individual service plan (ISP). Form H1700-1 and Form H1700-2 only upload to the MCO's ISP folder in TxMedCentral and may not be uploaded in any other folder: Form H1700-1, Individual Service Plan (Pg. 1) and Form H1700-2, Individual Service Plan (Pg 2); Form H1700-3, Nursing Plan; Form H1700-A, Reason for STAR+PLUS HCBS Program Items/Services; Form H1700-A1, Certification of Completion/Delivery of STAR+PLUS HCBS Program Articles/Services; Form H1700-B, Non-STAR+PLUS HCBS Program Services; Form H2060, Needs Assessment Questionnaire and Task/Hour Guide; Form H2060-A, Addendum to Form H2060; Form H2060-B, Addendum for needs assessment, where applicable; form H6516, Community First Choice Assessment. 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 Serial 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 home (NF) residents transitioning to the STAR+ PLUS Home and Community Based Services (HCBS) program, continues to be uploaded to TxMedCentral. Form H1700-1, completed for community members, is filed with the Texas Medicaid & Healthcare Partnership (TMHP) Long Term Care (LTC) Online Portal. Form H3676, Managed Care Pre-Enrollment Assessment Authorization This form is uploaded to the SPW folder and may not be uploaded into another folder. An A or B number is added to indicate whether program support unit (PSU) or MCO personnel uploaded the form. Two-Digit Plan ID Form # Member ID, Medicaid # or SSN Member Last Name (first four letters) Section number serial number of form ## 3676 123456789 ABCD A of 2 This file would be called ##_3676_123456789_ABCD_A_2.doc if it is uploaded by PSU employees. This file would be named ##_3676_123456789_ABCD_B_2.doc if it is uploaded by the MCO. Form H2065-D, Notification Managed Care Program Services Form Is H2065-D is to the SPW folder and may not be uploaded in another folder. Two-Digit Plan ID Form # Member ID, Medicaid # or SSN Member Last Name (first four letters) Section Number Serial Number of form ## 2065 123456789 ABCD D 2D or 2A Denials are encoded with a D (denial) immediately after the serial number of the form. This denial file would be named ##_2065_123456789_ABCD_D_2D.doc. Approvals are encoded with an A immediately after the serial number. This approval file is named ##_2065_123456789_ABCD_D_2A.doc. If a member has an isp generated electronically, Form H2065-D is available on the LETTERS tab of the TMHP LTC Online Portal when the member's ISP is selected. Form H2065-D is only uploaded to TxMedCentral for people without electronic ISPs. MCOs must check the TMHP LTC Online Portal to check for updates and notifications generated electronically by Program Support Unit (PSU) staff. Form H2067-MC, Managed Care Programs Communication This form is uploaded to the SPW folder and may not be uploaded into another folder. An M or S is added to the serial number to indicate whether the MCO or PSU staff uploaded the form. Two-Digit Plan ID Form # Member ID, Medicaid # or SSN Member Last Name (first four letters) Section number serial number of form ## 2067 123456789 ABCD 2M or 2S This file would be named ##_2067_123456789_ABCD_2M.doc if it is uploaded by the MCO. This file would be named ##_2067_123456789_ABCD_2S.doc if it is uploaded by PSU employees. In addition to the standardized naming convention for Form H2067-MC, a separate naming convention has been developed to address the use of Form H2067-MC for NF residents requesting the transition to the community under the STAR+PLUS Home and Community Based Services (HCBS) program. These individuals are considered to be accelerated cases for application to the STAR + PLUS HCBS program. Both mco and PSU staff should be able to easily identify specific communications for these cases. An M or S continues to be added to the serial number to indicate, respectively, whether the MCO or PSU staff have uploaded the form. The new naming convention for uploading Form H2067-MC, on both member and non-member matters in an NF, expands as follows: Two-Digit Plan ID Form # Member ID, Medicaid # or SSN Member Last Name (first four letters) Section Number Sequence Number of Form ## 2067 123456789 ABCD 1M or 1S MFP Form H2067-MC file uploaded by the MCO would be named ##_2067_123456789_ABCD_1M_MFP.doc if uploaded by the MCO. Form H2067-MC file uploaded by the MCO would be called ##_2067_123456789_ABCD_1S_MFP.doc if uploaded by PSU staff. Folders The STAR+PLUS MCOs use the following folders for all STAR+PLUS HCBS program related uploads. Each MCO has two folders with three-letter IDs: ISP — Individual Service Plan, which includes Form H1700-1 and Form H1700-2; contains; SPW — STAR+PLUS HCBS program, which includes: Form H2065-D, Notification of Managed Care Program Services; Form H3676, Managed Care Pre-Enrollment Assessment Assessment; and Form H2067-MC, Managed Care Programs Communication. Primary folder: MCO Three-letter IDDS Secondary Map: TxMedCentral Maps by Plan AMC — Amerigroup MCO AMCISP AMCSPW EVR — United Healthcare Community Plan MCO EVRISP EVRSPW Mol — Molina MCO MOL ISP MOLSPW SUP — Superior MCO SUPISP SUPSPW BRV — Cigna-HealthSpring MCO BRVISP BRVSPW 5120 Identifying Managed Care Members in the Texas Integrated Eligibility Redesign System Revision 19-1; As of June 3, 2019, the individual-summary screen in the Texas Integrated Eligibility Redesign System (TIERS) includes a managed care segment for each person who is currently or is enrolled in managed care. On the Individual Search screen, enter the person's data and select Search. The results of the search are displayed in the Search Results field. Select the name of the person on the hyperlink. The Individual Overview screen appears. Move over the Individual # field and select Managed Care. The person's managed care information will appear. Specific managed care information is located in the field of Individual Managed Care History. The data elements in the bottom of the screen are: Provider - Plan - Program - County - Start Date - End Date - Status - Eligibility - Candidacy. These fields contain the following information: Provider — Contains the name of the provider contracted by the managed care organization (MCO) to provide services to members. Plan - Includes the name of the MCO that provides Medicaid services to the member. Program — For managed care members, STARPLUS appears in this area. County - Individual county of residence. Start date — Date enrollment began under this plan. End date — Date enrollment terminated under this plan. Status — Describes the type of action. Eligibility — Choices are 'candidate', 'registered' (active) and 'suspended'. Candidacy — Describes the status of the individual. STAR +PLUS Plan Codes Service Area Plan 2011 Molina 46 Sept 1, 2011 Superior 47 Sept 1, 2011 Dallas Molina 9F 1 March 2012 Superior 9H 1 March 2012 El Paso Amerigroup 34 March 1, 2012 Molina 33 March 1, 2012 Harris Amerigroup 7P 1, 2011 United Healthcare 7r 1 Sept 2011 Molina 7S Sept 1, 2011 Hidalgo Cigna-HealthSpring H7 1 March 2012 Molina H6 1 March 2012 Superior H5 March 1, 2012 Jefferson Amerigroup 8r 1 Sept 2011 United Healthcare 8s Sept 1 1, 2011 Molina 8t 1 September 2011 Lubbock Amerigroup 5A March 2012 Superior 5B 1 March 2012 Medicaid Rural Service Area (RSA) West Texas Amerigroup W5 Sept 1 , 2014 Superior W6 September 1, 2014 Medicaid RSA Northeast Texas N3 Sept 1, 2014 United Healthcare N4 Sept 1, 2014 Medicaid RSA Central Texas Superior C4 1 Sept 1, 2014 United Healthcare C5 Sept 1, 2014 Nueces United Healthcare 85 Sept 1, 1, 2014 2011 Superior 86 Sept 1, 2011 Tarrant Amerigroup 69 Sept 1, 2011 Cigna-HealthSpring 6C 1 Sept 2011 Travis Amerigroup 19 Sept 1, 2011 United Healthcare 18 Sept 1, 2011 5121 Medicare-Medicaid Plan (MMP) Codes Revision 19-1; As of June 3, 2019 Service Area Plan Name Plan Codes Plan Codes Data Bexar Amerigroup 4F 9/1/15 Molina 4G 9/1/15 Superior 4H 9/1/15 Dallas Molina 9 J 9/1/15 Superior 9K 9/1/15 El Paso Amerigroup 3G 9/1/15 Molina 3H 9/1/15 Harris Amerigroup 7Z 9/1/15 United Healthcare 7Q 9/1/15 Molina 7V 9/1/15 Hidalgo Cigna-HealthSpring H8 9/1/15 Molina H9/1/1/1/1 15 Superior HA 9/1/15 Tarrant Amerigroup 6F 9/1/15 Cigna-HealthSpring 6G 9/1/15 5200 Service Authorization System Revision 18-2; As of September 3, 2018, 5210 Managed Care Data in the Service Authorization System Revision 19-1; As of June 3, 2019, the STAR+PLUS Home and Community Based Services (HCBS) program is authorized by the managed care organization (MCO) and registered by program support unit (PSU) employees in the Service Authorization System Online (SASO) with a Service Group (SG) 19 and a service code (SC). If the member's individual service plan (ISP) is electronic, the Texas Medicaid & Healthcare Partnership (TMHP) Long Term Care (LTC) Online Portal records the appropriate SG/SC combination, which is verified by PSU employees. Service codes are based on the following: Service code 12: Use this service code when registering initial service authorizations or annual resealing service authorizations received up to 90 days before the end date of the current 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 with Service Code 13 that is 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 with Service Code 12 with an effective date one day after the service termination and an end date of one year minus one day from the ISP's effective date. Example: An ISP reassessment will be received on June 5, 2017, for an ISP that ended May 31, 2017. To register this reassessment, you register a single service authorization record with Service Code 13 — Nursing with a start date of June 1, 2017 and an end date of June 30, 2017. Then register a second service authorization record with Service Code 12 — Case Management with a start date of July 1, 2017 and an end date of May 31, 2018. Automatic Registration Example: A Reassessing ISP will be submitted to the TMHP LTC Online Portal on June 5, 2017 an ISP that ended on May 31, 2017. One service authorization record with Code 13 — Nursing is system generated with a start date of June 1, 2017 and an end date of June 30, 2017. A second service authorization record with Service Code 12 — Case Management is generated by the system with a start date of July 1, 2017 and an end date of May 31, 2018. 5220 Money follows the Person Demonstration Entitlement Tracking and Service Authorization System Online Data Entry Revision 20-1; As of March 16, 2020 the time spent in a nursing home (NF) does not count for the period of 365 days; therefore, tracking is required to ensure that money follows the Person Demonstration (MFPD) individuals receive the full 365-day entitlement period. The legal period begins on the date on which the person who agrees to participate in the demonstration is enrolled in the STAR+PLUS Home and Community Based Services (HCBS) program. The managed care organization (MCO) uploads Form H2067, Managed Care Programs Communication, to TxMedCentral in the MCO folder, indicating how many days the member has spent in the NF. This information will be sent after the 365th day. See Section 3520, Money Follows the Person Demonstration. The tables below are intended to assist program support unit (PSU) employees in making accurate entries in the Service Authorization System Online (SASO). Example 1 — No institutionalisation during the 365-day period. Start Date Service Group Service Code Comments Fund Code 02-13-19 06-15-19 1 1 Individual dismissals from the nursing facility (NF). The NF start and end dates are derived from forms submitted by NFs. Blank 06-01-19 06-01-19 19 12 One-day registration for the managed care organization (MCO) capitation payment. SASO record introduced by PSU staff. Blanco 06-15-19 06-14-20 19 12 PSU employees enter saso-record and enter fund code as 19MFP for the entire period. 19MFP 06-15-20 06-30-20 19 12 PSU staff enters the remaining period of the individual services plan (ISP) without the 19MFP fund code. Blank example 2 — Institutionalisation over the 365-day period. Start Date Service Group Service Code Comments Fund Code 02-13-19 06-15-20 1 1 Individual is dismissed from the NF. The NF's start and end date are derived from forms submitted by NFs. Blanco 06-01-20 06-01-20 19 12 One-day registration to set up the MCO capitation payment. SASO record introduced by PSU staff. Blanco 06-15-20 06-14-21 19 12 PSU employees enters saso-record and enters fund code as 19MFP for the entire period. 19MFP 06-15-21 06-30-21 19 12 PSU personnel enter the remaining ISP period without the 19MFP fund code. Blank The MCO informed PSU staff that this member had spent a total of 15 days in hospital during the PSU personnel should correct SASO as follows: 06-15-21 06-29-21 19 12 PSU employees enter the MFPD period for the 15 days the individual was in hospital. 19MFP 06-30-21 06-30-21 19 12 MFPD period reached the 365th day on 06-29-21. 06-29-21. one day to go. Blank example 3 — Institutionalisation over the 365-day period. Start Date Service Group Service Code Comments Fund Code 02-13-19 06-15-20 1 1 Individual is dismissed from the NF. The NF's start and end date are derived from forms submitted by NFs. Blanco 06-01-20 06-01-20 19 12 One-day registration to set up the MCO capitation payment. SASO record introduced by PSU staff. Blanco 06-15-20 06-14-21 19 12 PSU employees enters saso-record and enters fund code as 19MFP for the entire period. 19MFP 06-15-21 06-30-21 19 12 PSU personnel enter the remaining ISP period without the 19MFP fund code. Blanco 07-01-21 06-30-22 19 12 PSU staff enters reassess ISP. Blank The MCO informed PSU employees that this member spent a total of 25 days in the hospital during the MFPD period. PSU personnel should correct SASO as follows: 06-15-21 06-30-21 19 12 PSU employees enter the MFPD period for the 16 of the 25 days the individual was in hospital. 19MFP 07-01-21 07-09-21 19 12 PSU personnel enter the MFPD period during the last nine days of the 25-day period in which the individual was in hospital. 19MFP 07-10-21 06-30-22 19 12 PSU personnel will enter the remainder of the reassessment ISP period. Blank example 4 — Institutionalisation in NF during the MFPD period. Note: The difference between example 2 and example 4 is that for NF stays, the PSU staff must correct star+plus HCBS program or NF overlaps. Start Date Service Group Service Code Comments Fund Code 02-13-19 06-15-20 1 1 Individual is dismissed from the NF. The NF's start and end date are derived from forms submitted by NFs. Blanco 06-01-20 06-01-20 19 12 One-day registration to set up the MCO capitation payment. SASO record introduced by PSU staff. Blanco 06-15-20 06-14-21 19 12 PSU employees enters saso-record and enters fund code as 19MFP for the entire period. 19MFP 06-15-21 06-30-21 19 12 PSU personnel enter the remaining ISP period without the 19MFP fund code. Blanco 08-15-20 08-29-20 1 1 The NF start and end dates are derived from forms submitted by NFs. Blank PSU personnel are aware that this person has spent a total of 15 days in the NF during the MFPD period. PSU employees should correct SASO as follows: 06-15-20 08-14-20 19 12 PSU employees must correct the STAR+PLUS HCBS program or NF overlap. 19MFP 08-30-20 06-29-21 19 12 PSU personnel enter the MFPD period, including the 15 days the member was in the NF. 19MFP 06-30-21 06-30-21 19 12 MFPD period reached the 365th day on 06-29-21. ISP had one day left. Blank 5300 Texas Medicaid & Healthcare Partnership Long Term Care Online Portal 19-1; As of June 3, 2019 5310 Using the TMHP Long Term Care Online Portal Revision 19-1; As of June 3, 2019, the Managed Care Organization (MCO) must submit the Medical Necessity and Level of Care (MN/LOC) Assessment through the Texas Medicaid & Healthcare Partnership (TMHP) Long Term Care (LTC) Online Portal Portal a determination of the MN and associated value of the resource usage group (RUG). MCOs submit the MN/LOC rating as: First assessment, submitted when an applicant or individual is assessed for the STAR+PLUS Home and Community Based Services (HCBS) program or is eligible for Community First Choice (CFK) services. Annual review. Significant change in status assessment for members who only receive CFCs as an upgrade for HCBS. The MCO has the ability to correct or activate reviews submitted within specific time limits. Corrections are completed when certain data elements need to be corrected (see the TMHP Community Waiver User Guide to determine which fields to correct). Inactivations are completed when a correction is needed after the 14-day correction time has elapsed and when the field(s) that require correction cannot be corrected and the assessment of the TMHP LTC Online Portal should be removed. The MCO has access to the TMHP LTC Online Portal to verify: MN status and RUG; monitor workflow actions resulting from the submission of the MN/LOC assessment or the Individual Service Plan (ISP); Manage workflow messages and take action; and submit Form H1700-1, Individual Service Plan (Pg.1), for the first, change, and reassess members excluding age-outs and nursing (NF) residents transitioning to the STAR+PLUS HCBS program. More information about submitting Form H1700-1 through the TMHP LTC Online Portal is available in Appendix XXVI, Long Term Care Online Portal User Guide for Managed Care Organizations. Submitting the MN/LOC Assessment via the TMHP LTC Online Portal creates MN, Level of Service (LOS) and Diagnosis (DIA) records in the Service Authorization System Online (SASO). The RUG value is in the LOS record. Status messages appear in the TMHP LTC Online Portal workflow workbook when an MN/LOC review is submitted. Additionally, error messages with status codes appear when TMHP processing cannot be completed. Status messages can be generated when: reviews have missing information; the system cannot link the assessment to an applicant or individual file; the individual is enrolled in another 1915c Medicaid waiver program; assessment forms are not in order; corrections are made to reviews after saso records have been generated based on the assessment; changes in the MN or LOS status affecting the applicant or individual services; or previous SASO records were manually changed within the current individual service plan (ISP) period. This list is not Messages appear in the workflow folder to indicate whether or not the TMHP LTC Online Portal action has been processed as complete. In some situations, MN, LOS, and DIA records are not generated to SASO; in other situations, SASO records become SASO records however, messages can still appear in the workflow for the required action. PSU personnel: May update SASO records and/or take specific case actions based on the MN and RUG information in the TMHP LTC Online Portal; document answers in the TMHP LTC Online Portal to workflow messages displayed for an individual by clicking on appropriate buttons related to the messages; and must check tmhp LTC Online Portal workflow items to process case actions. CMS coordinators should contact PSU employees to update SASO records and/or take specific case actions based on the MN and RUG information in the TMHP LTC Online Portal. 5400 review of the administrative payment process 19-1; As of June 3, 2019 When an individual ages from the Texas Health Steps Comprehensive Care Program (THSteps-CCP), Medically Dependent Children Program (MDCP) or is approved for a nursing facility (NF) diversion lock, the Managed Care Organization (MCO) must authorize services to begin on the day you are eligible for the STAR+PLUS Home and Community Based Services (HCBS) program, which may not be the first of the month. If the eligibility date is not the first of the month, the MCO must follow the administrative payment process for STAR+PLUS services provided between the eligibility date and the date of enrollment for managed care, if any. The administrative payment process must be used for the Texas Health and Human Services Commission (HHSC) to issue payment to the MCO and to the MCO to pay the provider. Once the MCO authorizes services, prepares the provider: prepares Form 1500, Health Insurance Claim; and submit the form to the MCO within the 95-day submission period. Within five business days of receiving Form 1500, the MCO shall verify that the provider was authorized to provide the services billed on Form 1500, the information on Form 1500 complies with the requirements for clean claim as defined in the Uniform Managed Care Manual, Chapter 2.0, and the claim met the 95-day filing deadline. As soon as the MCO verifies this information, the MCO: form 1500 sends by secure email to the staff of the Program Support Unit (PSU) if the provider is authorized to provide the service; met the requirements for clean claim; and the claim has been lodged with the MCO within the 95-day deadline; or denies payment through the MCO refusal process if the provider: is not authorised to provide the services; did not meet the requirements for clean claim; did not meet the 95-day submission deadline. Within two working days of receiving Form 1500, PSU employees follow the requirements manual section. If the decision is to approve the administrative payment, the following will also be made: Contract Compliance and Support (CCS) sends the approved payment voucher to the State Comptroller for processing and payment to the MCO; and the MCO pays the provider within one week of receipt of the payment from the State Comptroller. If the decision is to payment, ERS staff email the PSU staff who emailed the request that the administrative payment was denied and the reason for the denial. Within two business days of receiving email from the ERS, the PSU staff who submitted the request for administrative payment informed the MCO of the approval or denial decision by uploading Form H2067-MC, Managed Care Programs Communications, to TxMedCentral. Section 6000, Specific STAR +PLUS HCBS Program Services Revision 20-2; From 1 October 2020 6100 Home and Community Based Services Revision 18-2; As of September 3, 2018 6110 Program Overview Review 18-2; As of September 3, 2018 6111 Service Introduction Revision 19-1; As of June 3, 2019, the service array under the STAR+PLUS Home and Community Based Services (HCBS) program is designed to provide home and community-based services as cost-effective alternatives to institutional care in Medicaid certified nursing facilities. Eligible members receive services based on their specific needs, as defined by an assessment process, based on informed choice and through a personalized process. Employment agencies contracted with managed care organizations (MCOs) provide services to members who live in their own homes, foster homes, assisted living (ALFs) and other locations where service is required. The services provided are identified on the basis of an individual service plan (ISP) and are authorized by the MCOs, as identified in Section 6113, General requirements for MCOs, and in accordance with the ISP. 6112 Service locations for STAR +PLUS HCBS Program Revision 19-1; As of June 3, 2019, all services can be delivered to members at locations of their choice through the STAR+PLUS Home and Community Based Services (HCBS) program, with the exception of minor home modifications (MMCs). Nursing, therapy services, adaptive devices (including dental) and medical supplies can be provided to a STAR + PLUS HCBS program member residing in an assisted living facility (ALF) contracted to provide STAR+PLUS HCBS program services. According to Title 42 of the Code of Federal Regulations (CFR), Subdeel K, Section 441,530(a)(2), the following locations are excluded from star+plus HCBS program service locations, with the exception of extracurricular respite care: Nursing facilities (NFs); Psychiatric hospitals; Intermediate care institutions for persons with intellectual disabilities (ICF/IID); Hospitals providing long-term care; locations that have the qualities of an institution. 6113 General requirements for MCOs Revision 19-1; From 3 June 2019, the Managed Care Organisation (MCO) will have to coordinate and initiate the delivery and initiation of the service offering in form H1700-1, Individual Service Plan (Pg. 1). Services include: personal assistance (PAS); nursing services; physiotherapy (PT); occupational therapy (OT); speech therapy (ST) services; Cognitive therapy (CRT); adaptive tools; medical supplies; small house changes (MMCs); emergency services (ERS); assisted living (AL); foster care for adults (AFC); home-delivered meals; dental services; transitional emergency services (TAS); respite care; assistance at work; and employment. The MCO must identify, coordinate, and, if applicable, identify, coordinate, and, where appropriate, allow available value-added services, Medicare and other external sources (TP) before these services are authorized to the member's individual service plan (ISP). For exceptions or restrictions, see specific service descriptions. 6114 Review of the service plan 19-1; As of June 3, 2019, the managed care organization (MCO) must authorize all services identified on the individual service plan (ISP). When sending an authorization to a provider, the MCO can send the following: Form H1700-1, Individual Service Plan (Pg. 1); Form H1700-2, Individual Service Plan (Pg. 2); Form H1700-3, Nursing Plan; Form H1700-A, Reason for STAR+PLUS HCBS Program Items/Services; Form H1700-A1, Certification of Completion/Delivery of STAR+PLUS HCBS Program Articles/Services; Form H1700-B, Non-STAR+PLUS HCBS Program Services; Form H2060, Needs Assessment Questionnaire and Task/Hour Guide; Form H2060-A, Addendum to Form H2060; Form H2060-B, Addendum for needs assessment, Form H6516, Community first-choice assessment; other forms and assessments, if any. The MCO must send all functional assessment documentation to the provider on request. The MCO will upload the signed Form H1700-2 to the XXXISP folder in TxMedCentral using the appropriate naming convention. All other forms are stored in the member's file folder. If Form H1700-1 is electronic, the MCO form H1700-1 will submit through the Texas Medicaid & Healthcare Partnership (TMHP) Long Term Care (LTC) Online Portal or TMHP Electronic Data Interchange. The MCO registered nurse (RN) service coordinator or MCO contracted RN service coordinator and the member or authorized representative (AR) must sign Form H1700-2 prior to the ISP's start date to certify that the proposed ISP accurately meets the member's needs. Oral authorizations are permitted for ISP changes, as long as the name of the person who gave the oral consent and the date on which the oral consent was given are included on the signature line. The proposed ISP should be submitted to the member following the development of the proposed ISP and the member must sign Form H1700-2 to indicate acceptance. 6115 Individual agreement for the review of services 18-2; From September 2018, Managed care organizations (MCOs) may choose to provide services through other payment arrangements with individuals awaiting adoption of STAR+PLUS Home and Community Based Services (HCBS) program eligibility. MCOs are not reimbursed for services provided before the star+plus hcbs program. The provider cannot be held responsible for shortages or failures in areas not included in the section of the member's individual service plan (ISP) when unnecessary care or care is provided by other means. 6116 Refusal to serve members Review 18-2; As of September 3, 2018 If a provider refuses to serve a member, the reason why the provider cannot adequately meet the member's needs should be disclosed in writing to the member's managed care organization (MCO). The reason for the refusal of the provider must relate to the restriction of the provider and not previous experience with the member or discriminated against due to age, disability or gender, etc. The provider should work with the MCO to coordinate alternative provider agency arrangements. The MCO must coordinate the transfer of services on behalf of the member. 6117 Review of the planning of services 19-1; As of June 3, 2019, services and care, as identified and authorized on Form H1700-1, Individual Service Plan (Pg. 1), should help the member to achieve or maintain the highest possible physical, mental and psychosocial well-being. The services provided are tailored to the member's objectives and needs based on her or his medical condition, mental and functional limitations, ability to manage himself and availability of family and other support. The managed care organization (MCO) must ensure that the informed choice and convenience of the member are included in the planning and delivery of the member's care by concerned professionals. The service planning process should be personal and the individual service plan (ISP) should reflect the member's objectives, needs, strengths, and preferences regarding the mode of delivery of STAR+PLUS Home and Community Based Services (HCBS) program services. Members should be encouraged and able to play an active role in determining their ongoing care plan (POC). MCOs must recognize and support the member's right to a dignified existence, privacy and self-determination. 6118 Review of personal assistance services 18-2; From September 3, 2018, personal assistance services (PAS) will provide assistance to members in carrying out daily life (ACLs) and instrumental activities of daily life (IADLs) based on the member's needs. Most members receive PAS through Community First Choice (CFK), with the exception of members who are only medical assistance (MAO), or members who also need protective supervision. Protective monitoring is not a benefit of CFCs. PAS includes assistance in the performance of ACLs and IADLs needed to maintain the home as a sanitary and safe environment. PASS is provided to the member, as authorized on Form H1700-1, Individual Service Plan (Pg. 1), or as delivered through CFK. The State allows a member to a member or legally except for a legally responsible person, to be the member's provider for this service if the relative or legal guardian meets the requirements for this type of service. Federal and state rules prohibit a spouse from being a paid PAS provider. 6118.1 Description of the review of personal assistance services 19-1; As of 3 June 2019, personal emergency services (PAS) are among others, but are not limited to: assisting with basic self-care tasks known as activities of daily life (ACLs). These include, but are not limited to, self-feeding, dressing, bathing, personal hygiene and care, transfer, and to the toilet; instrumental activities of daily life (IADLs). These are activities that allow an individual to live independently in the community. These include, but are not limited to, cleaning and maintaining the home, preparing meals, shopping for groceries, and taking prescribed medications; the provision of the extension of therapy services; providing assistance with ambulation and balance; help with drugs that are normally self-administered; performing health work as defined by the Texas Board of Nursing; performing nursing duties delegated and under the supervision of a registered nurse (RN), in accordance with the Texas Board of Nursing rules; accompany the

member on trips to obtain medical diagnosis, treatment or both; and providing protective supervision. The managed care organization (MCO) must authorise and provide PASS as indicated on Form H6516, Community First Choice Assessment, or Form H2060, Needs Assessment Questionnaire and Task/Hour Guide, Form H2060-A, Addendum to Form H2060; and form H2060-B, Needs Assessment Addendum, and only authorize, if applicable, to members who live in their own home or other community institutions. Activities purchased under PAS are limited to the member's personal space and exclusively to the member's personal needs. The following examples of services that cannot be reimbursed under the STAR+PLUS Home and Community Based Services (HCBS) programme are: the provision of non-service-related pets for domestic help; ironing; moving furniture; cleaning windows; and carrying out site work, with the exception of removing garden hazards. Shopping Shopping is intended for the purchase of groceries, medicines or other items that support the health, safety and well-being of a member. This can be done by the supervisor on behalf of the person or the accompanying can accompany the individual to with this task. Neither the provider nor the clerk can charge the member for transport costs incurred in carrying out this task. Ambulation Ambulation is a personal care task that involves unskilled assistance when walking or transferring while taking the usual precautions for safety (i.e., standby assistance, gentle support of an elbow for balance or ensuring balance of a one This does not mean a nurse intervention. No special precautions are required, except for security measures. To facilitate safe member amputation or movement, it may be necessary to ensure safe paths throughout the house for the member. Examples include people using wheelchairs, walkers or crutches, or for members with a visual impairment. The caregiver or member (or authorized representative (AR)) focuses on this activity during the orientation and on a permanent basis for a supervisor who provides services to a member who needs help. The member's primary caregiver (PCP) can request specific ambulation orders. If ambulation is permitted as a nursing task, the service coordinator may not allow ambulation as an unskilled task on Form H2060, Form H6516 and any addendums to Form H2060. Allowing ambulation as a nursing task and at the same time as an unskilled task is doubling services. When completing the functional assessment on form H2060 and any addendums to Form H2060, the service coordinator should take into account the member's need for ambulation. If it is found that the member needs both skilled and unskilled ambulation assistance, the service coordinator in the case must establish why and how the member needs both. The service coordinator can approve both if there is no duplication. Escort Escorting is for healthcare-related appointments and does not include the direct transport of the member, or the receipt or exchange of health information by the supervisor. Escort services can be provided for security needs, to enter or exit a building or to remain safe during the waiting period while attending medical appointments. Transportation for Medicaid members to Medicaid appointments is available in each county through the Medical Transportation Program (MTP). Transportation is not included as an activity in the escort task. Protective supervision The purpose of protective supervision is to ensure the health and well-being of a member with a cognitive impairment, memory impairment or physical weakness. Protective supervision is permitted by the MCO, and ensures supervision of the member during cases where the informal support of the member is not available. Protective supervision is only supervision and does not include the delivery of personal care tasks. Protective supervision is appropriate when it is necessary to protect the member from injury due to hair or his cognitive/memory impairment and/or physical weakness. For example, if the member is left unattended, it may wander out, turn on electrical appliances and burn themselves, or try to walk and then Protective supervision is not routinely permitted for members who can live safely on their own, nor is it intended to provide 24-hour care. Protective monitoring is not an advantage of CFCs and may be on a member's individual service plan (ISP), if the member receives CFK. Exercise A member may ask, or a doctor may ask for help when walking as a form of exercise. A member must be ambulatory in order to be able to carry out an authorised PAS activity. Therapy Extension Licensed Therapists can choose to instruct the PAS caregiver in the appropriate way to assist the member in the follow-up therapy sessions. This help or support provides reinforcement of instruction and tools in the rehabilitation process. Therapy extension is documented on Form H2060-A. 6118.2 Personal Assistance Services Attendants Revision 19-1; From 3 June 2019, personal emergency services (PAS) will be carried out by care workers who are not themselves recipients of PAS; employed by a contracted healthcare organization (MCO) contracted provider or employed by the member or employer of record under the Consumer Directed Services (CDS) Option; are not the spouses of the members; to perform all services available within their area of competence; can serve as backup escorts to start services, prevent service disruption, and provide ongoing service; are required to provide services that meet the health and safety needs of a member; and, if applicable, meet additional eligibility requirements under the CDS option. 6200 Nursing Services Overhaul 18-2; As of September 3, 2018, nursing services covered by the Texas Nursing Practice Act and provided by a registered nurse (RN) (or licensed professional nurse (LVN) under the supervision of an RN) are licensed to practice in the state. In the Texas state plan, nursing services are only for acute conditions or exacerbations of chronic conditions of less than 60 days. Nursing services provided in the STAR+PLUS Home and Community Based Services (HCBS) program cover nursing duties related to ongoing chronic conditions such as medication administration and the supervision of delegated tasks. This broadens the scope of these services beyond comprehensive state planning services. Comprehensive state planning services are services that exceed the benefits permitted under the state plan. Nursing purchased through the STAR+PLUS HCBS programme may be competent or specialised in nature and cannot replace a member's acute care allowance. Nursing services are assessment, planning and interventions provided by a person licensed to participate in professional nursing or vocational nursing in Texas, or a permit in a state that has adopted the Nurse Licensure Compact. Proof of valid license can be verified by viewing the license of the on the Texas Board of Nursing website on . To ensure the quality of care for members in the STAR+PLUS HCBS programme, the managed care organization (MCO) is responsible for coordinating services after a significant change in the member's condition. The MCO may become aware of a significant change by interacting with members, family, or an authorized representative (AR) and by conducting interim reviews on the current STAR+PLUS HCBS program members. The MCO is responsible for initiating appropriate services in a timely manner and supports to meet the care and well-being of member interventions in a timely manner. 6210 Settings revision 18-2; From 3 September 2018, nursing services can be provided in a private home or family home, in a personal care facility, an assisted living facility (ALF) or an adult foster care unit (AFC). Care services purchased through the STAR+PLUS Home and Community Based Services (HCBS) programme may not be offered in the following institutions as defined in 42 Code of Federal Regulations (CFR), §441,530(a)(2): Nursing facilities (NFs); Psychiatric hospitals; Intermediate care institutions for persons with intellectual disabilities (ICF/IID); Hospitals providing long-term care; locations that have the qualities of an institution. 6220 Nursing Services to Meet Member Needs Review 18-2; As of September 3, 2018, members of the All STAR+PLUS Home and Community Based Services (HCBS) program are meeting medical necessity (MN) and need one or more nursing duties, as described in the Texas Administrative Code (TAC), Title 40, §19.2401. It is the responsibility of the managed care organization (MCO) service coordinator to identify and document in the individual service plan (ISP) or Form H1700-B, Non-STAR + PLUS HCBS Program Services, how the member nurse requirement (s) will be met. The member's nursing needs may be met by direct or delegated nursing, health maintenance activity (HMA), informal support or a combination, as described below: Direct nursing by a registered nurse (RN) or a licensed vocation nurse (LVN). This includes nursing services with a third-party resource (TPR) as the payer and nursing with the STAR+PLUS HCBS program as the payer. Delegation by an RN to an unlicensed counsellor (UAP), such as a personal tutor in accordance with texas nursing board rules, which can be delivered through Community First Choice (CFK) or the STAR+PLUS HCBS program. RN provision that a nursing job (s) is an HMA in accordance with Texas Board of Nursing rules. HMAs include the performance of nursing duties by a paid supervisor and informal support. For a member who chooses the provider or service responsibility option (SRO), the MCO service coordinator, in collaboration with the agency RN, makes the determination that a nurse's job is an HMA. Informal such as unpaid family members, can be trained in providing nursing duties to meet the needs of a member. The MCO service coordinator must identify and document the tasks to be performed by the informal support on Form H1700-B, and the informal support must agree to perform the nursing duties. For information on delegation and HMAs, HMAs, to the TAC for Texas Board of Nursing, Title 22, Part 11, Chapters 224 and 225. 6230 Nursing Services in Assisted Living Facilities Revision 20-1; As of March 16, 2020, assisted living facilities (ALFS) must have sufficient staff to assist with the medication regimens of members (TAC), Title 26, §553.41). Nursing for this task can be included on the individual service plan (ISP), depending on the needs of the member and the facility type. Licensed nurses who own or are employed by the facility are able to administer medication directly to members living in ALFs, but are not required to do so. In ALFs, the transfer of nursing duties to the caregivers of the facility is not permitted by licensure. See Section 7200, Assisted Living Services, Section 7224, Personal Care 3 and Section 7230, other services available to members. If an ALF does not provide nursing due to licensure, other facility staff may not provide services other than personal emergency services (PAS) and the administration of medicines. If a resident needs additional services that are not available in the ALF, the managed care organization (MCO) must ensure that the member's needs are met. The MCO can do this through a contract with a Home and Community Support Services Agency (HCSSA) or an independent healthcare provider. Only provided by the ALF includes assistance in feeding, dressing, moving, bathing or other personal needs or maintenance; or general supervision or supervision of the physical and mental well-being of a person in need of assistance to maintain a private and independent residence in the ALF; or help a member manage his or his personal life, regardless of whether a guardian has been appointed for the person. 6240 Nursing Services in Adult Foster Care Homes Revision 18-2; As of September 3, 2018, the RN service coordinator will determine a member classification level for foster care services (AFC) based on the assessment by the registered nurse (RN) service coordinator (MCO). McOs should take into account a need for limited or greater assistance in the performance of daily life activities (ACLs) and conduct that occurs at least once a week in assessment and determination, as well as other identified needs of the member. Nursing services can be purchased through the STAR+PLUS Home and Community Based Services (HCBS) program, depending on the member's assessed need and THE AFC home rating. For more information, see Section 7133 Classification Levels. 6250 Specialized Nursing Overhaul 18-2; As of 3 September 2018, specialist nursing services have been provided by a registered (RN) or licensed professional nurse (LVN) available through the STAR+PLUS Home and Community Based Services (HCBS) program. Specialised nursing services can be used when a member by a doctor, daily trained nursing: cleaning, dressing and extracting a tracheostomy; or help with respiratory or respiratory care. 6300 Therapy Services Revision 19-1; As of June 3, 2019, therapy services offered through the STAR+PLUS Home and Community Based Services (HCBS) program will be long-term services and will not replace a member's acute care allowance. Therapy services include the evaluation, research and treatment of physical, functional, cognitive, speech and hearing disorders and/or disabilities. Therapy services include the full range of activities led by a licensed therapist under her or his state license. Therapy services are provided directly by licensed therapists or by assistants under the supervision of licensed therapists in the member's home, or the member may receive the therapy in an outpatient clinic or clinic. If the therapy is provided outside the member's place of residence based on the member's choice, the member is responsible for providing his or his or his own transportation or access to the Medicaid Medical Transportation Program (MTP). If the therapy is provided outside the member's home due to the convenience of the provider, the provider is responsible for transporting the member. If a member lives in an adult foster home (AFC) or is offered an assisted living facility (AL) and therapy in an outpatient clinic or clinic (see Section 6112, ServiceLocations for STAR+PLUS HCBS Program), the AL provider or AFC provider is responsible for arranging transportation or transporting the member directly. Occupational therapy (OT), physical therapy (PT), speech therapy (ST) and cognitive rehabilitation therapy services are covered by the STAR+PLUS HCBS program only after the member has exhausted her or his therapy benefit under Medicare, Medicaid or other external resources (TPRs). Providers contracted with the managed care organization (MCO) must provide the OT, PT, ST and cognitive rehabilitation therapy (CRT) services as indicated on the member's individual service plan (ISP). Individuals providing therapy services must be licensed in Texas in their profession or are licensed or certified as assistants and employed directly or through subcontract or personal service agreements with a provider or through the Consumer Directed Services (CDS) Option. PT is defined as specialized techniques for evaluation and treatment associated with functions of neuro-musculo-skeletal systems provided by a licensed physical therapist or a licensed PT assistant directly under the supervision of a licensed physical therapist. PT is the evaluation, research and use of exercises, rehabilitation procedures, massage, manipulations and physical agents (such as mechanical devices, cold, air, light, water, electricity and sound) using diagnosis or treatment. OT consists of and procedures to promote or improve safety and performance in daily life activities (ACLs), instrumental activities of daily life (IEDs), education, work, play, leisure and social participation. It is provided by a licensed occupational therapist or a certified OT assistant who is directly supervised by a licensed occupational therapist. ST in the STAR+PLUS HCBS programme is defined as evaluation and treatment of disorders, disorders or deficiencies related to an individual's speech and language. The range of speech, hearing and language therapy services offered to star+plus HCBS program participants exceeds the status plan, as the service is available to adults in this context. It is provided by a speech-language pathologist or a licensed employee in speech language pathology led by a licensed speech pathologist. 6310 Review of assessment and therapy 18-2; As of September 3, 2018, at the request or recommendation of members of the nurse, primary care provider or service coordinator for a therapy assessment, the service coordinator of the managed care organization (MCO) must work with the member to select a provider for the assessment. The review must be submitted by the provider for the MCO to authorize service hours based on physician orders and medical necessity (MN) assessment. Any therapy for the management of a chronic condition should be included in the individual service plan (ISP). 6320 responsibilities of approved therapists in STAR +PLUS HCBS Program Revision 18-2; As of 3 September 2018, the responsibilities of the approved therapists are, among other things, but are not limited to: assessing the member's need for therapy, adaptive aids and minor home changes (MMCs); providing direct therapy as permitted in the individual service plan (ISP); monitor the delivery of therapy provided by the therapy assistant as permitted in the ISP; inform the doctor and other team members of changes in the health status of the member for which a service plan needs to be changed; training of the member's supervisor or carer to extend therapeutic interventions; train the member to use adaptive tools; and participate in interdisciplinary team meetings, if necessary and at the request of the managed care organization (MCO). 6330 Cognitive rehabilitation therapy revision 18-2; As of September 3, 2018, cognitive rehabilitation therapy (CRT) is a service that helps a member learn or re-learn cognitive skills lost or altered due to damage to brain cells/chemistry, so that the member can compensate for the lost cognitive functions. rehabilitation therapy is provided when determined to be medically necessary (MN) through an assessment carried out by a suitable professional. Cognitive rehabilitation therapy is provided in accordance with the individual service plan (ISP) provided by the and includes strengthening, strengthening or restoring previously learned behavior patterns, or establishing new patterns of cognitive activity or compensatory mechanisms for affected neurological systems. Qualified providers include: Psychologists Licensed under Texas Occupations Code Chapter 501; Licensed speech and language pathologists under Title 3 of the Texas Occupations Code, Subtitle G, Chapter 401; or Occupational therapists under License 3 of the Texas Occupations Code, Subtitle H, Chapter 454. 6400 Adaptive devices and medical supplies Revision 19-1; As of June 3, 2019, adaptive devices and medical supplies will be specialized medical devices and supplies, including devices, controls, or devices that allow members to increase their skills to perform daily activities (ACLs), or to observe, monitor, or communicate the environment in which they live. Adaptive devices and medical supplies are reimbursed with STAR +PLUS Home and Community Based Services (HCBS) program funds, when specified in the Individual Service Plan (ISP), with the aim of providing individuals with a safe alternative to nursing home (NF) placement. This service shall also include items necessary for life support, additional supplies and equipment necessary for the proper functioning of such objects; and durable and unsustainable medical equipment not available under the Texas State plan, such as vehicle modifications, service animals and supplies, environmental adjustments, everyday life tools, reachers, custom utensils, and certain types of elevators. The annual cost limit of this service is $10,000 per ISP year. The managed care organization (MCO) can exceed the cost limit of $10,000; However, the MCO may not include costs of more than $10,000 for cost reports, claims, meetings, or financial statistical reports. The State allows a member to select a relative or legal guardian, other than a legally responsible person, to be the supplier of the member for this service if the relative or legal protector meets the requirements for this type of service. Adaptive devices and medical supplies are limited to the most cost-effective items that meet the member's needs; directly assist the member in preventing premature NF placement; and nf residents a chance to return to the community. 6410 List of adaptive devices and medical supplies Revision 18-2; As of September 3, 2018, adaptive devices and medical supplies will not be covered by the STAR+PLUS Home and Community Based Services (HCBS) program until the member benefits of the state plan any outside sources (TPIs) have exhausted, including product guarantees or Medicare and Medicaid home health that the member qualifies for. If a vehicle modification costs $1,000 or more and the vehicle is driven more than 75,000 miles or is more than four years old, the managed care organization (MCO) contracted 'must be obtained in a written evaluation by an experienced mechanic to ensure the sound mechanical condition of all major parts of the vehicle; document the experience of the mechanic doing the evaluation; and include the actual cost of the written evaluation as part of the billing costs not to exceed $150. Adaptive devices, including repair and maintenance (including batteries) not covered by the warranty, consist of but are not limited to tracking: lifts: wheelchair lifts; hydraulic, manual or other electronic lifts; stair lifts; bath chair lifts; ceiling lifts with tracks; transfer bank; mobility aids, including batteries and chargers: manual or electric wheelchairs and necessary accessories; adapted wheelchair with documentation of cost-effectiveness; scooters on three or four wheels; mobility bases for bespoke chairs; brackets, crutches, walkers and walking sticks; forearm platform mounts for walkers and motorized/electric wheelchairs; prescribed prosthetic devices; prescribed orthotic devices, orthopaedic shoes and other prescribed footwear, including diabetic shoes if the member does not have Medicare and there is a documented medical need and a doctor's order for the shoes; diabetic slippers or socks; prescribed fitness equipment and therapy aids; portable slopes; breathing aids: ventilators or breathing apparatus; backup generators; oxygen containers or concentrators and related supplies; continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BiPAP) machines, including headgear; nebulizers; portable air purifiers and filters for a member with chronic respiratory diagnosis such as asthma, chronic obstructive pulmonary disease (COPD), bronchitis or emphysema; suction pumps; s stimulus meters and peak flow meters; positioning devices: stand boards, frames and bespoke seating systems; electric or manual hospital beds, tilt frame beds and necessary accessories; hospital beds, including electrical checks, hand crutches or other items related to bed use (Medicare/Medicaid can treat hospital beds, special mattresses and special hospital bed sheets for skin analysis); replacement mattresses; egg crate mattresses, sheepskin and other medically related fillings; wheelchair cushions; elbow, knee and heel protectors and hand rollers for positioning; armslingers, armbades and wrist splints; belly binders; trapeze beams; communication tools (including repair, maintenance and batteries): augmentative means of communication: direct selection communication companies; alphanumeric communicators; scan communicators; coding of communicators; and cordless phones for persons who cannot use conventional phones; voice amplifiers, tools and tools; interpreters; switches or pneumatic switches and appliances: sip and puff pastry control; adaptive switches or devices; environmental control locks; electronic devices; voice-activated, light-activated and motion-controlled devices; medically necessary (MN) durable medical equipment not covered in the state plan for the Texas Medicaid Program; temporary rental or rental of medically necessary durable medical equipment to enable repair, purchase, replacement of essential equipment or temporary use of the equipment; payment of premium deductible and co-insurance (for items covered by the STAR+PLUS HCBS program), including rental for Medicare or TPRs, if not covered under the qualified Medicare beneficiary or the Medicaid Qualified Medicare beneficiary programs; modifications or additions to primary transport vehicles: vans; driving control: brake or throttle manual operation; dimmer relays or switches; horn buttons; wrist rests; hand extensions; gas pedals from the left; right levers; gear shift levers; steering spinners; MN air conditioning unit prescribed by a doctor for persons with respiratory or heart problems or people who cannot regulate temperature; the removal or installation of wheelchair seats; installation, adjustment or placement of mirrors to overcome visual obstruction of wheelchairs in the vehicle; raise the roof of the vehicle, lower the floor or adjust the suspension of the vehicle to a person driving in a wheelchair; installation of frames, carriers, lifts for the transport of mobility aids; installation of trailers for trailers used for the transport of wheelchairs or scooters; Note: If the adaptive assistance is a vehicle change, the program provider must obtain written approval from the vehicle owner before making the change. The owner must sign and date the approval. The MCO must maintain that the contracted supplier has ensured that the specifications for a vehicle modification contain information on the vehicle to be modified, including: the year and model of the vehicle; a finding that the vehicle is the primary vehicle of the member; proof of ownership of the vehicle; the current state control and registration for the vehicle; the required state insurance for the vehicle; mileage of the vehicle; a specified list of components and accessories, including prices; a specified list of required work, including labour costs; and warranty coverage. sensory adjustments: corrective lenses, including glasses not covered by the State Plan; hearing aids not covered by the State Plan; auditory adjustments to mobility equipment; and adaptive equipment for everyday activities (ACLs): aid tools: reachers; weighted equipment; holders; feed materials, including: electric self-feed; food processors and blenders – only for members with muscle weakness in the upper body or who have no manual skills and cannot use manual conventional kitchen appliances; variations of Utensils: shaped, curved, constructed utensils; long-treated equipment; addition of frictional cover; coated feeding equipment; medication reminder systems, including systems for the visually impaired; walking straps and physical fitness aids; specially adapted kitchen appliances; toilet seat reducer rings, unless member lives in an institution for assisted living (ALF); bed commodes; hand-held shower sprays unless member lives in an ALF; shower chairs, unless member lives in ALF/residential care facility; electric razors; electric toothbrushes; water picks; service animals and maintenance, including veterinary costs; tables over the bed, unless the member lives in an ALF; safety devices, such as: safety filling; helmets; elbow and knee pads; visual warning systems; medically necessary heating and cooling equipment for members with respiratory or heart problems, people who cannot control the temperature or people who suffer from temperature; a window or portable air conditioner, including wiring, for a member's main living room, such as a bedroom; medical supplies necessary for therapeutic or diagnostic benefits for: tracheostomy care; pressure ulcer care; ostomy care; lung, respiratory/respiratory care; catheterization. Other types of necessities include: incontinence supplies, including nappies, disposable or washable bed cushions, briefs, protective linings, pull-ups, wipes, moisture-protective mattress covers, moisture barrier cream, ordinary or antiseptic wipes (if a medical need is documented), sheets, towels and washcloths (as MN); food supplements; enteral food formulas and supplies; stems and tooths; diabetic necessities (strips, lances and syringes); Transcutaneous Electrical Nerve Stimulation (TENS) units/deliveries/repairs; stethoscopes, blood pressure monitors and home thermometers; blood glucose monitors; medical alarm bracelets; grinds or biohazard containers; anti-embolism snake/stockings, such as thromboembolic disease snake; and approved enemas, if not available through the State Medicaid plan or other TPRs. Other necessary items related to hospital beds may include electrical checks, hand crutches or other items related to bed use. Medicare/Medicaid can cover hospital beds and special mattresses. Special sheets, such as hospital sheets, can be covered. The STAR+PLUS HCBS program pays for a Geri chair if the member is alert, oriented and able to remove the tray table without help and as desired. Otherwise, the Geri chair is considered a restraint and the STAR+PLUS HCBS program does not pay for restrictions. Gloves Gloves purchased through the STAR+PLUS HCBS family or caregiver use programme in the care of a member with incontinence, or if the member has an active infectious disease transmitted through bodily fluids. Examples of active infectious diseases that methicillin-resistant Staphylococcus aureus (MRSA) and hepatitis. Gloves can be purchased for family or caregiver use to provide wound care to protect the member. Documentation by the MCO-contracted provider should support the need for gloves to be left in the home and for family or caregiver use only. If the member has other conditions that require frequent use of gloves, the MCO nurse must give his or her approval. Adaptive Help Exclusions The following examples are examples of items that may not be purchased with star+plus HCBS program funds. These items include, but are not limited to: hot water stove; combination heating, light and exhaust fan; filters for heating and cooling system; non-adapted appliances, such as refrigerators, heaters, dryers, washing machines and vacuum cleaners; water filtration systems; central air conditioning and heating; multiple air conditioning units to cover an individual's home; non-adapted home furnishings (except permitted through Transition Assistance Services (TAS) or Additional Transition Support): cookware; non-hospital bed mattresses and feathers, including Adjustamatic, Craftmatic, Tempur-Pedic®, Posturepedic and Sleep Number® beds; cushions (excluding neck cushions and support wedge cushions); electrical heating elements (heating cushions, electric blankets); recreational items, equipment and supplies, including: bicycles and tricycles (2, 3 or 4 wheels); helmets for recreational purposes; trampolines; swing sets; bowling and fishing gear; karaoke machines; entertainment systems; all-terrain vehicles; memberships of gyms, spas, health clubs or other fitness facilities; communication points, including: phones (standard, wireless or mobile); pagers; pre-paid minute cards; monthly service charge; computers for the following justifications: educational purposes; self-improvement/employment purposes; improving general computer skills; access via the Internet and via e-mail; games and fun/craft activities; office equipment and supplies, including: fax machines; printers/copiers; scanners; internet and e-mail services; Note: A person who has access to the Consumer Directed Services (CDS) option can purchase office equipment and supplies through the CDS budget. gloves for universal precautions, or gloves used by MCO contracted provider, an adult foster care (AFC) provider or a contracted provider staff; personal items for APLs, such as hygiene products such as soap, waterless soap, toothbrush, toothpaste, deodorant, powder, shampoo, lotions (except moisture barrier products), female (except when documented for use as an incontinence device), hand shavers razors, washcloths, towels, bibs and first aid supplies; garments; food; bottled water (for drinking and cooking); food drinks and products, such as Anjeration Instant Breakfast, V-8 Juice, Slim Fast, fruit juices, fruit juices, water, vitamin, food and protein bars, cereals; vitamins, minerals and herbal supplements and over-the-counter medicines; title, permit and registration for trailers or vehicles; wheelchairs and scooters to facilitate participation in recreational activities and sports; vehicle repairs, as part of normal maintenance; repairs are part of the normal maintenance of vehicles and cannot be covered. Installation of heavy shocks as required by a lifting system may be included as part of the modification of the vehicle. trailers (including taxes) for the transport of wheelchairs or scooters; experimental medical treatments and therapies, such as equestrian therapy; and the installation of gas or propane pipes. 6420 Approval of adaptive devices and medical supplies revision 20-2; As of October 1, 2020, the service coordinator of the managed care organization (MCO) identifies the member's basic needs for adaptive devices and STAR+PLUS Home and Community Based Services (HCBS) program medical supplies along with the estimated cost on form H1700-1, Individual Service Plan (1. The MCO must provide documentation to support the medical need for all adaptive devices and medical supplies. The documentation must be provided by the member's ordering, referring or prescribing provider. This can include a doctor, physician assistant, nurse, registered nurse (RN), physiotherapist, occupational therapist or speech pathologist. The service coordinator must use Form H1700-A, Rationale for STAR+PLUS HCBS Program Items/Services, to record the medical need and reason for purchasing the item(s). Adaptive devices and medical supplies are only approved by the MCO for purchase as a STAR+PLUS HCBS program service if the documentation supports the requested item(s) as necessary and related to the member's disability or medical condition. The MCO determines whether the submitted documentation is sufficient and decides whether an adaptive assistance or medical delivery is necessary and is related to the member's condition. The MCO will make the final decision if the purchase is necessary and will be authorized on the individual service plan (ISP). The acute care benefit for all equipment or medical supplies must be spent before STAR+PLUS HCBS program benefits can be used. If the member's request for a particular adaptive or medical delivery is rejected, the member must receive written notification of the denial of the specific item according to the requirements described in the Uniform Managed Care Manual, Chapter 3.21. If the member requests an item that the MCO considers not to be medically necessary or the member's disability or medical condition, the MCO must send a notification of action to the member. For situations where the member requested an adaptive or medical and the item(s) are documented by the nurse or other medical professional as medically necessary, the MCO has the possibility to approve the article(s). If not approved, the MCO must send a notification of action to the member. The member may appeal against the denial by appealing to the MCO. The member will not receive adaptive help or medical supplies unless the denial is reversed. If the denial is reversed, the item is added to the ISP. The cost of the article is reflected in the ISP which was in force at the time of the appeal. Service plans must be individualized to the member. All items must be related to the member's disability or medical condition and be used to support or increase the level of independence. If the provider is unable to deliver the adaptive tools within the appropriate time limits, the provider must notify the MCO via Form H2067-MC, Managed Care Programs Communication, and include the reasons why the adaptive assistance will be too late. The MCO shall assess the information to determine whether the reason for the delay is sufficient or whether additional intervention is necessary. The MCO may need to discuss the reasons for the delayed delivery with the member and the staff of the provider. If the requested adaptive assistance is not provided in the current ISP, the item must be transferred to the new ISP. If the authorization on the new ISP causes the ISP to exceed the annual cost limit, the nurse can authorize the service based on the date the item was ordered by the provider as the date of delivery of the service and the provider may be charged to the previous ISP. 6421 Lift Chair Approvals Review 18-2; From September 3, 2018, lift seats can be authorized as adaptive tools as part of the STAR+PLUS Home and Community Based Services (HCBS) program service array. Use the following procedures as an attempt to buy the elevator chair using Medicare funding. Once the managed care organization (MCO) determines an elevator seat may be required or requested by the member, the MCO assesses the member to determine whether the member meets all of the following criteria required for Medicare to pay for the lift mechanism: The member must have severe arthritis of the hip or knee or have severe neuromuscular disease. The chair lift mechanism should be part of the doctor's treatment and be prescribed to improve, or arrest or delay deterioration of the member's condition. The member should be completely unable to stand up from a chair in her or his home. Once standing, the member should have the option to with or without assistance. Member does not meet all criteria If the member does not meet all Medicare criteria, the MCO fills out Form H1700-A, Rationale for STAR+PLUS HCBS program articles/services. The MCO should be the following on Form H1700-A, Section 4, Lift Chair: Plus Mechanism. Together with Form H1700-A, the MCO must make a prescription or signed by the doctor showing the need for the lift chair, especially in which the member has difficulty or is unable to stand up from a chair; and statement from the doctor or provider stating specifically that once standing, the member has the ability to ambulate or transfer with or without assistance. The MCO approves the cost of the lift chair plus the mechanism if the request meets all the criteria and the above documentation is received. Member meets all criteria If the MCO determines that the member meets all the criteria for Medicare to pay for the lift mechanism, the MCO: approves the cost of the lift chair minus the mechanism; empowers the provider of durable medical equipment to supply the elevator chair and Medicare bill for the mechanism; and must document that Medicare covers the mechanism. If a request for an elevator seat minus the mechanism is approved by the MCO, but the provider later asks for additional funds for the mechanism denied by Medicare, the MCO can approve the request if it meets all STAR+PLUS HCBS program criteria. To avoid billing issues, the effective date of the change to add the resources for the lift mechanism should be the same as the effective date of the first amendment completed to approve the elevator seat without the mechanism. 6430 Effects of Changing MCOs on Adaptive Aids Procurements Review 18-2; As of September 3, 2018 If a member moves to another managed care organization (MCO) while an adaptive assistance is on order or in the process of delivery, the MCO that authorized the service is responsible for the payment and delivery of the adaptive assistance. 6440 Temporary rental and rental overhaul 18-2; From September 3, 2018 equipment rental allows repair, purchase or replacement of the equipment, or temporary use of the equipment. The duration of the rental of equipment must be based on the individual circumstances of the member. If the medical professional and/or member is not sure that the medical equipment will be useful, the equipment must be rented for a trial or short-term period before purchasing the equipment. The cost of renting equipment versus purchasing equipment can be investigated, if you are currently renting the equipment. Rental can be more cost effective than direct purchase of an item. The expected duration of the use of equipment can be taken into account in the decision to rent or buy. It can be more cost effective, after renting for a period of time, to buy the equipment instead of continuing to rent. If the member prefers to buy the rented equipment, the managed care organization (MCO) must properly document the equipment functions and is for the member, so STAR +PLUS Home and Community Based Services (HCBS) program funds can be spent. 6450 Deadlines for purchase and delivery of adaptive devices and medical supplies Revision 18-2; Effective Effective 3, 2018 6451 Time Frames for Adaptive Aids Revision 18-2; As of September 3, 2018, the Managed Care Organization (MCO) must purchase and guarantee any adaptive assistance within 14 business days of the permit (except vehicle changes), taking into account the effective date of the individual service plan (ISP) form or the date on which the form is received, depending on later. If delivery is not possible in 14 business days, the MCO must document the reason for the delay. The MCO must notify the member and the notification of documents of any delay, with a new proposed date for delivery. Notification must be provided on or before the 14th working day following the authorisation. If delivery does not take place before the new proposed date, the MCO must document further delays and notification from the document member until the adaptive tools are delivered. The MCO must consent to a vehicle change at the entry date of the member's ISP. The MCO should work with the provider and member to ensure that the vehicle modification takes place as quickly as possible. 6452 Deadlines for Medical Supplies Revision 18-2; As of September 3, 2018, medical supplies are expected to be delivered to the member within five business days of receiving STAR+PLUS Home and Community Based Service (HCBS). The provider must deliver medical supplies within five business days from the start date on the individual service plan (ISP). The current supply of these items by the member should be considered. For example, if the member has a supply of diapers that are expected to last a month, the diapers allowed on the ISP do not need to be delivered immediately. If the provider cannot provide a medical delivery within five business days due to unusual or special needs or availability, the provider must submit Form H2067-MC, Managed Care Programs Communication, to the Managed Care Organization (MCO) before the fifth day explaining why medical delivery cannot be delivered within the required time frame and including a new proposed delivery date. If there is an existing delivery of medical supplies at the date of service initiation, the MCO must write existing delivery of the necessary medical supplies on hand in the progress notes as verification that supplies were available to the member and do not require delivery at this time. The stockpiling of medical supplies must not take place. Supplies, such as incontinence and wound care supplies not covered by Medicaid Home Health and required on a permanent basis, must be delivered so that there is no more than a three-month supply in the member's home at a time. 6460 Co-Insurance and Deductible 18-2; As of September 3, 2018 Reimbursement of the cost of co-insurance for the purchase or rental of adaptive devices or the purchase of supplies reimbursed by Medicare or private health insurance are available if the following conditions are met: the member does not have coverage under the Qualified Medicare Beneficiary (QMB) or the Medicaid Qualified Medicare Beneficiary (MQMB) programs; adaptive assistance or medical delivery is included in the service definition of this handbook or is pre-approved by the Management of the Managed Care Organization (MCO); and the documentation submitted supports the need for the article(s) for the disability or medical condition of the person. Reimbursement for the co-insurance amount to Medicare or private health insurance for therapy services or the rental of adaptive devices is a cost-effective way to use third-party resources (TPRs). The cost of a co-insurance should be billed under adaptive tools. In cases where a member is not covered by the QMB or MQMB programs and cannot pay her or her premium deductible under a TPR for items covered by the STAR+PLUS Home and Community Based Services (HCBS) program, the excess may be listed under adaptive devices on Form H1700-1, Individual Service Plan (Pg. 1), for a fee. 6470 Bulk purchase of medical supplies Revision 18-2; From September 3, 2018, the managed care organization (MCO) can choose to purchase medical supplies in bulk. The cost of storing inventories can be reported on the annual cost report as an authorized cost. The medical delivery is billed at the unit rate based on the invoice cost of the bulk purchase divided by the number of units purchased. 6500 Review of dental services 18-2; From September 3, 2018 dental services are those services provided by a dentist to preserve teeth and meet the medical needs of the member. Dental services must be provided by a dentist license by the State Board of Dental Examiners and enrolled as a Medicaid provider with Texas Medicaid & Healthcare Partnership (TMHP). The Managed Care Organization (MCO) service coordinator provides the necessary dental services for STAR+PLUS Home and Community Based Services (HCBS) program members with licensed and registered dentists. The MCO should discuss with the STAR+ PLUS HCBS member program all available resources to cover the cost of dental services and consider these resources before providing dental services through STAR+PLUS HCBS program. If dental services are on the individual service plan (ISP), the MCO must authorize and coordinate a referral to a dental provider within 90 days of the member's request, unless there is documentation that the member requested a later date. 6510 review of dental services 18-2; As of September 3, 2018 Permitted dental services include: emergency dental treatment procedures necessary to monitor bleeding, relieve pain and eliminate acute infection; preventive procedures necessary to prevent the imminent loss of teeth; treatment of injuries to teeth supporting structures; dentures and the cost of the assembly and preparation of dentures, including extractions, moulds, etc.; routine and preventive dental treatment. The managed care organization (MCO) must ensure that dental requests meet the criteria for permitted services before they provide services, except in an emergency. Dental services are provided by STAR +PLUS Home and Community Based Services (HCBS) program when no other financial resources for such services are available and when all other resources available, except value added services (VAS). VAS does not need to be used prior to waiver services. VAS varies by MCO. The State allows a member to select a relative or legal guardian, other than a spouse, to be the member's supplier for this service if the relative or legal guardian meets the requirements to provide this type of service. Payments for dental services are not made for cosmetic dentistry. The annual cost limit of this service is $5,000 per individual service plan (ISP) year. The $5,000 cap can be waived by the MCO at the request of

the member only when the services of an oral surgeon are required. 6520 Documentation of dental services by a dentist review 19-1; As of June 3, 2019, the managed care organization (MCO) or its contractor must ensure that all applications for dental treatments contain documentation by a professional dentist of the need for dental services. A dentist should determine the medical need (MN) for dental treatment and submit a detailed treatment plan to the MCO to document the MN and all specific dental procedures that need to be completed. The dentist may not invoice the member of the STAR+PLUS Home and Community Based Services (HCBS) program for the remainder of the cost above the approved amount. Form H1700-A, Rationale for STAR+PLUS HCBS Program Items/Services, must be completed by the MCO to record the medical need for requested STAR+PLUS HCBS program items or services. MN for dental services is completed by the professional dentist, as described above. Form H1700-A can be filed instead of the process described above, if the information is sufficient to describe the medical need for dental services. 6530 Deadlines for the introduction of dental services Review 20-1; As of March 16, 2020, the managed care organization (MCO) must work with the member to provide a dentist or contracted dentist by the first day of the member's individual service plan (ISP) identify them. The MCO must send a license to the dentist within seven days of receiving the dental treatment plan. Services should be started within 90 days of the development of the treatment plan, unless the member or dentist has a documented preference for a later initiation date. 6600 Small House Changes Revision 18-2; As of 3 September 2018, minor home modifications (MMCs) which make physical adjustments to the home of a member, member, by the service plan, which is necessary to ensure the health, well-being and safety of the member, or which enable the member to function with greater independence in-house. Such modifications may include the installation of ramps and grab beams, widening of doorways, alteration of bathroom facilities or installation of specialised electrical and sanitary systems necessary to house the medical equipment and supplies necessary for the member's well-being. Excluded are those adjustments or improvements to the house that are of general use, and are not of direct medical or corrective benefit to the member, such as carpet, roof repair, central air conditioning, etc. Adjustments that contribute to the total square footage of the house are excluded from this benefit. All services are provided in accordance with applicable state or local building regulations. Changes are not made to institutions that are leased, owned or controlled by providers contracted with the managed care organization (MCO). The State allows a member to select a relative or legal guardian, other than a spouse, to be the member's supplier for this service if the relative or legal guardian meets the requirements to provide this type of service. 6610 Responsibilities regarding minor changes to the House Review 16-1; As of March 1, 2016, the Managed Care Organization (MCO) must determine and document the member's needs and preferences for the MHM to ensure cost-effectiveness in the purchase of small home modifications (MMCs). and document the need for the MHM. The MCOs have their own policies and procedures regarding bidding, placing contracts, doing inspections and completing MHM's. 6620 List of Minor Home Modifications Revision 19-1; As of 3 June 2019 The following minor adjustments to the house (MHM) include the installation, maintenance and repair of approved items not covered by the warranty: Purchase of wheelchair ramps; protective canopies over ramps; Adjustments or additions to accessible bathroom facilities; wheelchair-accessible showers; sink changes; changes to the bath; toilet adjustments; water tap controls; floor urinal and bidet adjustments; changes and additions to existing structures required for accessibility adjustments; adjustments to the turnaround space; Adjustments or additions to accessible kitchen facilities; sink changes; sink cut-outs; adjustments to the turnaround space; water tap controls; changes or additions to existing structures required for accessibility adjustments; or work surface adjustments or additions; cabinet adjustments or additions; Specialized accessibility or safety adjustments or additions, including repair and maintenance; door-widening; electrical wiring; gripping beams and handrails; automatic door openers, doorbells, door scopes and adaptive wall switches; wall switches; safety adjustments and alarms; medically necessary air filtration devices; light alarms, doorbells for hearing and visually impaired; floor levelling, only when the installation of a ramp is not possible; vinyl floors or industrial carpet necessary to ensure the safety of the member prevent falls, improve mobility and adapt a living space occupied by a person unable to safely use the existing floor area; medically necessary steam cleaning of walls, carpet, support equipment and cladding; extension or extension of garage and/or carport to house the primary transport vehicle and to enable persons using wheelchairs to enter and exit their vehicles safely; installation of pavement for access from unconnected garage and/or driveway to residence, where the existing surface condition poses a safety risk to the person with a disability; porch or patio leveling, only when the installation of a slope is not possible; safety glass, safety alarms, safety door locks, fire safety inspections and safety screens; for example for persons with serious behavioural problems; safety screens for residence, for persons with cognitive impairments or persons whose safety would be compromised if they were to wander; protective padding and corner protectors for walls for members with impaired vision and mobility; recessed lighting with mesh upholstery and metal dome light covers to compensate for violent aggressive behavior; for example for persons with autism or mental illnesses; renovations of noise reduction to provide greater sound insulation; for example for persons with autism or mental illnesses; replacement of the door for accessibility; motion sensory lighting; intercom systems for persons with reduced mobility; and lever door handles. Ramps can be installed for better mobility for use with scooters, walkers, walkers, etc., or for members with reduced ambulation, as well as for wheelchair mobility. In some cases, and according to supporting documentation, multiple changes may be required for accessibility and mobility, such as ramps and hand rails for members with reduced ambulation. There is no limit to the number of wheelchair ramps that can be allowed, provided that the total cost does not exceed the cost limit, but documentation should support the justification for additional ramps related to medical needs or health and safety of the member. Carbon monoxide detectors cannot be purchased under STAR+PLUS Home and Community Based Services (HCBS) program as a fire safety adjustment and alarm. for items (or repair of items) or service calls that are considered routine maintenance and home maintenance cannot be approved. Items that cannot be approved by the service coordinator include: floor coverings (other than industrial quality); newly built carports, porches, patios, garages, porches or decks; Electric landscaping and yardwork or supplies; roof repair or replacement; gutters; leaking faucet repair; lifts; house painting; electrical upgrades and/or sockets, unless it is necessary to count custom equipment of power or a safety risk exists; air duct cleaning and maintenance; pest control. Heating and cooling equipment can be approved as an adjustment tool. Installation of approved heating and cooling equipment is included in the cost of the adaptive device. Support platforms are often used to support cooling equipment installed in home windows. The support platforms attach themselves in a clamp-like way without fasteners. The cost and installation of support platforms are considered an adaptive tool. The installation of heating and cooling equipment may require an adjustment of the house (e.g. additional wiring or widening of the windows). The modification of the house should be allowed as an MHM. Flooring applications, including vinyl and industrial carpet, should not be allowed for adjustments or improvements to the home that are of general use and are not of direct medical or corrective benefit to the member. 6630 Minor Home Modification Service Cost Lifetime Limit Revision 20-2; As of October 1, 2020 There is a lifetime limit of $7,500 per member for this service and $300 per year for repairs. Once the $7,500 cost limit is reached, only $300 per year per member, excluding associated costs, is allowed for repairs, replacement, or additional changes. The managed care organization (MCO) is responsible for obtaining cost-effective changes that are permitted on the member's individual service plan (ISP) that is more fully described in Section 6117, Service Planning, and Title 1 Texas Administration Code (TAC) §353.1153(c)(1). If a member's ISP contains a defined need for minor home modifications (MMCs) that exceed the lifetime benefit limit, the MCO is allowed to exceed the cost limit without prior authorization from the Texas Health and Human Services Commission (HHSC). The MCO may not include lifetime limit charges for cost reports, claims, meetings, or financial statistical reports. If a member changes MCOs, the losing MCO must provide documentation to the acquiring MCO regarding mhm expenses. See Section 3413, Switching from one MCO to another within the same service area. 6640 Landlord Approval for Minor Home Changes Review 16-1; As of 1 March 2016 If the member has a landlord or if the owner of the property is not a member, written approval must be obtained initiation of a requested change. 6700 Review of employment services 18-2; With effect from 3 September 2018 6710 Revision of employment aid 20-2; From 1 October 2020, labour market assistance to help a member find paid work in the community includes: employment preferences, work skills and requirements for work and working conditions; finding potential employers providing employment compatible with a member's established preferences, skills and requirements; and contact a potential employer on behalf of a member and negotiate the employment of the member. Documentation must be kept in the member's report that the service is not available to the member under a programme funded under Section 110 of the Rehabilitation Act of 1973 or under a program funded by the Individuals with Disabilities Education Act (Title 20 U.S.C. §1401 et seq.). The credentials of a worker must meet one of these options: Option 1: a bachelor's degree in rehabilitation, business, marketing or a related field in the field of human services; and six months of documented experience in providing services to people with disabilities in a professional or personal environment. Option 2: an associate degree in rehabilitation, business, marketing or a related human services area; and a year of documented experience in providing services to people with disabilities in a professional or personal environment. Option 3: a high school diploma or a general equivalency diploma (GED); and two years of documented experience in providing services to people with disabilities in a professional or personal environment. 6720 supported revision of employment 18-2; From 3 September 2018, supported employment will be provided to maintain a competitive job, to a member who, due to a disability, needs intensive, continuous support to be self-employed, work at home or perform in a working environment where people without disabilities are employed. Supported employment includes adjustments, supervision, training in relation to a member's assessed needs and earning at least the minimum wage (if not self-employed). In the state of Texas, this service is not available to members who provide waiver services under a program funded under Section 110 of the Rehabilitation Act of 1973. Documentation is kept in the file of the member that the service is not available to the member under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.). The credentials of a supported employment provider must meet one of these options: Option 1: a bachelor's degree in rehabilitation, business, marketing or a related field of human services; and six months of documented experience in providing services to people with disabilities in a professional or personal environment. Option 2: An associate's in rehabilitation, business, marketing or a related human services area; and a year of documented experience in providing services to people with disabilities in a professional or personal environment. Option 3: A High School Diploma or State of Texas Certificate of High School Equivalence; and two years documented experience in providing services to people with disabilities in a professional or personal environment. Section 7000, STAR+PLUS HCBS Program and Services Revision 20-2; As of October 1, 2020 7100 Adult Foster Care Overhaul 18-2; As of 3 September 2018 7110 Introduction Revision 20-1; From 16 March 2020, adult foster care (AFC) will provide 24-hour residential and care services and support for people who are unable to live independently due to physical or behavioural conditions. Services and support may include assistance and/or supervision in daily life, including meal preparation, housekeeping, counsellor services, personal care, nursing duties and the provision or provision of transport. The STAR+PLUS Home and Community Based Services (HCBS) applicant or member who chooses AFC must stay with a contracted STAR+PLUS HCBS program AFC home provider that meets the minimum standards and licensing requirements set out in Annex XXIV, minimum standards for STAR+PLUS AFC Homes, and Home Providers. AFC home providers must be contracted directly with the member's managed care organization (MCO) or with an AFC provider agency contracted with the member's MCO. The person qualified to supply AFC (AFC home provider) must be the primary caregiver. AFC home providers must live in the household and share a common living space with the member. Detached living spaces do not constitute a communal living space. AFC home providers can serve up to three adult residents in a qualified AFC home without a permit as a personal care home or assisted living facility (ALF), and can be the AFC home provider at home or the STAR+PLUS HCBS program applicant or member at home. AFC home providers with four or more residents, who are also contracted with the Texas Health and Human Services Commission (HHSC), are required to have a Type C Personal Care Home license. AFC homes with four to eight AFC residents must be licensed as an ALF, with restrictions on the number of residents at each level who can live in the home. The three levels of eligibility for AFC are explained in Section 7133, classification levels of Adult Foster Care Members. ALF licensing requirements can be found in Title 26 Texas Administrative Code (TAC), Chapter 553. Each resident referral includes members receiving services in the STAR+PLUS HCBS program and AFC or individuals. AFC home providers can serve a combination of STAR+ PLUS HCBS program members and individuals paying in a qualified or licensed AFC home house, as long as the AFC home provider continues to meet the minimum standards specified in Appendix XXIV, and additional other standards may be specified by the MCO. When the AFC home provider The STAR+PLUS HCBS program member who receives AFC at home will receive AFC home enrollment. indicated by an asterisk in Appendix XXIV, the MCO or the AFC provider agency contracted by MCO may be waived, as appropriate. Other minimum standards, with the exception of home safety requirements, may be waived at the discretion of the MCO or on the recommendation of the AFC provider agency contracted by MCO, as long as the AFC provider agency contracted by MCO has completed a home assessment and the member's needs can be adequately met through the STAR+PLUS HCBS program and AFC-specific services. Such conclusions should be documented by the AFC provider agency contracted by MCO and approved by the MCO. The MCO is responsible for ensuring the AFC member receives all necessary AFC services, including the license of other required services and nursing duties. STAR+PLUS HCBS program AFC members must pay their own room and board fees and, if possible, contribute to the cost of AFC services through a copayment to the AFC home provider. The only time room and sign is not needed is when the AFC home provider moves with the member and the member at home becomes the AFC home. Chamber and board arrangements must be documented in the member's file by the MCO or by the AFC provider agency contracted by MCO. If an AFC property is contracted with HHSC to provide services to an applicant or member who receives AFC through HHSC, the MCO or the provider agency contracted by MCO may, if applicable, request a copy of the qualification documents for home provider AFC and AFC from HHSC. These documents contain HHSC findings regarding the qualifications of the AFC home and AFC home provider. 7111 Target review 18-2; As of September 3, 2018, the purpose of the STAR+PLUS Home and Community Based Services (HCBS) adult foster care (AFC) program is to promote the availability of appropriate services in a domestic environment for members who are older and have disabilities to improve a member's dignity, independence, individuality, privacy, choice and decision-making. The STAR+PLUS HCBS program requires that each AFC member has sufficient living space to ensure his or her privacy, dignity and independence. 7112 MCO Contracting Options Revision 18-2; As of September 3, 2018, the Managed Care Organization (MCO) offers STAR+PLUS Home and Community Based Services (HCBS) adult foster care (AFC) program through one of two contracting methods: Contracting with an individual AFC home provider; or contract with an AFC provider responsible for: the qualification of the AFC home and AFC home provider; ensure that the AFC requirements and minimum standards in Appendix XXIV, minimum standards STAR+PLUS AFC homes and home providers will continue to comply unless waived as described in Article 7110, introduction; and reporting a significant change in the member's needs or status to the MCO. If the MCO attracts contracts with AFC provider agency, the MCO has oversight of the AFC provider agency. The MCO retains responsibility for its member(s). 7113 Review of foster care services for adults 19-1; As of June 3, 2019, the Home Care Provider for Adult Care (AFC) must provide unison care, support and supervision, if necessary, in an AFC home that is either qualified on the basis of minimum standards or licensed by the Health and Human Services Commission (HHSC) (for homes serving four or more residents). Services may include: Personal Assistance Services (PAS) — Assistance with activities related to the care of the physical health of the member, which includes, but is not limited to bathing, dressing, preparing meals, nutrition, exercise, grooming (routine hair and skin care), toilets and transfer/ambulating. A STAR+PLUS Home and Community Based Services (HCBS) adult foster care (AFC) member program may not receive a STAR+PLUS HCBS program ONLY while the member is resident in a AFC STAR+PLUS HCBS program. Form H6516, Community First Choice Assessment, or Form H2060, Needs Assessment Questionnaire and Task/Hour Guide, and any addendums to Form H2060 are completed by the managed care organization (MCO) to determine the tasks required for completion by the AFC home provider. The MCO must, where applicable, provide a copy of the required PAS tasks to afc's home provider and to the AFC provider agency contracted by MCO. Transportation - Arrangement of and/or direct transportation of members to meet their basic needs for food, clothing, toiletries, medicines, medical care and necessary therapy. Supervision - Periodic checks or visits by the provider to the member during the 24-hour period to ensure that the member is good and safe. For some members with more intensive medical needs or behavioural problems, more frequent supervision is required. Meal preparation — Preparation or provision of meals suitable to meet the member's needs. Cleaning - Household-related activities that are essential to the health and comfort of the member, such as changing bedding, cleaning, laundry, shopping, arranging furniture, washing dishes and storing purchased items. AFC services, with the exception of 24-hour monitoring provided to all STAR+PLUS HCBS programme AFC members, are delivered where necessary, with the flexibility to meet the member's needs as restrictively as possible. For example, STAR+PLUS HCBS program AFC members may not need help with medication or assistance with transportation, but the services are available to all STAR+PLUS HCBS program members in AFC homes. PAS tasks must be provided indicated on Form H2060 and any addendums to Form H2060. The AFC home provider may provide more services for the member than are allowed, as the changing needs of the member may justify, but may not reduce or stop services without prior prior with the MCO. Star+PLUS HCBS program members, as recipients of Medicaid, are entitled to medical transportation services. Transportation is provided to Medicaid-covered medical appointments. Access to emergency medical transportation is available to members through the Medical Transportation program. 7114 Other long-term services and support available for Adult Foster Care Members Review 19-1; From 3 June 2019, the managed care organisation (MCO) can provide or provide the following services. Adaptive devices and medical supplies — Medical devices and supplies that include devices, controls, or devices specified in the Care Plan (POC) that enable individuals to increase their skills to perform daily activities (ACLs) or to observe, monitor, or communicate the environment in which they live. Nursing Services — Member services can be provided through the STAR+PLUS Home and Community Based Services (HCBS) program. Nursing services include assessment, planning and interventions provided by a person licensed to participate in professional nursing practice as a registered nurse (RN) or licensed professional nurse (LVN) by the Texas Board of Nursing (BON) or a license in a state that has adopted the Nurse Licensure Compact. Small home modifications (MMCs) — Services that assess, address and make changes and/or improvements to a home to enable the member to live in the community and ensure safety, safety and accessibility. MMCs are limited to changes identified and approved by the MCO on the Individual Service Plan (ISP). If the adult foster care (AFC) home is the member's home, the member must agree to changes to the house. If the AFC home provider is the owner of the home, the AFC home provider must agree to changes to the home. If the AFC home provider is the tenant of the house, the owner must be contacted and informed of the necessary changes. Permission to make the changes must be obtained in writing from the homeowner and tracked with Form H1700-A, Rationale for STAR+PLUS HCBS Program Items/Services. When the AFC home provider and member or STAR+PLUS HCBS program applicant meet to interview each other and complete Form 2327, individual/member and provider agreement, the MMCs must be included in Various Arrangements if the AFC House is not home to the member. Both the member and the AFC home provider must sign Form 2327 which agrees to all included information and provisions. In order to prevent the member from unnecessarily issuing his or her allocation for MHM's, a grace period of 30 days are allowed for the member to adjust to the AFC placement before any changes are initiated. If the health or safety of the member is endangered without the necessary changes upon entry into the AFC House, AFC House, of the 30 days can be made based on the recommendations of the interdisciplinary team (IDT) and approved by the MCO. MHM's remain in a STAR + PLUS HCBS program AFC at home, even if the member for whom the changes were made permanently leaves the house. Dental Services - Services provided by a licensed dentist to preserve teeth and meet the dental requirement of the member. Occupational therapy (OT) — Interventions and procedures to promote or improve safety and performance in the instrumental activities of daily life (ACCs), education, work, play, leisure and social participation. Services consist of the full range of activities undertaken by an OT or a licensed occupational therapy assistant led by a licensed occupational therapist and under his/her state license. Physiotherapy (PT) — Specialized techniques for evaluation and treatment related to functions of the neuro-musculoskeletal system. Services consist of the full range of activities undertaken by a physical therapist or a licensed physiotherapist assistant led by a licensed physiotherapist and within the scope of his/her state license. Speech therapy (ST) — The evaluation and treatment of disorders, disorders or deficiencies related to a member's speech and language. Services include the full range of activities undertaken by a speech and language pathologist under the scope of the pathologist's state license. Cognitive Rehabilitation Therapy (CRT) - A service that helps an individual learn or re-learn cognitive skills that have been lost or altered due to damage to brain cells/chemistry to enable the individual to compensate for lost cognitive functions. CRT is provided when found to be medically necessary through an assessment carried out by a suitable professional. The assessment is not covered by this service. CRT is provided in accordance with the plan of care developed by the assessor, and includes strengthening, strengthening or restoring previously learned behavior patterns, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Employment Services (EA) — Services that help the member find competitive employment or self-employment. Supported Employment Services (SE) — Services that help the member maintain competitive employment or self-employment. Day activity and health services (DAHS) — Includes nursing and personal care services, physical rehabilitation services, food services, transport services and other support services. These services are provided in facilities that are or certified by the Texas Health and Human Services Commission (HHSC). Each of the above services is provided according to the member's needs as indicated on the ISP, with with the exception of DAHS, which is not included on the ISP. The MCO makes referrals for DAHS, coordinates delivery and advises the AFC home provider or MCO-contracted provider agency of any updates to the ISP or referrals for DAHS. Members who need nursing may be able to obtain nursing services at a DAHS facility. The MCO service coordinator will, if applicable, work with the AFC home provider or provider and the member to determine where the member's needs can best be met. Star+PLUS Home and Community Based Services (HCBS) program members who reside in an AFC home without RN as the AFC home provider can receive up to 10 units of DAHS per week. For level III AFC homes, refer to Section 7133.2, AFC Homes that correspond to AFC member levels, for DAHS eligibility. 7120 Minimum standards for all adult foster care homes and home care providers Revision 18-2; From September 3, 2018, all foster homes (AFC) homes and AFC home providers must be qualified initially and annually in accordance with the minimum standards set out in Appendix XXIV, minimum standards for STAR+PLUS AFC homes and home providers. 7121 AFC Homes with four or more residents and members Review 20-1; As of March 16, 2020 An adult foster care (AFC) home provider must obtain a permit for assisted living (ALF) if the AFC home provider wishes to serve four or more private paying residents and/or members. The AFC home provider can apply for an ALF license from the Texas Health and Human Services Commission (HHSC) Regulatory Services Division. The license must be renewed annually and requires an annual fee. Licensing standards for different types of AL facilities can be found in Title 26 Texas Administrative Code (TAC), Chapter 553. The AFC home provider must submit a copy of the ALF license to the managed care organization (MCO) or MCO-contracted AFC provider agency before submitting login credentials and upon renewal. The AFC home provider must report any issue(s) identified by HHSC Regulatory Services to the AFC Provider Agency identified by HHSC Regulatory Services. AFC home providers must meet all applicable requirements in the minimum standards for AFC. AFC home providers with an AL license may not serve more than a total of eight adult residents in a small group home. AFC homes of four or more residents, without an HHSC contract, are also subject to the following two sets of regulations: Appendix XXIV, Minimum Standards for STAR+PLUS AFC Homes and Home Providers; and licensing standards for assisted living facilities, found in Title 40 TAC, Chapter 92. The stricter requirements apply when the requirements of the series of regulations conflict. For example, an AFC home with a permit as a small group house must meet the requirement that a supervisor be present at all times when the occupants are in the facility. This requirement applies regardless of the number of members residing in the facility. If the MCO uses a contracted AFC provider agency, the contracted AFC provider agency must provide copies of any licenses for AFC homes of four or more residents when the MCO asks them. 7122 Small houses for one to three residents and members Revision 18-2; As of September 3, 2018, a home foster care provider (AFC) serving up to three residents, including members of the STAR+PLUS Home and Community Based Services (HCBS) program, may be the relative of a member, with the exception of the spouse. While these small homes do not require a license, AFC homes and AFC home providers must meet the standards set out in Annex XXIV, minimum standards for STAR+PLUS AFC Homes and Home Providers. As described in Section 7110, Introduction, if the AFC home provider moves to the AFC member's home, AFC home requirements in Annex XXIV may be waived at the discretion of the managed care organization (MCO) or MCO-contracted AFC provider agency. 7123 MCO responsibilities review 19-1; From 3 June 2019 The responsibilities of managed care organisation (MCO) include: providing information to interested applicants about possible foster care for adult (AFC) homes and coordinating visits to the homes; developing an individual service plan (ISP); coordinator of the interdisciplinary team (IDT); authorize AFC services; evaluation and coordination of services for the Member; notify the member, the home provider of AFC and the AFC provider agency, where applicable, of room, board and copayment amounts, as described in Section 3236, Copayment and Room and Board; processing changes and carrying out annual reassessments of the member; completing an assessment to ensure that the needs of a particular member can be met in a given house; recruiting, contracting and credentials AFC homes and housing providers; processing AFC home and home provider applications; orient and train at home services; approval of private wage earners; ensure that the AFC minimum standards are complied with initially and continuously; carrying out annual requalification assessments of AFC's home and home provider; carrying out administrative evaluations; and processing AFC provider payments. An MCO may also choose to enter into a contract with an AFC provider agency on behalf of the MCO to facilitate the management of AFC home and home providers. When this happens, the contracted AFC provider agency is responsible for the provisions laid down in its contract with the MCO. However, the MCO retains overall responsibility for all with regard to the provision of AFC services and the supervision of the AFC provider agency contracted by MCO and the member. 7130 Adult Foster Care Eligibility Revision 18-2; As of September 3, 2018, applicants and members must meet the basic requirements for star+plus home and community based services (HCBS) and specific specific in connection with AFC. Basic requirements for the STAR+PLUS HCBS program can be found in Section 3230, Financial Eligibility, and Section 3240, Waiver Requirements. AFC applicants or members are identified for the STAR + PLUS HCBS program AFC based on their assessed care needs. See section 7133, classification levels of adult foster care members. 7131 AFC Intake, Assessment and Response to Request for Services Revision 19-1; From 3 June 2019, adult foster care (AFC) will be suitable for persons who, due to physical, mental or behavioural circumstances, are unable to live independently and who need and want the support and safety of family life. AFC may be suitable for individuals who: looking for alternatives to facility care; or interested in leaving institutional care, but are unable to resume independent living. When discussing AFC as an option for applicants or members, the managed care organization (MCO) or MCO-contracted AFC provider must explain the room and board requirements and ensure that the applicant or member understands that he or she must pay a portion of the monthly income for room and board. If the AFC home provider moves to the member's house, payment for room and board does not apply. The MCO must also explain that some members residing in an AFC home are additionally required to contribute to the cost of their AFC services by paying a copayment, regardless of whether the AFC house is the member's house. For more information, see section 7152, Copayment and Chamber and Board requirements. 7132 Review of potential adult foster care homes review 19-1; As of June 3, 2019 If the applicant or member appears to meet the eligibility criteria, the managed care organization (MCO) or MCO-contracted provider shall provide the applicant or member with information on adult foster care services (AFC), including potential AFC providers and AFC housing. The AFC provider agency contracted by MCO or MCO may arrange visits to suitable AFC properties or, if the applicant or member is able or has family/support available, the applicant or member and family may make arrangements to visit potential AFC homes. The purpose of the visits to potential AFC dwellings is to have the applicant or member assess the property and have the AFC home provider assess whether the applicant or member will be a suitable occupant of the AFC home. The AFC provider agency contracted by MCO or MCO may contact the AFC home provider and share information about the applicant or member, including the specific needs and characteristics of the applicant or member, to ensure that the potential AFC home provider is aware of the responsibilities involved in caring for the applicant or member and to prevent a possible mismatch of the applicant or member and the AFC home provider. As part of the review, MCO service coordinators should be mco service coordinators if the applicant or member can be left alone for up to three hours and can document this on Form H1700-A, Justification for STAR+PLUS HCBS Program Items/Services. The MCO service coordinator must inform AFC's home provider directly or via the AFC provider agency contracted by MCO, if applicable. If the applicant or member cannot be left alone, the AFC home provider is responsible for providing or arranging 24-hour supervision. In order to assist the applicant or member in the selection of the AFC property, the AFC provider agency contracted by MCO or MCO relies on the recommendation of the registered nurse (RN) to complete the STAR+PLUS Home and Community Based Services (HCBS) program assessment with respect to the needs of the applicant or member. See section 7133 below, classification levels. If the MCO does not enter into a contract with an AFC provider, the MCO's RN must also assess whether the applicant or member is able to safely evacuate the AFC property. 7133 Classification levels Revision 18-2; As of September 3, 2018, the classification (payment levels) for adult Foster Care Members (AFC) will be used to identify potential AFC applicant or member assessed, and are based on the member's assessed care needs, as determined by the required face-to-face assessments for STAR+PLUS Home and Community Based Services (HCBS) program services and the individual service plan (ISP) completed by the managed care organization's service coordinator (MCO). Determine and document whether an applicant or member is suitable for AFC based on the condition and behavior of the applicant or member. Develop a service plan that suits the needs of the applicant or member and is specific to a particular AFC home provider, taking into account the capabilities of the AFC home provider. The AFC provider agency contracted by MCO would, if applicable, be involved in the identification of the capabilities of AFC home user providers. 7133.1 Levels of adult foster care members review 19-1; From 3 June 2019, the managed care organisation (MCO) will use the Medical Necessity and Level of Care (MN/LOC) assessment, Form H6516, Community First Choice Assessment of Form H2060, Needs Assessment and Task/Hour Guide and addendums. The registered nurse (RN) service coordinator determines the classification level of a member for adult foster care (AFC) services. McOs should take into account limited or greater assistance in carrying out activities of daily life (ACLs) (transfer, walking, dressing, eating, toilets, baths), and behaviors that occur at least once a week in assessment and determination, as well as other identified of the member. Below are the classification levels of a member's daily assistance or supervision requirements. Level I AFC member A member who needs help with identified needs, including a minimum of: one ADL and at least once a week; or two ACLs. AFC Member AFC Level II Member who needs help with identified needs, including at least: two ACLs and behaviour(s) that occur at least once a week; or three ACLs. LEVEL III AFC members A member who needs help with identified needs, including at least: three ACLs and behavior(s) that occur at least once a week; or four ACLs. 7133.2 AFC Home Provider corresponding to AFC Member Levels Revision 19-1; As of June 3, 2019, the Home Care Provider for Adult Care (AFC) must be able to meet the needs of the member in the AFC institution in conjunction with the STAR+PLUS Home and Community Based Services (HCBS) program and other available support. If the member's care needs exceed the capacity of the AFC home provider, the service coordinator of the managed care organization (MCO) must reassess the member and offer alternative care options. The AFC home provider who is a registered nurse (RN) and the AFC home provider RN substitute must provide proof of the current license to the MCO or MCO contracted provider agency (if any) initially and annually thereafter. The MCO RN service coordinator will complete the medical necessity and level of care (MN/LOC) assessment, both first and year after. AFC home providers with STAR+PLUS HCBS program members cannot care for more than a fully dependent AFC resident. The MCO RN service coordinator must respond to a request for a change in service within the individual service plan (ISP) year. Health maintenance activities (MMAs) are tasks that can be exempted from the delegation of registered nurses on the basis of the MCO RN assessment. MMAs may enable the member to remain in an independent environment and go beyond activities of daily life (ACLs) due to the higher skill level required to perform them (as found in the Texas Board of Nursing rules in 22 Texas Administrative Code §225.4(8)). For members residing in Level I, Level II and Level III AFC dwellings not operated by an RN, the skilled nursing needs must be identified by the MCO service coordinator as MMAs; purchased as nursing services on the ISP; provided by Medicare, Medicaid home health or other source; a nurse of a day activity and health services (DAHS) or a combination of the above options. For members residing in level I, Level II and Level III AFC homes operated by an RN, the skilled nursing needs must be identified by the MCO RN service coordinator as MMAs; afc home provider nurse or nurse provided by Medicare, Medicaid home health or other source; or a combination of the above options. AFC members who receive nursing services and who live with an RN and are the AFC provider from home are not eligible for day care and health services (DAHS). 7134 Review of adult protection services and review of foster care for adults 18-2; From 3 September 2018 2018 section provides details on when Adult Protective Services (APS) personnel request adult foster care (AFC) as a resource for individuals who may benefit from AFC. 7134.1 Placing of adult protection clients in the review of foster care for adults 19-1; As of June 3, 2019, Adult Protective Services (APS) may want to move a foster family (AFC) (AFC) to an AFC home where a STAR+PLUS Home and Community Based Services (HCBS) program member resides. The managed care organization (MCO) must approve the APS person and make sure that the APS person is appropriate and document this in the MCO file. This includes determining the: APS individual medical and behavioral health needs are met; capacity of the AFC home provider to meet the needs of the APS individual; and the compatibility of the service provided to the APS person with the provision of services to existing AFC members who can live in the AFC home. If the MCO determines that the placement of the APS person is not appropriate, the APS person may not move to the AFC house and the APS employee must make other housing arrangements. 7134.2 Investigations of investigations of adult foster care providers review 19-1; As of June 3, 2019 Every time Managed Care Organization (MCO) employees of an MCO-contracted foster care (AFC) provider agency suspect abuse, neglect or exploitation (ANE) of an AFC member in an AFC home without a permit, staff must report this immediately to Adult Protective Services (APS). Reports of ANE in a licensed AFC home should be made to the Texas Health and Human Services Commission (HHSC) Regulatory Services Division. The AFC provider agency contracted by MCO must also inform the MCO. If reports of ANE in an unlicensed AFC home are made to APS by other parties, the staff of the AFC provider agency contracted by MCO or MCO may not be informed of members' allegations against an AFC provider until the allegations have been validated. However, the APS staff may request the provider agency contracted by MCO or MCO to assist in the provision of alternative services during the course of the investigation if the alleged mistreatment poses an immediate threat to the safety of the member or other AFC residents. The MCO handles disenrollment and corrective action against the AFC home provider, if any. HHSC takes the necessary licensing actions for licensed AFC homes. If HHSC terminates the licensing of an AFC property and the MCO is unable to find a suitable alternative residence for the member, the member will be referred to APS for assistance in moving the AFC home. A member in an AFC residence without a permit that has permission may decide not to move from the AFC house, even if the claim has been validated. In this case, the member's AFC services will be refused, payments to the property will be terminated and an MCO-contracted provider agency will withdraw from the support of from the house. However, the member may continue to live in the AFC house without a permit by entering into a private remuneration arrangement in that house. If a member who lives in an unlicensed AFC property and does not appear to have the possibility of consent refuses to move from an unlicensed AFC property in which a person identified as the offender resides in a case of validated ANE and is in a state of ANE, the MCO must make a reference to APS. The staff of the AFC provider agency contracted by MCO must send a referral to the MCO and APS if the agency's staff identifies this situation. If ANE's substantiated claim is in a licensed AFC home, the offender must be removed from the AFC home and the licensee must submit to HHSC a plan to protect the health and safety of all residents. The resident doesn't have to move. 7135 Individuals in Adult Foster Care Overhaul 18-2; From 3 September 2018, home care providers (AFC) will be able to hire individuals. The AFC home provider should contact the managed care organization (MCO) when considering admitting a private salary person before he or she is accepted into the AFC home. The purpose of the approval is to determine the: suitability of AFC for the private remuneration individual based on the condition of the individual and the behavior; capacity of the AFC property to meet the needs of the private payment group; and the compatibility of the service provided to the private sector and the provision of services to AFC members. If the MCO determines that placement in an AFC property is inappropriate, the AFC home provider cannot accept the private payment person. Any placement issues should be resolved by the MCO. 7140 Adult Foster Care Managed Care Organization Procedures Review 18-2; As of September 3, 2018, this section includes details for a managed care organization (MCO) in determining the suitability of an applicant for adult foster care (AFC) and for developing the applicant's individual service plan (ISP). 7141 Review of the eligibility provision 18-2; As of September 3, 2018 To determine whether foster care (AFC) qualifies for foster care (AFC), the Managed Care Organization (MCO) must determine that the applicant or member meets all criteria for the STAR+PLUS Home and Community Based Services (HCBS) program and complete an assessment to determine the classification level of the applicant or member. If the AFC placement is with an individual AFC home provider contracted with the MCO, the MCO must also ensure that the applicant or member has an agreement with a registered AFC home provider and the applicant or member and or home provider are appropriately tailored to the classification and needs of the applicant or member before the MCO pays for AFC services. If an MCO offers contracts with an AFC provider agency to perform AFC management services, the provider agency contracted by MCO may activities related to the qualification of the home and the home provider before the MCO pays for AFC services.

See Section 7133, Classification Levels. 7142 Review of the planning of services 19-1; From 3 June 2019, the member's care plan will have to address functional, medical, social and emotional needs and how the adult foster care (AFC) home provider will respond. The managed care organization (MCO) should assess whether other resources in the community should be used to meet the member's specialized needs. The use of these resources should be documented in the member's care plan. The MCO must complete Form H6516, Community First Choice Assessment or Form H2060, Needs Assessment Questionnaire and Task/Hour Guide, Part A, Functional Needs Assessment to document the specific personal assistance tasks with which the AFC home provider must assist the member. The AFC home provider may provide more services for the member than identified on Form H2060 as the changing needs of the member may justify, but may not reduce or discontinue services without consulting the MCO or MCO-contracted AFC provider agency. After approval for AFC, the MCO determines whether the member has special needs that require additional control in the AFC House. The MCO must document all special needs or interventions in the file on form 2327, individual/member and provider agreement. Use the space Other special arrangements under the Various Arrangements section. The AFC provider agency contracted by MCO or MCO will contact the member and the AFC home provider to arrange the first visit and a negotiated relocation date for the member or the AFC home provider. If there are health issues related to the member, the MCO nurse may be consulted and a recommendation can be made for the member to have a physical or medical examination before going to the AFC house. The MCO coordinates with the interdisciplinary team (IDT) and the AFC home provider contracted by MCO, if applicable, with respect to the care of the AFC member. 7150 Completion of the care review plan of paragraph 19-1; With effect from June 3, 2019 On or before the date the member begins receiving adult foster care services (AFC), a face-to-face meeting with the member and the AFC provider of the home club is required to discuss the member's care plan (POC) and complete Form 2327, individual/member and provider agreement. The interdisciplinary team (IDT), including the staff of the AFC provider contracted by managed care organisation (MCO), if applicable, and the member and/or family, the authorised representative (AR) or guardian may be included in the meeting. The meeting should preferably be in the AFC house. The MCO should discuss the POC of the member and/or the family, AR or guardian and gain insight with them on how the AFC home provider will meet the member's needs. This discussion should be the member and the family, AR or guardian that the AFC home provider is sufficiently willing to provide services to the member and that adjustments run smoothly. The MCO must document the POC and any special needs of the member or special agreements between the member and AFC home provider on Form 2327. If the applicant or member is already in the AFC House, Form 2327 must be personally completed by the MCO service coordinator with the applicant or member and the AFC home provider or provider agency, if applicable, before the MCO pays for AFC services initially and at an annual reassessment. 7151 members and review of the AFC agreement for home providers 19-1; As of June 3, 2019, the managed care organization (MCO) will document the service arrangements and the consent of the room and board payment on form 2327, Individual/Member and Provider agreement. The MCO or the MCO-contracted adult foster care (AFC) provider agency checks all information about the agreement with the member, family, authorized representative (AR) or guardian and the AFC home provider. All the terms of the agreement and the following topics should be discussed in the discussion: A full description of the member's care needs and the frequency of the services required. The need and frequency of surveillance. The start and end dates on Form 2327. A detailed description of the rights and responsibilities of the member and the AFC home provider. An explanation of the right of the home provider and AFC to privacy and confidentiality. The monthly dollar amount the member agrees to pay the AFC home provider for room and board, as documented on Form 2327. The arrangements for a trust fund if the member of the STAR+PLUS Home and Community Based Services (HCBS) program member requests such a service from the AFC home provider. An inventory of the AFC member's personal belongings. The names, addresses and telephone numbers of the persons required to be notified in an emergency, including the member's doctor, family members and/or AR or guardian. Any special habits and needs of the member and any special arrangements or agreements between the member and the AFC home provider. Any additional training needs of the AFC home provider and methods to obtain that training. The rights and responsibilities of both the member and the AFC home provider for reporting the MCO, MCO-contracted AFC provider agency, if applicable, of problems such as illnesses, side effects, hospitalizations, acts of violence, accidents or complaints of abuse, neglect or exploitation. The Texas Health and Human Services Commission (HHSC) Managed Care Compliance & Operations (MCCO) should be informed if the member, the PROVIDER contracted by MCO or the home provider of AFC have a complaint or issue regarding the health and safety of the member. Other conditions that reflect changes in the condition of the member that may affect the afc services. The MCO or MCO-contracted provider agency should fully discuss with the AFC home provider the options for transition issues that arise after the member moves to the AFC home or when the AFC home provider moves to the member's home. The discussion should include reporting procedures and appropriate measures to address problems and problems, and the impact of a new housing situation on the family and other residents in the home. The member and the AFC home provider must sign Form 2327 after all of the above issues have been discussed and both parties agree. Form 2327 must be completed and signed before AFC is authorized and reautified. Significant changes to the terms of the agreement must be reported by AFC's home provider within five business days. All incidents, as stated in Appendix XXIV, minimum standards for STAR +PLUS AFC Homes and Home Providers, must be reported by the AFC home provider to the MCO service coordinator assigned to the member, and the AFC provider agency contracted by MCO, if applicable, within 24 hours of the incident. 7152 Copayment and Chamber and Administrative Requirements Revision 19-1; As of June 3, 2019, Copayment and Chamber and Board will apply to members of adult Foster Care (AFC), as described in Section 3236, Copayment and Room and Board. If the AFC service is offered in the member's own home, the member is not required to pay room and board. It is the responsibility of the managed care organization (MCO) to ensure that the member and the MCO-contracted AFC provider agency, if applicable, are informed in writing on Form 2327, Individual/Member and Provider Agreement when board and board are terminated. It is the responsibility of the MCO-contracted AFC provider agency to notify the AFC home provider when space and board are waived. The copayment, if applicable to the member, may be waived. If copayment applies, the AFC member's copayment amount is listed on Form H2065-D, Notice of Managed Care Program Services, which is sent to the member by the Program Support Unit (PSU) staff and uploaded to TxMedCentral. Form H2065-D is used to notify the member of the contract for the first month of the authorized service and the following months. The MCO delivers a copy of Form H2065-D to the AFC home provider. The room and board amount, if applicable, shall be entered on Form H2065-D and Form 2327. The member does not pay a room and board if the AFC withdraws home provider from the member. The contracted by MCO or MCO must ensure that the member's home provider and AFC understand that the room and board arrangement with the AFC home provider is separate from the MCO payment for AFC services. The member pays the AFC home provider the room and board amount listed on Form 2327 and Form H2065-D. If the member moves to the AFC house in the middle of the month, the amount of board for the month will be prorated and the member and AFC home provider will be informed about the prorata amount. If the copayment and/or room and board amounts change, the MCO must inform the home provider of AFC and the member of the new amount before the change, as described in Article 3239, Copayment Changes. The member must pay the copayment and room and board of directors costs by the eighth day of the month. If the member does not pay the required fees, the member may not be eligible for STAR+PLUS Home and Community Based Services (HCBS) program AFC Services. The STAR+PLUS HCBS program AFC home provider must collect the member's copayment. The AFC home provider must keep the receipts for all copayments collected. AFC's home provider must deduct the copayment amount authorized on Form H2065-D from repayment claims filed with the MCO or notify the AFC provider agency contracted by MCO of the amount collected. If a STAR+PLUS HCBS program AFC member does not pay the copayment and/or room and the board, the AFC provider agency contracted by MCO or MCO must investigate the member's omission, including contacting the member to find out why the fees were not paid. Even if there is a legitimate reason, such as the income check the member is not received by the eighth day of the month, the member is still required to pay the fees. Grievances between the member and the AFC home provider are not legitimate reasons for the member to withhold payments due. Such complaints should be resolved through the intervention of Texas Health and Human Services Commission (HHSC) Managed Care Compliance & Operations (MCCO) and the MCO. If the member refuses to pay the fees or there is no legitimate reason not to pay, the MCO writes a letter to the member's member or representative (AR) representative explaining the consequences of the continued refusal to pay. If the member does not pay the required fees within 30 days of the expiration date, the MCO afc services may terminate to the member. If STAR+PLUS HCBS program AFC is delivered in the AFC home provider's home, the member can then be evicted from the home, according to local eviction regulations and procedures. 7153 Review of trust funds 19-1; As of June 3, 2019, the managed care organization (MCO) must offer money management assistance from the adult home care provider (AFC) to the member and document it when the member accepted or refused the assistance. If the member shows an interest in money management, the MCO documents the expressed interest on Form H2067-MC, Managed Care Programs Communication and sends the form to the AFC home provider. The requirement for services money management can also be documented on Form 2327, individual/member and provider agreement. The AFC home provider must maintain trust fund records. The AFC home provider must: have written permission from member, his or her guardian, power of attorney or applicable person to deal with the personal financial affairs of the member; keep member trust accounts separate from the AFC home provider's business accounts. The separate account must be identified Trustee (name of the STAR + PLUS Home and Community Based Services (HCBS) program AFC home provider), Member's Trust Fund Account. If the AFC home provider maintains a trust fund, the AFC home provider must: deposit the member's monthly income into the account; and write a check for the copayment and the room and board payment from the trust fund account in the AFC home provider operating account. Staff may not deposit the member's monthly income into the company account and then transfer the personal needs and room and expenses allowance to the trust fund account; make member trust fund data available for assessment by the MCO or AFC Home Provider Office during working hours without prior notice; do not charge the member for services that the AFC home provider is expected to provide for the member; do not charge the member for banking services if the member's trust fund is in a merged account; obtaining and tracking the current written individual data of all financial transactions relating to the personal funds of the member who handles the AFC home provider. AFC's home provider must include at least the following in the records: the member's name; identification of the representative or responsible party of the member; date of admission; earned interest from the member; and transactions - the AFC home provider can choose one of the following options: tracking the date and amount of each deposit and withdrawal, the name of the person who accepted the withdrawn funds and the balance after each transaction. Any withdrawal must be signed by the member. If the member is unable to sign when money is withdrawn from his/her trust funds, the transactions or receipt must be signed by a witness other than the AFC provider or employee/contractor of the provider; keep signed receipts indicating what the funds included were spent on, the date of expenditure and the amount spent. The receipt must be signed by the person responsible for the money and the member. If the member is unable to sign his or her name, a witness other than the provider's home provider, employee or contractor must sign the transaction or receipt; and to divide the interest earned on a pooled interest bank account into one of the following options: pro rata of each member on the basis of an actual interest rate; or pro rata of member based on his or her end-of-quarter balance. The following information shall be included on receipt for all the money received or deposited into the member's trust fund: the name of the member; date on which the money was received; source of the money; amount received; And And if applicable, return to the member. All information relating to the member's trust fund shall be kept in the manner set out above and available for verification without prior notice. 7154 Hospital leave revision 18-2; As of September 3, 2018 If a member receives adult foster care (AFC) services in an AFC home that is not the member's home, the member may be required to reserve the space during the hospital stay by paying the daily bed hold fees, if the provider requires such a fee, which is the negotiated daily rate of the managed care organization (MCO) pays the AFC home provider or MCO-contracted provider agency. The AFC home provider does not invoice the MCO for the days when the STAR+PLUS Home and Community Based Services (HCBS) program AFC is included. The AFC member's charge is the full payment to the AFC home provider or the AFC provider agency contracted by MCO when an AFC member is in hospital. During the first home visit, the AFC provider agency contracted by MCO or MCO assesses the afc member's responsibility to pay for a waiting book when he is at home and documents it on Form 2327, Individual/Member and Provider Agreement. Hospital leave does not apply when the AFC home provider moves to the member's house. 7155 Authorisation of the review of foster care for adults 19-1; As of June 3, 2019 After star+plus home and community based services (HCBS) program eligibility and all additional foster care (AFC) procedures are completed, the Managed Care Organization (MCO) authorizes AFC on Form H1700-1, Individual Service Plan (Pg. 1). Employees of the Program Support Unit (PSU) send the member Form H2065-D, Notification of managed care program services. The MCO sends the following completed documents to the AFC home provider and MCO-contracted AFC provider agency, if applicable: a copy of Form H1700-1; additional applicable ISP forms: Form H2060, Needs Assessment Questionnaire and Task/Hour Guide, or Form H6516, Community First Choice Assessment; Medical necessity and level of care assessment; and Form 2327, Individual/Member and Provider Agreement. 7160 Review quality of care 19-1 check; From 3 June 2019, the registered Nursing (RN) Service Coordinator (Managed Care) (RN) will monitor the quality of care and service provided to meet the needs of the members of the STAR+PLUS Home and Community Based Services (HCBS) programme receiving the adult Foster Care Services (AFC). The service coordinator will appropriately address all identified issues to improve health and protect the member. During regular verification visits, the MCO RN service coordinator should contact mco management and the MCO-contracted AFC provider agency, if applicable, if afc's home provider does not meet the needs of the member or home provider, needs additional support or training to meet the The physical and medical condition of the AFC member should be carefully monitored to determine whether the initial problems have been resolved and/or new problems arise as a result of reduced functional capacity or disease. Form 2327, Individual/Member and Provider Agreement (see No 1 under Various Arrangements), is used to document special monitoring schedules and other resources used in the care plan (POC). When the AFC home provider withdraws from the AFC member, it is the MCO's responsibility to ensure that the afc member's needs are met and there are no health and safety concerns. If problems are reported or identified, the rights of the AFC member should be protected and the adjustments to the care plan should be implemented accordingly. 7170 Major amendments review 18-2; As of September 3, 2018, it is the joint responsibility of the managed care organization (MCO) and the contracted adult foster care (AFC) home provider, or MCO-contracted AFC provider agency, to ensure that the AFC member is in an appropriate setting to meet his or her needs. When the AFC member has a change in functional need, medical status or behavior, it is the responsibility of the AFC home provider to notify the AFC provider agency contracted by MCO or MCO within 24 hours. The MCO should follow up with the affiliated and AFC home provider to determine whether changes to the care scheme are needed. The MCO should give special attention to members who have significant changes in functional need, medical status or behavior that may mean AFC services are no longer appropriate. Family members and/or authorized representative (AR) or guardian should be notified of these changes and the MCO service coordinator should discuss with them and the member how the member can remain in the AFC House. If the member has had a decrease in his or her medical condition or functional ability, the MCO RN service coordinator must determine whether a visit should be made to assess the member's medical status. Long-range care plans should be fully discussed with the member and/or the family, AR or guardian and the AFC home provider to ensure that everyone is aware of the potential and limitations of AFC services for members with deteriorating medical or functional conditions. Members who become unfit for AFC should be informed of other available options. In this decision-making process, assistance should be provided to members and family, AR or guardian and, if necessary, with transfer activities. If the AFC home provider decides that the member is no longer suitable for AFC, the AFC home provider should contact Mco. The MCO is responsible for preparing the member for the transition when the member becomes inappropriate for a particular AFC home or AFC services. 7171 Termination of the review of foster care services for adults 19-1; As of 3 June 2019 During the stay of a member in an adult foster home (AFC) (AFC) changes in his or her condition or the care required. If the member needs services that cannot be provided by the AFC home provider, the managed care organization (MCO) must consult with the AFC home provider about the member's increased needs to ensure that the necessary care is obtained. Another provider, such as a Home and Community Support Services Agency (HCSSA), can provide skilled care in the AFC home. If the skilled services provided by the provider, such as an HCSSA, are not sufficient and other services are not available to support the member, the MCO, in cooperation with other members of the interdisciplinary team (IDT), should explore alternatives. The AFC home provider is expected to take action if the member's condition deteriorates or the member is a threat to his or her own health and safety or the health and safety of others. The AFC home provider is required to notify the AFC provider agency contracted by MCO and MCO, if applicable, of actions taken on the same day of consciousness. Where necessary, the MCO shall follow the procedures laid down in Article 7172, discharge and termination for health and safety reasons. AFC home providers cannot reduce or terminate AFC services to members without prior approval from the MCO and must follow procedures for providing a 30-day written notice, except for a member whose conduct or condition threatens the health or safety of him or her or others. During the 30 days following the written notification to the member, the MCO shall be responsible for working with the member to ensure that alternative services are available. Once a member is identified as inappropriate for AFC, the MCO must negotiate a time frame with the member, family, authorized representative (AR) or guardian and the AFC home provider for the member to have a deputy individual service plan (ISP). The time frame shall be determined on a case-by-case basis, depending on the urgency and seriousness of the situation and how quickly an appropriate placement can be arranged. If the member has been a threat to the health and safety of other (s) or engages in inappropriate behavior that require the member to move immediately, the MCO should make every effort to find another housing arrangement as soon as possible. If other residential arrangements are not readily available to the member, the MCO must refer the member to Adult Protective Services (APS) to help find the right placement. If there is resistance to the relocation of the member, family, AR, guardian, or AFC home provider, additional support from the IDT may be needed to resolve the issue. The advises program support unit (PSU) employees to send Member Form H2065-D, Notification of Managed Care Program Services, by Form H2067-MC, Managed Care Programs Communication, to TxMedCentral to deny AFC services. The MCO follows PSU action by advising the member and the AFC home provider on the termination date of the AFC services listed on Form H2065-D. If the member switches to another AFC home or STAR+PLUS Home and Community Based Services (HCBS) program housing scheme, the MCO must notify the member and the AFC home provider of the change in services. If the member does not switch to another AFC or STAR+PLUS HCBS program and all STAR+PLUS HCBS program services are terminated, the MCO informs PSU employees by uploading Form H2067-MC to TxMedCentral. PSU employees will send the member form H2065-D and upload a copy of the form to TxMedCentral within three business days of uploading Form H2067-MC. If no services are provided in the member's home, the AFC home management provider has the right to initiate eviction proceedings as specified in the residents' rights and responsibilities of the AFC home provider. The MCO must ensure that the member and the delegate understand the consequences of expulsion. If the AFC home provider must use eviction procedures and the member has refused to make other housing arrangements, the MCO must refer the member to APS. If the member and the AFC home provider decide that the member remains in the house as a private payer, the MCO must give approval. The MCO should also ensure that the affiliated and AFC home provider understands that there are no MCO case management services or payment arrangements for a private payment member. For more information on how to deal with situations where the AFC member threatens the health and/or safety of himself or others in the AFC Home, see Section 7172, discharge and termination for health and safety reasons, below. 7172 Discharge and termination as a result of health and safety review 18-2; With effect from 3 September 2018, any member residing in the foster care of the foster care (AFC) whose medical condition, conduct or mental health threatens the health and/or safety of him or others shall be dismissed without notice from the AFC Home. The AFC home provider must take appropriate action if the member's medical condition deteriorates and requires more skilled intervention to ensure the health and safety of the member. Depending on the condition of the member, appropriate action may include calling emergency medical services, the member's doctor or the service coordinator of the managed care organisation (MCO) working with the member or the AFC provider agency contracted by MCO, if applicable. The AFC home provider must take action and notify the MCO on the same day that the AFC home provider is becoming aware of the need to respond to a change in the member's medical condition. The MCO should work with the AFC home provider or with providers of other services to arrange alternative services to meet the member's needs. Where the member's conduct ensures that the member has the health and safety of him or or others, the AFC home provider must take appropriate action, including calling the police or sheriff's department, the member's doctor, and includes the MCO service coordinator or MCO-contracted AFC provider agency, if applicable. The member should be removed from the AFC House as soon as possible if the member becomes a threat to the health or safety of him or her or others. In some cases, the MCO may call Adult Protective Services (APS) if hospitalization for psychiatric observation seems justified. The MCO must provide the member with a letter on the determination of a negative provision within three days of receiving information concerning an incident that justified the involuntary removal of the member from the AFC House. The effective date on the unfavourable determination letter shall be the date on which the form is dated and emailed/given to the member, even if the decision is appealed. Although the member cannot be denied all services through the STAR+ PLUS Home and Community Based Services (HCBS) program, the member has the right to appeal the decision of removal from the AFC home. The member may not remain at home during the appeal suit in the STAR+PLUS HCBS programme AFC. The MCO must work with APS or providers of other STAR+PLUS HCBS program services to arrange alternative placement for the member. In circumstances where the AFC home provider has moved in with the AFC member at home, the AFC member has the right to request termination of the contract at any time by contacting the AFC provider contracted by MCO or MCO and requesting assistance with the expulsion of the AFC home provider. The MCO should ensure that other STAR+PLUS HCBS program service options are offered if the AFC scheme is terminated. 7180 Annual review of afc paragraph 19-1; As of June 3, 2019 In addition to the regular reassessment of the STAR+PLUS Home and Community Based Services (HCBS) program, which includes the Managed Care Organization (MCO) registered nursing (RN) service coordinator completing the Medical Necessity and Level of Care, Form H6516, Community First Choice Assessment, or Form H2060, Needs Assessment Questionnaire and Task/Hour Guide, and addendums, and individual service planning (ISP) documents, the MCO or MCO-contracted adult foster care (AFC) provider agency must also continue to meet all eligibility requirements and complete Form 2327, Individual/Member and Provider Agreement. 7200 Review of assisted living services 18-2; As of 3 September 2018 7210 Introduction review 19-1; As of June 3, 2019, this section will apply to the STAR+PLUS Home and Community Based Services (HCBS) Assisted living services (AL) offer a 24-hour housing scheme for people who are unable to continue to function independently in their own home due to physical or mental disabilities. Services are provided in personal care facilities authorised by the Health and Human Services Commission (HHSC). Star+PLUS HCBS program members are responsible for their room and board costs and, where applicable, copayment for AL. The purpose of AL services is to promote the availability of appropriate services for the elderly and disabled in a domestic environment to enhance the dignity, independence, individuality, privacy, choice and decision-making capacity of the individual. The personal care institution must provide each individual with a separate residential unit to ensure their privacy, dignity and independence. 7211 Housing Options Licensed Personal Care Facilities Revision 19-1; From June 3, 2019, the apartment assisted living (AL) can be an efficient or one or two bedroom apartment, and each apartment must have its own bath and cooking facilities. An AL institution without an apartment is defined as a licensed personal care institution with residential units that do not meet the definition of an AL apartment, may have double occupancy and must be: detached; and a permit for 16 or fewer beds. STAR+PLUS Home and Community Based Services (HCBS) program AL contracts specify whether the facility is contracted to provide services under the housing options of AL or AL Non-Apartment. The provider may not provide STAR+PLUS HCBS program services in a housing option for which the provider does not have a contract to provide services. If a provider wishes to keep both AL (single occupancy) and AL apartments (double occupancy) in one facility, the member's contract must specify that information. If the AL provider wants to limit the types of apartments in the facility available to star+plus HCBS program members, the provider must specify these restrictions in the contract, either at the time of signing or by modification. The apartments in question must meet all qualifications as specified in this section. If there are no such specifications in the contract, all types of apartments in the facility should be available to star+plus HCBS program members. If the provider limits the type of apartment available to STAR+PLUS HCBS program members and no apartment of that size is available, they may refuse to accept a STAR+PLUS HCBS program member, based on the fact that no space is available. This applies either to a member who wants to move to the facility from the outside, or to a private pay member who is currently in the facility and who joins the STAR+PLUS HCBS program. The member would then have the option to review other available AL facilities (ALFs) in the area or foster care for adult (AFC) dwellings. Detached is defined as not physically connected to approved nursing home, hospital or other approved personal care facility, unless the total licensing capacity of both personal care facilities does not exceed 16 beds. For physical connection, at least a covered walkway between buildings is required. To the request, portable kitchen units can be removed from the living room. 7211.1 Single Occupancy Apartments Revision 19-1; From June 3, 2019, an assisted living apartment environment (AL) will be defined as a single-person apartment that is a private space with individual living and sleeping areas, a kitchen, bathroom and ample storage space, as specified in the following: The apartment must have at least 220 square meters, excluding the bathroom. Apartments in pre-existing structures to be renovated should be a minimum of 160 square meters, including the bathroom. The kitchen is a space equipped with a sink, refrigerator, a cooking appliance that can be removed or disconnected, sufficient space for food preparation and storage space for utensils and supplies. A cooker can be a stove, microwave or built-in surface unit. The bathroom should be a separate room in the individual's living room with a toilet, sink and an accessible bath. The bedroom must have a single occupancy, except when the member applies for double occupancy. 7211.2 Double occupancy apartments Revision 18-2; As of September 3, 2018, an assisted living apartment (AL) must be a dual-occupancy apartment with a connected bedroom, kitchen and bathroom that provides at least 350 square feet of space per participant and meet the following specifications: Indoor common areas used by STAR+PLUS Home and Community Based Services (HCBS) program members can be included in calculating the minimum square meters. The part of the allocated common area shall not exceed usable square metres divided by the maximum number of persons having access to the common areas. The kitchen must be equipped with a sink, refrigerator, a cooker that can be removed or disconnected, sufficient space for food preparation and storage space for utensils and supplies. A cooker can be a stove, microwave or built-in surface unit. 7220 Description of the revision of services 19-1; As of June 3, 2019, the assisted living service (ALF) must provide 24-hour care in a personal care facility approved by the Texas Health and Human Services Commission (HHSC). Services include, but are not limited to: Home management – Assisting with household-related activities that are essential to member health and comfort, including changing bedding, cleaning, money laundering, shopping, storing purchased items and washing dishes. Transportation and escort - Providing and/or arranging transportation to: local community shopping areas where a member can buy items to meet his or her needs; recreational activities, excursions on site or by community; and the nearest available provider that can provide medical care that may include medical appointments, therapies and other medical care, unless arrangements are made to transport the member to medical care of the member. Licensure as a personal care facility requires the facility to use soap and toilet paper at all times for the use of members. Other personal items must be purchased by the member. Star+PLUS Home and Community Based Services (HCBS) program members who receive assisted living (AL) are entitled to medical transportation services through Medicaid for medicaid medical appointments. STAR+PLUS Home and Community Based Services (HCBS) program members receiving assisted living (AL) are entitled to receive medical transportation services through Medicaid for Medicaid-covered medical appointments. The ALF personnel are responsible for planning the transport according to the medical transport procedure. If the STAR+PLUS HCBS program member wishes to attend an activity outside the facility, which is not a group activity sponsored by the facility, the member is responsible for paying for his or her own transportation. 24 - Hourly checks — Periodic checks or visits to a member during each eight-hour shift to ensure that the member is safe and well. Meal services include: planning, cooking and serving three meals a day that are essential for the health and well-being of the member. Meals must be suitable in quantity and sufficient to meet and maintain nutritional needs, including those of members of special needs; and provide 100% of the recommended daily dietary allowance for adults, as recommended by the U.S. Department of Agriculture (USDA); providing special diets as required by the member's service plan; providing nutritional advice and nutrition information for the member; assist the Member with his or her meals, if necessary, including changes to the food texture, including grinding meat and mashing vegetables for members who have difficulty chewing; and food management, including help with spoon feeding in cases where the member is temporarily ill, bread bones and milk opening for members with hand deformities, paralysis or hand vibrations. Social and recreational activities include: organising activities that require group and member-initiated activities; opportunities to communicate with other people; providing interaction, cultural enrichment, educational or recreational activities, and other social activities on the ground or in the community in a planned programme to meet the social needs and interests of members; offering four planned social activities per week; and placing a monthly social or recreational activity at least a week in advance. Personal care tasks should be provided, as indicated on Form H2060, Needs Assessment Questionnaire and / Hour Guide, or Form H6516, Community First Choice Assessment, identified on the individual service plan (ISP) and approved by the MCO. A registered nurse (RN) must carry out the medication administration assessment. The AL provider is responsible through its licensing requirements for providing the administration of medications, which is the direct administration of all medications, or the assistance with or supervision of medication. This This injections, if necessary. Only a licensed nurse can give injections. The personal care institution may provide more services for the member than identified in the ISP, but no fewer services. 7221 Requirements for the revision of assisted living 19-1; As of June 3, 2019, members of the STAR+PLUS Home and Community Based Services (HCBS) program must accommodate members who wish to stay in a personal care facility in an assisted living license (ALF) contracted with the managed care organization (MCO) to provide STAR+PLUS HCBS program services. Licensing rules define a personal care facility as a facility that provides food, shelter, and personal care to four or more individuals who have no ties to the owner. The member is required to pay room and board, and possibly a copayment based on income in the assisted living (AL) institution. For detailed information, please refer to Article 3230, Financial Eligibility. 7222 Initial responsibilities for members residing in ALFs review 19-1; As of June 3, 2019, the managed care organization (MCO) is responsible for assisting the applicant or member in selecting an assisted living facility (ALF) that can meet his or her needs. The MCO sends an authorization to the ALF that selects the applicant or member. THE ALF staff must explain the copayment requirement and room and administrative expenses described in Section 3236, Copayment and Chamber and Board, and Annex VI, STAR+PLUS survey chart, to the applicant or member. Room and board must be paid for by each STAR+PLUS Home and Community Based Services (HCBS) program ALF applicant or member. A copayment is not required from supplemental security income (SSI) recipients. A carbon tax is required of al members whose financial suitability has been established on the basis of the special institutional criteria. The MCO should: determine the board of the applicant or member and board and copayment amounts, based on the Form H2065-D, Notice of Managed Care Program Services, received from Program Support Unit (PSU) personnel, for the first month of service and the ongoing copayment amount for subsequent months; document the amounts on Form H1700-1, Individual Service Plan (Pg. 1); inform the applicant or the member orally; send a copy of Form H2065-D to the supplier to notify the amounts to be 50 000 euros; and assist the applicant or member and provider in resolving problems relating to the collection of the applicant's or member's copayment and the parliamentary and administrative contributions. See section 3236 for copayment and room and board guidance. 7223 Admission to a review of the assisted living facility 19-1; 3 June 2019 For admission, the managed care organisation (MCO) faxes or e-mails to the assisted living institution (ALF): Form H1700-1, Individual Service Plan (Pg. 1); Form H1700-2, Individual Service Plan (Pg. 2); Form H1700-3, Nursing Plan; Form H1700-B, Non-STAR+PLUS HCBS HCBS Services; and Form H6516, community first choice assessment of form H2060, Needs Assessment Questionnaire and Task/Hour Guide, and Form H2060-A, Addendum to Form H2060; and form H2065-D, Notification of Managed Care Program Services. The STAR+PLUS Home and Community Based Services (HCBS) program ALF provider is expected to give the new member a tour of the ALF, including staff and resident introductions. Members are encouraged to bring basic furniture for bedroom spaces. In the event that the Member does not provide his or her own furniture, the facility must provide for each member: a bed with mattress; chair; table or dresser; drawer room; and locked closet space for clothing and personal belongings. The furniture supplied by the ALF must be maintained in good condition. 7224 Personal Care 3 Revision 19-1; From June 3, 2019, applicants or members with severe personal care needs who choose to stay in assisted living (AL) non-apartment settings may be approved for personal care 3 level services. Classification of a STAR+PLUS HCBS programme applicant or member at the level of personal care 3 is based on the assessed needs of the applicant or member, as evidenced by a value of two or more in one or more of the activities of daily life (ACLs) of transfer, eating or toileting, as assessed on medical necessity and level of care (MN/LOC) Assessment, Section G, Functioning Physical and Structural Problems, Column A, Self-Performance. During the first pre-registration assessment and annual reassessment, the nursing of the managed care organization (MCO) completes the MN/LOC Assessment and uses the information recorded for transferring, eating or toilets to make a recommendation about the needs of the applicant or member at the Personal Care 3 level. The recommendation is included on Form H1700-1, Individual Service Plan (Pg. 1). At the time of initial certification and annual reassessment, the MCO must verify Form H1700-1 to determine whether the applicant or member who chooses to stay in an AL institution without an apartment is identified as meeting the Personal Care Level 3. If the director nurse does not give a recommendation for Personal Care 3 level, the MCO must contact the nurse to obtain a Personal Care 3 level. The MCO documents the nurse's recommendation in the case. The MCO must inform the applicant or member that he or she meets the level of personal care 3 and ensure that the applicant or member is aware of all facilities contracted to provide care at level of personal care 3 by presenting a list of AL facilities that specifically identify the Personal Care 3 facilities. The MCO authorizes the personal care fee 3 if the applicant or member meets the level of personal care 3 and chooses to stay in a contracted Personal Care 3 facility. Changes may occur in a The health of HCBS program members during the individual service plan (ISP) year that may result in the member needing a greater level of care in an AL facility (ALF), or going to an AL institution from a community setting. The MCO should review the latest MN/LOC assessment to determine the care provider's recommendation regarding the level of the member's personal care and ensure that the member is given a choice of ALFs contracted at the personal care level 3 to provide a higher level of care. The designation of an ALF as a personal care 3 facility is determined in the contracting process. To qualify as a Personal Care 3 facility, the ALF must meet the following requirements: a personal care facility with a permit for four to sixteen beds in a non-apartment environment; offer 60 percent or more of its STAR+ PLUS HCBS program members with a single occupancy bedroom; during day and evening shifts, a minimum staff ratio of one direct care staff for each of the four members and at least one direct care staff member for every eight members during the night shift; and at least 60% of the total members served each month should need at least one-to-one staff assistance, as shown by a value of three or more in one or more of the ACLs of transfer, food or toilets, as assessed on the MN/LOC assessment. 7230 Other services available to Members Review 19-1; As of June 3, 2019, the following services will be provided according to the member's needs, as permitted on the individual service plan (ISP), as a STAR+PLUS Home and Community Based Services (HCBS) program service and not included in the daily rate (assisted living). The managed care organization (MCO) makes referrals for the services and coordinates the delivery. Adaptive devices and medical supplies - The STAR+PLUS HCBS AL Member Program is eligible for the necessary adaptive devices and medical supplies under the STAR+PLUS HCBS program. Adaptive devices and medical supplies are defined as medical devices and supplies that include devices, controls, or devices specified in the Care Plan (POC) that enable members to increase their ability to perform daily activities (ACLs) or to observe, monitor, or communicate the environment in which they live. For a list of adaptive devices and supplies that can be purchased through the STAR+PLUS HCBS program, see Section 6410, list of adaptive devices and medical supplies. Small home modifications (MMCs) — Services that assess the need, regulate changes and/or improvements in a member's home to enable the member to live in the community and to ensure safety, safety and accessibility. Minor changes to the home are limited to the changes identified and approved by the MCO on the ISP and apply only to type A facilities. (See Title 40, Texas Administrative Administrative §92.3, Types of assistance facilities.) Occupational therapy (OT) — Interventions and procedures to promote or improve safety and performance in the instrumental activities of daily life, education, work, play, leisure and social participation. OT services consist of the full range of activities offered by a licensed occupational therapist or a licensed occupational therapy assistant (OTA), if led by a licensed occupational therapist, within the scope of the State licensure. Physiotherapy (PT) — Specialized techniques for evaluation and treatment related to functions of the neuro-musculo-skeletal systems. PT services consist of the full range of activities undertaken by a licensed physical therapist or a licensed physical therapy assistant (PTA), led by a licensed physical therapist and under the state license. Speech therapy (ST) — The evaluation and treatment of disorders, disorders or deficiencies related to a member's speech and language. Services include the full range of activities undertaken by licensed speech and language pathologists under the scope of the pathologist's state license. Nursing Services — Services provided by an approved registered nurse (RN) or licensed professional nurse (LVN) under the State Licensure. Nursing services can be brought

into the personal care facility for the member. If the expected cost of the member's services exceeds the annual cost limit, the MCO will meet with the member to discuss options for care, such as other residential arrangements in adult foster care (AFC) or Title XIX Day Activity and Health Services. The member's choice of service delivery will be given the first priority as long as the cost to the service does not exceed the annual cost limit. Star+PLUS services are also being investigated by the MCO for the provision of all waiver services. The use of self-administered oxygen is permitted in a STAR+PLUS HCBS assisted living program (ALF). Since oxygen is a combustible substance, precautions should be taken to ensure that smoking is prohibited in or around the area where the oxygen itself is administered. 7240 Chamber, Board and Copayment requirements Revision 18-2; As of September 3, 2018, the member must pay the required fees to be eligible for assisted living services (AL). Refusal to pay the required costs may result in the termination of the services. The facility must designate an expiry date for copayment and space and board of directors in writing. The expiration date should be applied in the same month the copayment and room and board. The facility must collect the full copayment and space and the board on or before the expiration date. If expiry date falls on a weekend or holiday, the facility must collect the full copayment and room and board on or before the first working day thereafter. 7241 Chamber and Administrative Requirements Revision 19-1; As of June June 2019 All members must pay the parliamentary and administrative expenses to be eligible for assisted living (AL). Chamber and board cannot be waived, but an assisted living institution (ALF) can choose to accept an applicant or member for a lower amount. Star+PLUS Home and Community Based Services (HCBS) program policies do not allow the applicant or member to accept or reject. The room and board fee is based on the Supplemental Security Income (SSI) federal benefit rate (FBR), minus a personal needs fee of $85. This is a fixed rate unless there is a change to the FBR. In general, the FBR only changes annually on 1 January. Room and board fees are adjusted accordingly based on that change. For the first month of entry, the monthly rate is divided by the number of days in that month and then multiplied by the number of days the member is in the ALF. The managed care organization (MCO) must notify the applicant or member of the original amount of the board and pay the current amount of space and board. 7241.1 Copayment Requirements Revision 19-1; As of June 3, 2019, the amount of copayment that the member must pay will be determined by Medicaid for the Elderly and People with Disabilities (MEPD) specialists by using the MEPD copayment worksheet. European Parliament specialists shall determine the amount available. The managed care organization (MCO) communicates the amount of copayment each member is to pay the provider. Program Support Unit (PSU) staff mail form H2065-D, Notice of Managed Care Program Services, to the member and upload a copy of Form H2065-D to TxMedCentral. Once received via TxMedCentral, the MCO sends a copy to the assisted living institution (ALF), which describes the amount of the first month and the amounts of the following months. 7242 Personal leave revision 18-2; As of 3 September 2018, the member is entitled to 14 days of personal leave from the assisted living institution (ALF) per year. The member is responsible for the room and board costs and the copayment for personal leave days. A day of personal leave is defined as 24 consecutive hours. Star+PLUS Home and Community Based Services (HCBS) program assisted living (AL) members must opt out upon leaving the facility and sign up upon return. The login log must contain at least the following information: the person's name; time and date of departure; destination; emergency contact; and type of leave (e.g. personal or hospital leave). 7243 Nursing Services for AL Members Review 19-1; As of June 3, 2019 As a member an assisted living institution (ALF) all medication administration, including injections, will be provided by the nurse. It is possible that a member living in an ALF does not require nursing duties to be provided by the STAR+PLUS Home and Community Based Services (HCBS) program. Examples of this can occur when the member is only nursing need for medication administration that is provided by the nurse or when the member is receiving nursing services through Medicare. 7244 Response to AL Member State Condition Change Revision 19-1; As of June 3, 2019 If the member experiences a change in health or conditions in relation to the amount and type of care the member needs, the managed care organization (MCO), in cooperation with the other members of the interdisciplinary team (IDT), the provider, and the member or the authorized representative (AR) may explore other means to adequately serve the member in his or her current environment. The use of day care and health services (DAHS) for daily nursing duties or the direct provision of nursing by caregivers can be explored as alternatives that would prevent disruption of the member's residential arrangements. Nursing duties cannot be delegated in assisted living facility (ALF) institutions. If a member exhibits conduct or impairment of mental health that threatens the health or safety of himself or others, or the member's needs exceed the facility's licensing capacity, the AL provider must take appropriate action and notify the MCO orally on the following business day. The provider must confirm the oral report in writing within seven days. The MCO should take appropriate action based on the oral notification to assess the member's eligibility for the STAR+PLUS Home and Community Based Services (HCBS) program. Please refer to Article 7251, facility reporting and notification requirements. If a STAR+PLUS HCBS program member living in an assisted living apartment (AL) poses a security risk to the member or others due to the operation of the stove or cooking unit in the apartment, the AL provider may disconnect the appliance and notify the MCO the following business day. The MCO should investigate the situation and document any recent or earlier incident that indicates a threat to the health or safety of the member or others. The MCO, in cooperation with the IDT, the AL provider, and the member's family or AR, will make a decision on whether to reconnect or proceed with the decoupling of the cooking unit. The decision is documented on Form H2067-MC, Managed Care Programs Communication, which is sent to the AL provider within three business days of the IDT meeting. 7245 Hospital and nursing facility continues to overhaul 19-1; From June 3, 2019 Hospital stays To keep bed during the hospital stay reservation, the member must pay the daily room and board fees. The guard on the bed of the facility or the negotiated guard the keeping of beds for the reservation of a member's space during the hospital stay may not exceed the maximum amount set by the managed care organisation (MCO). The facility did not bill the MCO for days when the member is in the hospital. The member's room and board costs, used as bed-keeping the full payment to the facility when a member is in the hospital. The facility must notify the MCO via Form H2067-MC, Managed Care Programs Communication, when the member has been in the hospital for 30 days. The MCO monitors the member's situation for up to four months each month to determine whether the stay becomes permanent. If the member remains in the hospital for more than four months, the member is written out systemically. The MCO must notify the PSU via Form H2067-MC. A hospital includes a rehabilitation hospital or a rehabilitation floor or wing of a medical hospital. Nursing Facility Stays For issues related to nursing home (NF) payment, see the Medicaid for the Elderly and People with Disabilities Handbook, Section H-1700, Deduction for Home Maintenance. The MCO must follow the Uniform Managed Care Contract (UMCC), Attachment B.1, Section 8.3.2.6, Nursing Facilities, related to NF stays. 7246 Termination for non-payment of the required contribution to the revision costs of care 19-1; As of June 3, 2019 If the member or the authorized representative (AR) does not pay the full copayment and room and board at the facility's expiration date, the facility must notify the member or AR and the managed care organization (MCO) in writing that the payment has not been received. The facility shall make oral notification no later than the first working day following the expiry date. The facility follows in writing within five days of the member or the AR failing to pay the required payments. Upon receipt of the written notification, the MCO coordinates: coordinates with the facility to convene a meeting of the interdisciplinary team (IDT) within five working days of receipt of the written notification. The IDT shall include, where applicable, the member, a representative of the Facility, the MCO and the AR; examine with the member and IDT whether there are new circumstances preventing the member from making the required payment. The circumstances to be taken into account are: the member has a situation with a mandatory payback period or other changes in income requiring an adjustment of the measurable income; circumstances indicate that the member is being exploited by another person; and there are other situations where the member and the facility may conclude an agreement for the member to pay the required payments; makes every effort to resolve the problem with the member and the facility; advises the member on the consequences arising from the refusal to make the required payments to the assisted living institution (ALF), including: termination of eligibility; expulsion; and be placed at the end of the interest rate list if the member is for services tendered; and asks the member to read and sign Form 2119, Residential Care or Assisted Living Contribution Recognition, if the situation cannot be resolved and the member continues to refuse to pay the required payments. The form states that the refuses to pay the required payments and understands the consequences of not meeting this eligibility requirement. If the member refuses to sign, the MCO documents the refusal on Form 2119 and has a witness sign. The MCO shall leave the member a copy of Form 2119 and shall retain the original copy with the signature in the member's file. The MCO advises the member that he or she will receive a notice to terminate the services. The MCO also advises the member that he or she will not be allowed to move to another ALF, while the member has an outstanding balance on the current ALF, and the current ALF may deable the member for refusing to pay. After the IDT meeting, the MCO must: make any correct references to adjust the countable income; reference to adult protective services (APS), where exploitation is suspected; or coordinate termination notice with Facility and Program Support Unit (PSU) personnel by sending Form H2067-MC, Managed Care Programs Communication, within five days of the IDT meeting. If the situation cannot be resolved and the member refuses to pay for any reason, within three working days of the notification of the MCO, PSU staff: mail the member Form H2065-D informing them that the services will be terminated at the end of the month following the end of the 30-day notification period, as indicated on Form H2065-D , unless the member pays the required payments. In the comments section of Form H2067-MC, PSU staff advise the member that the services will end and the facility may expel the member if the payment is not made by the date indicated on Form H2065-D; send the facility a copy of Form H2065-D; fax a copy of Form H2065-D to the Specialist Medicaid for the Elderly and People with Disabilities (MEPD); upload a copy of Form H2065-D to TxMedCentral in the MCO's SPW folder, using the correct naming agreement and a copy of Form H2065-D, following the instructions of Section 5110, TxMedCentral Naming Convention and File Maintenance; and email a copy of Form H2065-D to the ERS mailbox for MAO members. If the member does not appeal: the facility may initiate expulsion proceedings by giving the member a written eviction notice indicating the expulsion, as from the date indicated on Form H2065-D. and the member has not made any other living arrangements by the denial date, the facility makes a reference to APS. and the facility is in accordance with the terms of its license and contract regarding the expulsion of members, the facility puts the member on the date stated on the written eviction notice. the member will appeal against the effective date of the action on Form H2065-D, psu employees will notify the MCO by uploading a copy of Form H2065-D to TxMedCentral in the MCO's SPW folder. The member may receive other services, but will not be eligible for assisted living (AL) until all outstanding payments have been made. 7250 business standards business standards 19-1; From 3 June 2019, assisted living (ALFs) must give each member the choice of a private or semi-private space; to reserve space up to three days from the agreed entry date for each referred member before requesting a different referral; point to a separate bedroom for members in two facilities where members of the nursing facility (NF) are housed in the facility; and accept all managed care organization (MCO) referrals when space is available. The only reason why a STAR+PLUS Home and Community Based Services (HCBS) program assisted living (AL) provider might refuse to accept a referral is if the member's condition makes the member inappropriate for the facility according to the facility's personal care license. Having a communicable disease does not necessarily make a member inappropriate for placement in an AL institution. Transmission of communicable diseases and diseases can be prevented by the application of infection control procedures, including universal precautions. Licensing standards for personal care facilities require facilities to implement infection control policies and procedures, including universal precautions, to protect employees and residents from these and other diseases, and infectious diseases. If the transmission of the condition or disease cannot be controlled, the member cannot be placed in a STAR +PLUS HCBS program AL setting. In order to receive AL services under the STAR+PLUS HCBS programme, the applicant must first be determined to be eligible for the STAR+PLUS HCBS programme. Program Support Unit (PSU) staff coordinate with Medicaid for elderly and disabled (MEPD) specialists, if any, to complete the Medicaid eligibility provision. The MCO discusses residential options with the member so that the member can choose his or her preference. If an ALF is chosen, an oral reference to the provider is made as a warning that space is needed. The start date for services is a negotiated date between the MCO, the member, and the AL provider. The initial copayment amount is calculated based on the start date. Form H1700-1, Individual Service Plan (Pg. 1) and applicable attachments are sent as follow-up, along with a copy of Form H2065-D, Notice of Managed Care Program Services, which authorizes the provider to provide STAR+ PLUS HCBS program services, and Form H2067-MC, Managed Care Programs Communication, confirmation of the negotiated service initiation date. Note: Appropriate action should be taken if the facility determines that a member is threatening the health and safety of himself or others. If a stove or cooking unit is required disconnected, the MCO service coordinator, in cooperation with the interdisciplinary team (IDT), makes this decision. The IDT must also include the MCO, the AL provider and any representative of the member or the delegate (AR). The The provider may disconnect the heater or cooking unit if the member exhibits a behavior that threatens the health and safety of him or her or others. The ALF must inform the MCO service coordinator of the decoupling the following business day after the performance. The MCO investigates the situation and documents recent or previous incidents that indicate a threat to the health or safety of the member or others. If a decoupling is decided, the MCO service coordinator documents actions on Form H2067-MC that is sent to the AL provider within three days. Note: The ALF must make oral notification no later than the first working day after the expiration date. Within five business days of receiving notice from the provider that the member has not paid for the copayment or room and board, the MCO form uploads H2067-MC to TxMedCentral in the XXXSPW folder using the appropriate naming convention. Form H2067-MC serves as a notification to PSU employees that the member has not paid the copayment or the board. Within three working days, PSU employees must send the H2065-D member form in which the services are terminated if the member does not pay the copayment and the Board and board within 30 days of the date on Form H2065-D. If a STAR+PLUS HCBS program member does not pay his or her copayment and/or room and board within 30 days of the date on Form H2065-D, the MCO will contact the member to find out why the fees have not been paid. Even if there is a legitimate reason (such as the income check the member is not received by the 10th day of the month) for non-payment of the required fees, the member is still required to pay the fees. If the member simply refuses to pay the fees, or if there is no legitimate reason not to pay his or her, the MCO writes a letter to the member, with copies to the facility manager and to the member's responsible party, if any, explaining the possible consequences of continued refusal to pay. The MCO is responsible for working with the member during this period to ensure that alternative services will be available. If the member refuses to leave the facility when his or her services are terminated, the facility must follow written eviction procedures. In addition, ALFs: shall carry out a health assessment with the member within three days of admission to the facility; each member within three days of the date of the dedication of the service to provide training in the emergency or disaster procedures and the evacuation plan. The training must be documented in the member's file. The facility must also document all the training and orientation provided to members and staff are provided; provide services in accordance with the member's health assessment or individual service plan (ISP); document the daily activity and provision of the member's service on the daily census report; obtain written approval from the before the discharge of a member, except where MCO staff cannot be reached and the member threatens the health or safety of himself or others; help the member to prepare for the transfer or discharge; offer at least four social and recreational activities per week; payment of the member in accordance with copayment and chamber and board policy. If the payment is not made on the tenth day of the month, the facility shall inform the member by the 11th day of the same month at the latest; enable the member to manage his or her finances and/or trust funds. The facility must assist the member in the management of his or her finances only if the member requests assistance in writing; repayment, within five working days of the member's dismissal, the full balance of the personal funds of the member who deposited the facility into an account. This applies to copayments and trust funds; and inform the member orally and in writing, before or at the time of admission, of bed hold policy for hospital or nursing home (NF) stays, personal leave, eviction procedures, all available services in the facility, and costs for services not paid by the MCO and/or not included in the facility's baseday rate. Examples of costs not paid by the MCO may include the destruction of facility ownership or any additional costs, such as pet deposits. Items not to be provided by the AL provider through the ALF licensing standards (e.g. returned cheque fees, service deposits) may be charged to the member if stated in the admission agreement. The MCO may contact Texas Health and Human Services Commission (HHSC) Regulatory Services Division regarding any questionable items charged to the member. 7251 Review of facility reporting and notification requirements 19-1; As of June 3, 2019, the facility will be required to report orally to the managed care organization (MCO) the following events relevant to member services the following business days after the action. These events must be followed up in writing within five working days of the action and may lead to MCO intervention and/or termination of services, including, but not limited to: significant changes in the member's health and/or condition, such as: the member enters a hospital, nursing facility (NF), state school or state hospital; death of a member; or serious incidents or emergencies involving the member or staff of the Facility; and changes based on actions of members, such as the member: is dismissed because he or she threatens the health or safety of himself or others; leaves the calls for an end to services; refuses to comply with the individual service plan (ISP); does not pay the copayment; exceed the days of leave; and requests to move to another facility. If a member exhibits behaviour that threatens the health or safety of himself or others, or that of the Member exceeding the facility's licensing capacity, the provider's written notification should explain the situation and the reasons why the member is no longer suitable for the services. With the confluence of the MCO, the discharge can be practical as soon as possible: the health or safety of persons in the facility would be at risk if the member remained in the facility; whether the member's medical needs escalate beyond the facility's ability to meet the member's needs. For example, the mental state of the member may deteriorate to the point that involuntary commitment to a psychiatric institution is necessary. 7252 Review of member documentation 18-2; With effect from 3 September 2018, the Facility shall keep records for each member containing at least the following information: health assessment; serious incidents or emergencies involving members or facility personnel; incidents where a member threatens the health or safety of himself or other residents in the facility; documentation where the member has used 10 personal days of leave during the member's current individual service plan; documentation where the member's needs exceed the licensing capacity of the personal care institution; termination of services to a member; hospitalisation of a member; death of a member; and documentation when a member asks to move to another facility. 7260 Review of staff and training requirements 18-2; As of September 3, 2018, the facility must provide all employees with training in fire, disaster and evacuation procedures within three working days of employment. The training should be documented in the facility records. 7270 Copayment and Trust Fund Records Revision 18-2; From 3 September 2018 7271 Copayment Revision 11-3; As of 1 September 2011, the facility must keep receipts for all copayments collected. The facility must deduct the copayment amount as documented on Form H2065-D, Notice of Managed Care Program Services. The facility must maintain a current members copayment ledger system that reflects all costs and all payments from or on behalf of each member. This system should reflect all copayment costs, payments and balances; it should be maintained in accordance with generally accepted accounting principles. If a copayment member is paid from a trust fund, the facility still needs to prepare a receipt. The ledger should also reflect space and board costs and payments, and the member must provide a receipt for room and board payments. 7272 Trust Fund Records and Written Receipts Revision 19-1; As of 3 June 2019, the facility must trust funds based on recognised tax and accounting principles and have written permission from the member to handle his or her personal financial affairs. Members should be informed that: the funds will be mixed with the resources of other members like the facility facility trust fund of the member; and the facility may assess the data of trust funds of all members whose funds are mingled. If the member cannot sign the transaction or initial, or if the member signs his or her name with a trademark (x), the transaction must be signed by a witness. The facility should: keep the accounts of the member's trust fund separate from the operational accounts of the facility. The separate account must be identified Trustee, (name of the facility), Member Trust Fund Account; make the member's confidence data available for assessment by the Facility without prior notice; do not charge the member for services that the facility is expected to provide for the member; refrain from charging the cost of banking services if the member's trust fund is in a merged account; obtaining and keeping the current written individual records of all financial transactions relating to the personal resources of the member handling the facility; and include at least the following in the information of the trust fund: the name of the member; identification of the representative or responsible party of the member; transactions; and the earned interest of the member. The facility can choose one of the following options: the date and amount of each deposit and withdrawal; the name of the person who accepted the funds withdrawn; and the balance after each transaction. Any withdrawal must be signed by the member. If the member is unable to sign when money is withdrawn from his or her trust fund, the transaction or receipt must be signed by a witness or signed receipts indicating the purpose for which withdrawn money was spent, the date of expenditure and the amount spent. The receipt must be signed by the person responsible for the money and the member. If the member cannot sign his or her name, a witness must sign the transaction or receipt. to divide the interest earned on a pooled interest bank account into one of the following options: in proportion to each member on the basis of an actual interest rate; on the basis of its final quarterly balance to each member; or pay monthly to each member's account if the interest is paid monthly. If the facility earns interest on a pooled interest account, the earned interest must be tabized into each member's account. Deposit shipments must be documented as interest in the member's ledger. All transactions must be booked by the middle of the next month. The facility can: maintain a running balance; or calculate a balance at the end of the month. the facility maintains a trust fund, the facility staff must: give the member a receipt for the money deposited into the trust fund; the monthly income of the member to the account; and write a check for the copayment and the room and board payment from the trust fund account in the facility operating account. Staff may use the monthly in the operating account and then deposit the personal needs and room and board fee in the trust fund account. If the member writes a check to be deposited into his or her trust fund account and there are insufficient funds to cover the check, the facility may only charge the member the actual insufficient funds fee charged by the bank. There is no requirement that the deposit in the trust fund be made on the same date that the money is received. However, the facility must ensure that the deposit form/bank statement reflects the same amount recorded on the voucher. 7273 Registers and Receipts Revision 18-2; As of September 3, 2018, the facility must ensure that the administration contains written receipts for all purchases made by or for members. A receipt is a written or computer-generated, signed payment record that was drawn up at the time of payment. If the payment is personal, the written or computer generated receipt must be signed and simultaneously with the payment. If the payment is by post, a declaration at the end of the month meets the requirement for a written receipt and an invoice for the following month. If one receipt is written for several articles, the receipt must clearly describe what covers the receipt. The file or receipt must contain the name of the member; date on which the money was received; coverage period; purpose of the payment; amount received; source of the money; any quantity recovered; signature of the facility representative. The facility is required to have both a trust fund ledger and a copayment ledger. A current copayment ledger system for members should be maintained that reflects all costs and all payments from or on behalf of each member. This system should reflect all copayment costs, payments and balances, and be maintained in accordance with generally accepted accounting principles. The facility must maintain both receipts for funds received from members and bank deposit receipts showing the deposited money. These amounts shall correspond to amounts recorded in the main book of the member's trust fund. This system should be maintained in accordance with generally accepted accounting principles. Seller withdrawals must be kept, regardless of what facility staff account is for trust fund transactions (withdrawals on a ledger, cash envelope, or individual chequebook register). They must keep receipts for each payment of a trust fund account that exceeds $1.00. The receipt, cash tape or is documentation of who actually received the money withdrawn from the trust fund account and that the money was spent as authorized. Unused money returned to the trustee of the trust fund must be reassigned to the member's trust fund account and properly documented. The conditions that allow withdrawal from the member's trust fund are: the purchase must be authorised by and for the benefit of the the costs must be reasonable; and facility staff do not benefit from the transaction. For example, purchase items in bulk and sell them at a higher price; or the member who has given permission to purchase a TV, stereo, refrigerator and staff uses it. 7274 Supplier Receipts Revision 11-3; With effect from 1 September 2011, the following information should be included on all receipts from trust fund providers (excluding long-term payments): member's name; the date on which the receipt is written; store name; amount of money spent or received; and purchased items. 7275 Group purchases revision 18-2; From 3 September 2018, one purchase will often be made for goods distributed to specific members (e.g. cigarettes). In that case, the invoice or receipt shall indicate the name of the members for whom the purchase was made; and a portion of the total price charged to each individual account. Group purchases are only allowed if they can be traced back to the member. 7276 Payment of copayment and board and board of trust fund review 18-2; As of September 3, 2018 It is an acceptable and recommended practice to deposit the member's income into the trust fund account and then pay the copayment and room and board from the trust fund account. In this way, the monthly payments of the member can be traced back to the trust fund. When the copayment and the board and board of the trust fund account are paid, the claim book of the corresponding member must show the correct credit in the member's account. Long-term payments For long-term payments, facility staff must obtain a signed declaration from the member or the responsible party authoring long-term payments on behalf of the member. Examples of long-term payments include insurance premiums, kerktide and cable TV. If the facility: has a signed statement from the member authorizes the facility to pay long-term payments on behalf of the member, they do not need a monthly receipt from the seller; or not authorize a signed statement from the member or the authorized representative (AR) to pay the monthly payment on behalf of the member, the facility must provide a supplier receipt that includes all items previously identified. Daily withdrawals for small purchases or small withdrawals Members usually require small amounts of money to meet their daily needs for items such as soft drinks, snacks, etc. It is often difficult to keep supporting documents for all these small purchases. The member's signature or consent for a cash withdrawal must be on the individual member's ledger, the cash envelope or a receipt. Bulk purchases Bulk purchase of the same items can be made by the facility. In this case, the member's signature and the amount of the purchase must be on the member's book or a receipt. 7277 Review of licence applications 18-2 of members; from 3 September 2018 If the member is unable to or if the member signs his or her name with a mark (X), the transaction must be signed by a witness. A witness is someone other than the: facility employee responsible for managing the trust fund accounts; supervisor of the employee managing the trust fund account; or person receiving payment for services to the member. 7278 Repayments to discharged or deceased members Revision 18-2; As of September 3, 2018, the Facility must repay the full balance of the member's money deposited into his or her trust fund account within five days of the member's dismissal. If the member dies, there may be no payment of his or her trust fund account, except for the repayment to the responsible party. No money may be provided to reimburse the facility for damage caused by the member to an assisted living apartment (AL). If there is a responsible party, the facility may request voluntary reimbursement prior to reimbursement, but the responsible party is not required to agree. Maintenance at the facility is included in the cost report as a fee cost. The two types of refunds are listed below: Check — If the refund has been made by a cheque, the cancelled cheque or a copy of the receipt must be signed by the member or party responsible. Cash - If the refund is made in cash, the receipt must be signed by the member or the responsible party. 7300 Respite Review 19-1; As of June 3, 2019, respite care services in the STAR+PLUS Home and Community Based Services (HCBS) program will be available at an emergency or short notice to relieve people who normally provide unpaid care for a STAR+PLUS HCBS program member who cannot take care of himself. 7310 Service Coordination tasks related to Respite Care Overhaul 20-2; From 1 October 2020 In order to be eligible for respite care, the member must live in his or her own home or with family members or other persons. The member may not live in an adult foster home (AFC) or assisted living (AL). The respite care provider may not be a primary caregiver, regardless of whether the respite care provider is related to the member, and may not live with the STAR+PLUS Home and Community Based Services (HCBS) program member for whom respite care is required. If the member's primary caregiver is the paid caregiver who also provides uncompensated care, in-home respite care should only be provided during those hours that the primary care provider would provide uncompensated care to the member. If the primary caregiver is the paid carer and will be absent during hours for which the primary care provider is normally paid, it is the of the file which has an obligation to provide a replacement carer during this period. Respite care is intended to relieve the primary caregiver during emergencies or scheduled short-term periods. Respite care should be allowed on the individual individual (ISP) before it can be delivered. The respite care rate for out-of-home settings includes payment for room and board. There are no members copayment or room and board fees for respite care in out-of-home settings. The service coordinator of managed care organization (MCO) is responsible for documenting the respite care required by the member. For example, a member must provide respite care every Friday afternoon so that the primary care provider can participate in the classroom, or a member primary caregiver has three four-day trips scheduled during the ISP years, or a health care provider has a history of emergency hospitalizations. The documentation of the MCO service coordinator should also support that the member meets the criteria to be eligible for respite care. The MCO service coordinator must provide supporting documentation on the number of hours requested or authorized when the maximum of 30 days is requested or authorized. Respite care cannot be allowed retroactively. For STAR+PLUS HCBS program members who are in need of respite care and respite care is not permitted on the ISP, the provider should contact the MCO for permission prior to the delivery of respite care. The member should be given the opportunity to choose from the contracted providers that are appropriate given the member's needs and the provider's licensed capabilities. In-home respite care is provided by licensed providers who enter into contracts with the MCO and/or a Home and Community Support Services Agency (HCSSA) contracted with the MCO to provide services. Out-of-home respite care is provided by licensed nursing facilities, licensed personal care facilities and licensed AFC homes. The provider providing in-home respite care is responsible for providing the personal assistance services authorized to the ISP, with the possible exception of delegated nursing duties. If a member receives in-home respite care and the supervisor who provides the personal care is not the same supervisor to whom the nursing duties were delegated, the nurse can provide the care care directly. It is necessary for the MCO to modify the ISP to include the increased direct nursing based on information provided by the provider. Other services (e.g. physiotherapy or minor adjustments to the home) can be provided at the same time as the in-home respite care. Respite care should be permitted on Form H1700-1, Individual ServicePlan (Pg. 1). Respite care services can be authorised as often as is necessary for the provision of primary care providers or primary care care to the maximum of 30 days per ISP year, within the limit of member's cost limit. For example, if two hours of respite care per week is to be used, the ISP authorization is for eight units of 15 minutes. The calculation is two hours a week once 52 weeks = 104 hours multiplied by four units of 15 minutes. The The limit on respite care is 30 days, equivalent to 720 hours equal to 2,880 units (30 days times 24 hours a day; 720 hours = 2880 15-minute steps), unless the MCO gives permission to exceed the 30-day limit. The MCO, which is responsible for coordinating STAR+PLUS HCBS programme services, must track which units a member has used. The provider may use Form H2067-MC, Managed Care Programs Communication, to inform the MCO of the dates and duration of the respite care services provided. The MCO can keep track of the number of respite care days used. 7311 MCO approval to exceed the respite service review of the service limit 19-1; As of 3 June 2019 To seek approval for exceeding the annual individual service plan (ISP) of 30 days for respite care, the provider must send a written request to the managed care organisation (MCO) documenting the need for additional respite care units; number of additional units required; cost estimate taking into account the location(s) where the respite care services will be provided; the total service plan falls within the member's ISP cost limit; and ISP is adequate and meets the needs of the individual in the community. The provider shall include his or her telephone number and address in the written request. The MCO shall give written approval or disapproval of the request. When assessing requests to exceed the respite care limit, the MCO should take into account the intention of respite care services to relieve the caregiver during emergencies or scheduled short-term periods. Approval to exceed the maximum of 30 days must be related to situations such as: members whose primary caregivers become ill, are hospitalized or have a family emergency; extenuating circumstances that ensure that care is needed outside routine or periodic respite care lighting; or a breakdown in the support of the member or family, increasing an increased risk of institutionalization due to the physical burden and emotional stress of providing continuous support and care to a dependent person. 7320 Respite care in-house 19-1; As of June 3, 2019, In-home respite care services provided by managed care organization (MCO) will provide short-term services to members who cannot take care of themselves due to the lack or need for relief for their unpaid primary care provider. In-home respite care is provided in the member's own home, as permitted on member's form H1700-1, Individual Service Plan (Pg. 1), when the unpaid primary caregiver needs relief. The provider is responsible for delivering the tasks are authorized on the ISP and Form H2060, Needs Assessment Questionnaire and Task/Hour Guide, and Form H2060-A, Addendum on Form H2060, during the time the member receives in-home respite care. The provider must record the member's clinical record: the in-home respite care provider received a briefing on the needs and preferences before services are provided; dates and duration of the services provided. In-home respite care services helps prevent member and/or family support breakdown and the resulting institutionalization, which can result from the physical burden and emotional stress of providing continuous support and care to a dependent person. The in-home respite care provider must provide the personal assistance service (PAS). The MCO may offer the in-home respite care provider the registered nurse (RN) the opportunity to either provide the necessary nursing services directly or delegate the nursing task(s) to the in-home respite care provider. In-home respite care services is not meant to be used when the primary caregiver should be out of the home for short periods of time (for example, to go to the pharmacy or grocery store to pick up medications or groceries). The primary caregiver should be encouraged to get out of the home for short respite care when the carer is providing the PAS. 7330 Respite Services Outside Home 19-1; From June 3, 2019, out-of-home respite care will provide a 24-hour residential facility in an adult foster home (AFC) home, a licensed personal care facility or a licensed nursing home (NF) for persons who, due to the unavailability of their primary caregiver, have no one to meet their needs at short notice. Services may include meal preparation, domestic assistance, personal care and nursing, assistance with daily life activities (ACLs), supervision, and the delivery or arrangement of transport. Nursing duties can be provided directly by licensed nurses in out-of-home respite care services or may be delegated as determined by the professional judgment of the registered nurse provider (RN) unless facility license prohibits delegation. 7331 review of the eligibility of paragraph 19-1; With effect from 3 June 2019, the member of the respite care shall: meet all eligibility criteria as specified in Article 3200; living in his or her own home; primary carer who needs help, either on an emergency or planned short-term basis; and not to stay in adult foster care (AFC) or a personal care facility. The applicant for STAR+PLUS Home and Community Based Services (HCBS) respite care services must complete the same fitness process as other STAR+PLUS HCBS program members. 7332 Review of the qualifications of the qualifications of providers 19-1; With effect from 3 June 2019, providers of out-of-home respite care providers must be licensed for nursing provision (NF); approved personal care facility; Or Health and Human Services Commission (HHSC) license adult foster care (AFC) at home. In order to provide STAR+PLUS Home and Community Based Services (HCBS) out-of-home respite care, the provider must complete and sign a contract with the managed care (MCO). The contract must be signed by both the provider and MCO before the provider serves members. 7333 Description of the revision of services 19-1; As of June 3, 2019, the star+plus home and community based services (HCBS) program member may receive out-of-home respite care in a nursing home (NF), a personal care facility, or a Texas Health and Human Services Commission (HHSC) licensed foster care (AFC) at home, with services to be provided as permitted on the individual service plan (ISP) and in accordance with the licensing obligation and the contract requirements for facilities. The STAR+PLUS HCBS program member can take any adaptive tools he or she uses to the off-home respite care facility. The managed care organization (MCO) provides the out-of-home respite care provider with the assessments and ISP attachments that are relevant to the services that the member will receive while in the facility or at home. The provider must provide services as indicated on the member's ISP attachments. 7334 Respite Care Services in a Personal Care Facility or AFC Home Revision 19-1; As of June 3, 2019, the STAR+PLUS Home and Community Based Services (HCBS) program member who receives respite care in a personal care facility or receives adult foster care (AFC) while in the respite care environment. The need for a service must be authorized on the individual service plan (ISP) before the member receives the service. The STAR+PLUS HCBS program member who receives respite care in an AFC home must be eligible for placement in the specific level of AFC home by meeting the specific criteria for that level of home. Nursing services provided in a Level I or Level II AFC house can be delegated, according to the professional judgment of the registered nurse of the provider (RN). Personal care institution licensure prohibits delegation of nursing duties. In assisted living (AL) out-of-home respite care settings, nursing care should be provided directly by licensed nurses. 7335 Respite care services in a nursing facility review 19-1; As of June 3, 2019, the STAR+PLUS Home and Community Based Services (HCBS) program member who receives respite care in a nursing home (NF) can receive therapy services from third-party providers. The member's need for a service must be authorized on the individual service plan (ISP) before it receives the service. The NF is responsible for providing the necessary nursing services to the member. 7340 Chamber and Board review 19-1; As of June 3, 2019, room and administrative expenses are not permitted for the STAR+PLUS Home and Community Based Services (HCBS) program member providing respite care outside the home Room and administrative expenses are included in the rates for respite care. 7400 Emergency Response Services Revision 18-2; From 3 September 2018 2018 Introduction to ERS review 18-2; From September 3, 2018, emergency response services (ERS) will be provided through an electronic monitoring system and will be used by functionally disabled adults who live alone or are functionally isolated in the community. In an emergency, the member can press a call button to ask for help. The electronic monitoring system, which has a 24-hour, seven-day-a-week monitoring capability, helps to ensure that the right person or service provider responds to a member's alarm call. 7420 ERS programme target revision 18-2; As of 3 September 2018, the objective of emergency response services

(ERS) under the STAR+PLUS Home and Community Based Services (HCBS) programme is to enable the elderly and disabled to maintain dignity, independence, individuality, privacy, choice and decision-making; and preventing or reducing inappropriate institutional care by providing home care and other forms of less intensive care. 7430 ERS members eligible for review 19-1; As of June 3, 2019, a member must: qualify for emergency services (ERS) through the STAR+PLUS Home and Community Based Services (HCBS) program: have been identified as eligible for the STAR+PLUS HCBS programme; mentally alert enough to operate the equipment properly, in the opinion of the service coordinator of the managed care organization (MCO); have a phone with a private line, if the system requires a private line to function properly; be prepared to sign a statement that allows the responder to make a break-in at the member's house if he or she is asked to respond to an activated alarm call and has no other means to enter the house to respond; and live in a place other than an assisted living institution (ALF) or foster care for adults (AFC) institution, institution or other institution where 24-hour supervision is available. Members eligible for Community First Choice (CFCs) must receive ERS through CFK, not through the STAR+PLUS HCBS program. Program Support Unit (PSU) employees will not accept or approve an initial or reassessment ISP with a January 1, 2016 starting date, or later that includes personal assistance services (PAS) or ERS for non-medical assistance only (MAO) STAR+PLUS HCBS program members. MCOs must upload Form H2067-MC, Managed Care Programs Communication, to TxMedCentral to notify PSU if a member simultaneously receives both STAR+PLUS HCBS program and CFC services. This is required for all non-MAO STAR+PLUS HCBS program members who also receive CFCs, regardless of whether the individual service plan (ISP) is manually uploaded or submitted electronically. 7440 Reference and of providers Revision 19-1; As of 3 June 2019 If the member is eligible for emergency care (ERS), the Managed Care Organisation (MCO) shares a contracted list of all ERS providers with the that a provider selects from the list. The member may request a provider change; However, the member must contact his or her MCO service coordinator to request the change. The MCO follows the procedures in Section 3600, Ongoing Service Coordination, and gives members an explanation of the service and requirements. 7450 rights relating to ERS review 19-1; As of 3 June 2019 If the member appears to be in need of emergency services (ERS), the service coordinator of the managed care organisation (MCO) will determine whether the member meets the general criteria for participation in ERS, as described in Article 7430, Member Eligibility. The MCO may involve other members of the interdisciplinary team in deciding on the physical and mental ability of the member to participate in the ERS program. ERS can be authorized through the STAR+PLUS Home and Community Based Services (HCBS) program when it appears that the member may need the ability to notify a respondent of an emergency. ERS services are limited to persons who live alone; are only for important parts of the day; have no regular primary caregiver for extended periods of time and which would otherwise require extensive supervision; or live with someone who is too incapacitated to call for help if necessary. In the course of the services, the MCO and the provider have a joint responsibility to keep each other informed of changes or problems. 7460 Revision of the rights of the provider 19-1; As of June 3, 2019, Managed care organization (MCO) has described the tasks of emergency departmental providers (ERS) in Texas Administrative Code, Part 1, Chapter 52, Subcapal D. 7500 Home-Delivered Meals Revision 20-2; With effect from 1 October 2020 7510 Description Revision 20-2; From 1 October 2020 The home-delivered meal benefit offers hot, nutritious meals delivered to the member's home. Meals provided by contracted agencies are approved by a dietician consultant who is either a registered dietitian licensed by the Texas State Board of Examiners or Dieticians or has a baccalaureate degree with major studies in food and nutrition, dietetics or food service management. 7520 Provider responsibilities review 20-2; As of October 1, 2020 Providers contracted to provide home-delivered meals must comply with the requirements of Texas Administrative Code (TAC), Title 40, Part 1, Chapter 55, Contracting to Provide Home-Delivered Meals. Home-delivered meals are delivered to the member's home, as permitted by the managed care organization (MCO). The meal must be delivered directly to the member or the responsible party. The MCO must require providers to ensure that the employee or volunteer the meal delivery provider, any illnesses of members, potential threats to the security of the member or observable changes in the condition of the member Provider. The MCO must require the provider to inform the MCO within one working day and in writing within five working days of the report. If the member or the party responsible is not at home to accept the delivery of a meal, the provider must comply with 40 TAC § 55.27(e). The MCO must inform the provider before or not later than the day when meal services are suspended. The MCO must suspend services in one of the following situations: The member joins an institution. The member requests suspension or termination of the services. The member dies. The MCO service coordinator instructs the provider to suspend the service. Unless the interruption is the result of one of the above situations, the MCO must require the provider to obtain the approval of the MCO service coordinator for service interruptions of more than two consecutive days. When the member requests a suspension of the services and specifies a date for the resumption of the services, the provider is not required to notify the MCO service coordinator. 7520.1 Frozen or shelf-stable meals overhaul 20-2; From 1 October 2020 A provider who completes contracts with the managed care organisation (MCO) to deliver home-delivered meals must agree to provide services: for a certain number of service days, with at least five meals per week; and to all eligible members in the service area, unless services are suspended or the provider is unable to offer a particular therapeutic medical diet. Home delivery service providers must submit a waiver request to the MCO if the provider determines that the supply of frozen or shelf stables requires stable meals for certain individuals within the provider's contracted service area. Each exemption granted shall apply for a period not exceeding one financial year. The supplier may not grant the exemption for the delivery of a hot meal five days a week prior to the approval of the application for exemption. 7600 Review of transitional assistance services 18-2; As of 3 September 2018 7610 Introduction review 18-2; As of September 3, 2018, Transition Assistance Services (TAS) is a STAR+PLUS Home and Community Based Services (HCBS) program service designed to help Medicaid members transition from a nursing home (NF). An NF resident fired from the facility in a waiver program is eligible to receive up to $2,500 in TAS for help setting up a household. TAS is available on a one-time basis and is not available to residents moving from an NF who are approved for assisted living (AL) or foster care (AFC) services. 7611 Review of the service description 18-2; From September 3, 2018, Transition Assistance Services (TAS) will pay for one-time, set-up costs for members who move from nursing homes to a community home. TAS is an advantage for basic and essential household items. Allowable costs are those necessary to the member establish a basic household and may include: payment of deposits necessary to rent an apartment or property; installation fees or deposits for the establishment of home utilities, including telephone, electricity, gas and water; purchase of essential furniture for the apartment or house, including table, chairs, blinds, food utensils, food preparation items and bath linen, cleaning supplies and toiletries; payment of removal costs required to live in or in the apartment; and payment for services to ensure the health and safety of the member in the apartment or house, such as pest control, allergen control or a one-time cleaning before the occupation. TAS does not include relocation services and is not available to assist the applicant in finding a home. 7620 Procedures for reviewing the first interview 18-2; As of September 3, 2018, applicants for all STAR+PLUS Home and Community Based Services (HCBS) program applicants located in a nursing home (NF) should be notified of the availability of Transition Assistance Services (TAS) and screened for the potential need for services. Within 14 working days of learning a request to move to the community, the service coordinator of the managed care organization (MCO) discusses the available living arrangements of the applicant or member in the community and asks the applicant or the member where he or she intends to live in the event of discharge from the NF. TAS may be taken into account when the applicant or member: plans to rent an unsullied apartment; plans to rent an uns made house; has a house, but all utilities are disabled while in the NF; has a house, but it may require cleaning, pest eradication or allergen control before it can be occupied again; or must have his or her belongings moved to the new home. If these or other situations arise in which the applicant can benefit from TAS services, continue screening for TAS. 7630 Identification of necessary articles and services Revision 19-1; As of June 3, 2019, the managed care organization (MCO) will conduct the interview with the applicant or the authorised representative (AR) to identify the applicant's needs and determine whether other resources are available to meet the needs. The MCO Service Coordinator completes Form 8604, Transition Assistance Services (TAS) Assessment and Authorization by highlighting each identified need and writing a description of the exact need. Example: If the applicant needs a deposit for electricity, the MCO enters the name and address of the utility and the required In. The applicant shall select a TAS agency from the list of contracted agencies. 7640 articles and services covered by TAS revision 18-2; As of September 3, 2018, Form 8604, Assessment and Authorization of Transition Assistance Services (TAS), is divided into three main categories: deposits, household needs and on-site preparation needs. 7640.1 7640.1 Review 18-2; As of September 3, 2018, deposits include rental and utility deposits, including basic phone service. Deposits or utility deposits must be in the name of the applicant or member. Deposit can be paid as long as the payment is specifically called a deposit and not rent, the payment is for a one-time fee, and the amount of payment is no more than the equivalent of two months rent. Transition Assistance Services (TAS) cannot pay for rent. TAS can be used to pay for arrears on previous utilities if the account is in the name of the member state and the member will not be able to get the utilities unless the previous balance is paid. TAS cannot pay the first month's payment to utilities. TAS can be used to pay for a phone because it has a basic need, but minutes or services on the phone are not allowed charges. TAS cannot pay for improved services outside of basic service. TAS funds can be used to pay for initial installation or reconnection costs for propane or butane service, including the minimum fuel delivery if the utility has a policy requiring a minimum fuel supply during the initial or reconnection service call. TAS funds cannot be used to top off a tank with fuel when the member's house is connected and has a supply of butane or propane. 7640.2 Household needs review 19-1; As of June 3, 2019, basic furniture or appliances will be available. This includes bedroom furniture, living room furniture, kitchen furniture, refrigerator, stove, washer, dryer, cleaning supplies and toiletries, etc. An applicant or member may apply for a specific make or type of appliance, furniture or other Driving Licence (TAS) as long as the cost limit meets the needs of the applicant or member. TAS articles may only be placed in a dwelling other than that of the applicant or member if the establishment is not available and necessary for the applicant or member to transfer to the community. TAS cannot pay for items that would only be used by the other person. If existing items are unusable and the lack of a usable basic or essential item creates a barrier that prevents the individual from returning to the community, the item is considered a need. 7640.3 Household Goods Revision 18-2; From September 3, 2018, Household items may contain pots, pans, dishes, silverware, cookware, bedding, towels, clock and other small items needed for the household. 7640.4 Small appliances Revision 18-2; From September 3, 2018 small devices include a microwave oven, electric can opener, coffee pot, toaster, etc. 7640.5 Cleaning Supplies Revision 18-2; From September 3, 2018 cleaning products include a mop, broom, vacuum, brushes, soap and detergents. 7640.6 Other unlisted items 18-2; From 3 September 2018 Every special special of the applicant or member who is not in the general list who meet the criteria as basic essential items to move to the community can be considered. 7641 Services and items not included in the review of transition assistance services 19-1; As of June 3, 2019, Transition Assistance Services (TAS) does not include items or services included in star+plus home and community based services (HCBS) program services such as adaptive devices, small home modifications (MMCs), medical supplies or medications. TAS does not include recreational items or devices, including televisions, video recorders or DVD players, games, computers, cable TV, satellite TV, fitness equipment, vehicles or other forms of transportation. TAS does not cover the cost of repairs or extension of the member's home. TAS is not used for renovation or renovation, upgrading of existing items or purchase of non-essential items. TAS funds cannot be used for food. The managed care organization (MCO) can refer the individual to emergency Supplemental Nutrition Assistance Program (SNAP) or local food pantry resources. Room and board are not allowed TAS fees. TAS does not pay for monthly rental or mortgage agreements or ongoing utility costs. 7642 Review of the preparation of the site 18-2; As of September 3, 2018, site preparation may include the following services: moving costs, including the cost of moving the items of the applicant or member from another location, or delivery costs for large purchased items; eradication of pests, if the place of residence of the applicant or member has been unattended and a type of eradication is necessary; icing control, if the place of residence of the applicant or member has been unattended or the applicant or member moves to a place which constitutes a respiratory health problem; or one-time cleaning, if the place of residence of the applicant or member has been unsupervised or the applicant or member moves to a private residence or apartment where no prior cleaning may be expected (for example, a family friend has an empty house available but cannot provide the cleaning). Transition Assistance Services cannot pay for septic systems. 7650 Estimated cost of articles and services revision 19-1; As of June 3, 2019, the Managed Care Organization (MCO) Service Coordinator provides a description and estimated cost of each item identified in each service category on Form 8604, Assessment and Authorization of Transition Assistance Services (TAS). The actual cost of an item can be used, if known. The amounts, actual or estimated, must be less than or equal to $2,500. The should be as specific as possible when describing which items are needed and what the estimated costs are. The description must contain size, color, specific types, or other identifying information, as specified by the member, member, the TAS Agency will help meet the member's needs. 7651 The estimated cost and authorisation of the review of the transition assistance services is 19-1 in total; As of June 3, 2019, the Managed Care Organization (MCO) service coordinator will be the service coordinator for The Transition Assistance Services (TAS) Assessment and Authorization, and enter the amounts in the totals section to arrive at the final amount to be approved under the TAS program. The total amount of $2,500 will not be entered as a flat rate. The applicant or member must sign the form stating that the items listed are the basic, essential needs necessary to move to the community, and he or she agrees that the selected TAS agency is authorized to make the purchases for him or her. The applicant or member shall select a TAS agency from the list of contracted agencies. The MCO service coordinator must explain to the applicant that the service will not be authorized until the applicant is eligible for STAR+PLUS Home and Community Based Services (HCBS) program services and is notified in writing that he or she is eligible. The MCO service coordinator must contact the applicant or the authorised representative (AR) before the certification is confirmed to verify that the applicant has made arrangements for the relocation to the community and has completed an expected discharge date. The MCOs encode these items as they were delivered before the arrival date. The MCO service coordinator includes TAS on Form H1700-1, Individual Service Plan (Pg. 1). The MCO service coordinator sends the applicant the notification of eligibility and sends the TAS Office Form 8604 and the authorization. The delivery date of the permit is two working days before the scheduled discharge date of the nursing facility (NF). Allow at least five business days between the date of the authorization and the completion date. The TAS office is expected to complete all services and articles by that date. For situations where a shorter end date is required, the MCO service coordinator should contact the TAS Office and negotiate an earlier date. The MCOs encode these items as they were delivered before the arrival date. Additional information from the applicant to the TAS Office may be included on Form 8604 or Form H2067-MC, Managed Care Programs Communication. Form 8604 shall be emailed after the applicant or member has been established to be eligible for waiver services. The TAS Office may only obtain items or services for which the agency has received permission on Form 8604. If the TAS Agency identifies other items or services that the applicant or member, the TAS agency must obtain prior permission from the MCO. See section 7652 below. 7652 Amendments to authorisation 19-1; As of June 3, 2019 If the Transition Assistance Services (TAS) agency or member identifies additional items required by the member after the TAS authorization is sent, agency must obtain approval from the managed care organization (MCO) on Form 8604, Transition Assistance Services (TAS) Assessment and Authorization, prior to obtaining the item/service. The TAS agency must remain within the total amount of the dollar allowed on Form 8604. If the total amount of items or services required exceeds the total amount allowed, the TAS Office must obtain prior approval and an updated Form 8604 from the MCO. The MCO service coordinator must update Form H1700-1, Individual ServicePlan (Pg. 1) to reflect the change in the amount for the funds allowed. The MCO must complete an amended Form 8604 within two working days when updating the licence to the TAS office, with the additional items and amounts accepted. MCO approval is required to authorize the delivery of TAS services. 7660 Responsibilities of the Transitional Assistance Office 18-2; As of September 3, 2018, the Transition Assistance Service (TAS) office will accept all members named by the managed care organisation (MCO). Upon receipt of the permit, the TAS authority should carefully review the forms and contact the MCO if there are any questions about what is allowed. This contact must take place on the next business day after receiving the forms and before a TAS purchase is made. The MCO shall contact the member if necessary to discuss the relevant point. The MCO will provide a revised TAS authorization form within two business days if it clarifies that an item has been authorized or approves a change in authorization. The TAS agency purchases the authorized items or services and arranges and pays for the delivery of the purchased items, if applicable. The TAS agency only purchases services or items within the amount allowed by the MCO in dollars. The TAS Office shall, if necessary, contact the member or the agent (AR) to coordinate the service. The TAS Agency provides the authorized services on the completion date registered on the TAS authorization form. The Agency shall provide a copy of the proofs of purchase and any original product warranty information to the member. The TAS agency keeps the original receipts, including VAT, delivery or installation costs. The TAS office shall orally notify the MCO of a delivery delay before the expiry date and document the delay. The agency will also contact the member or ar on the completion date to confirm that all authorized TAS services have been provided. 7670 Three-day monitor requires revision 10-0; As of 1 September 2010 The managed care organisation (MCO) checks the member within three working days of the dismissal date to ensure that services and items authorised through the Transition Assistance Office (TAS). If the member reports that items have not been delivered or services have not been performed, the MCO will contact the TAS Office by and follows up in writing. Written documentation must be kept in the member's case. 7680 Failure to leave the facility review 18-2; As of September 3, 2018 While the Managed Care Organization (MCO) is making every effort to confirm that the member has concrete plans to leave the facility, there may be situations where the member changes his or her mind or has a change in his or her health that makes it impossible for the member to move to the community as planned. In this situation, the MCO reports that the Transition Assistance Services (TAS) agency is no longer moving and that no more items may be purchased. The TAS agency should attempt to return items purchased on behalf of the member and collect a refund for the amount of the purchase. The TAS Agency should also try to recoup the securities, utilities and other deposits paid on behalf of the individual. If the TAS Office fails to return the item(s) for the amount of monies paid, or if the amounts paid on behalf of the member cannot be recouped, the TAS Office shall be entitled to the cost of the item(s) and/or the repayment of deposits paid, so as not to exceed the amount allowed. The TAS Office sends the MCO written notice stating that the item(s) cannot be returned or that the deposits could not be recouped. The MCO contacts a local charity to donate the items and makes appointments for pickup. The charity should serve individuals whose needs are similar to those of the person for whom the items were purchased or should be dedicated to helping individuals to set up a home. If the TAS office is able to return the item(s) or receive the deposits back, the TAS office is not entitled to a refund. If the TAS Office recoups part of the funds paid back, the TAS Office shall be entitled to the costs of the item(s) or will be less recouped. All claims that had been filed and paid for the item (s) or deposits would need to be adjusted by the TAS agency to repay the money to the MCO. If a service has already been provided (e.g. eradication of pests), the TAS Agency is entitled to the cost of the service, so as not to exceed the amount allowed. If the member is only in the community for a few days and returns to the nursing home (NF), the member will keep the item(s) purchased through TAS. 7690 notifications and review 19-1; As of June 3, 2019, the purpose and limitations of Transition Assistance Services (TAS) should be explained to the applicant or member in determining the needs of the applicant or member. The applicant or member appeal against a decision regarding a necessary item or service, but services should not be delayed as a result of the appeal. Form H2065-D, Notice of Managed Care Program Services, must be emailed by the staff of the Program Support Unit (PSU) within two business days of determining eligibility eligibility eligible for the STAR+PLUS Home and Community Based Services (HCBS) program service before the authorization of services. If the applicant or member has completed the discharge plans, Form 8604, Assessment and Authorization (Transition Assistance Services) can be sent to the TAS provider on the same day Form 8604, the Assessment and Authorization (Transition Assistance Services) to the TAS provider on the same day that Form H2065-D is sent to the applicant or member. If the discharge plans have not been finalised at the time of eligibility, Form 8604 may be sent to the TAS provider at a later date by the managed care organization (MCO). PSU employees may include information on Form H2065-D in the comments section. The MCO shall inform the applicant or member in writing of any changes to TAS services or articles. The TAS provider is given the provider permission to provide TAS services on Form 8604. Section 8000, Review service delivery options 20-1; As of March 16, 2020 8100 Selection of a Service Delivery Option Revision 20-1; As of March 16, 2020, all managed care organization (MCO) service coordinators (SCs) must present service delivery options to the applicant, member or statutory representative (LAR) at the initial assessment and subsequent annual reassessment. The service coordinator can use Appendix XVII, It's Your Choice: Decide how to review your personal assistance services, Form 1581, Consumer Options Review and Services (CDS) review, and Form 1582, Consumer Services Responsibilities, or a document made by MCO and with the approval of the Texas Health and Human Services Commission (HHSC) , to assist the applicant, the member or LAR in making the approval of the service delivery. 8110 Review of the Member Decision 20-1; As of March 16, 2020, Managed care organizations (MCOs) must obtain a signature on Form 1584, Consumer Participation Choice, indicating the choice for the member's service delivery. If a current member contacts the MCO at any time of the year for information about service delivery options, the MCO must provide the information to the member. The MCO must keep Form 1584 in the member's file and ensure that the member or the legally authorised representative (LAR) understands that he can request a service delivery option at any time by contacting the MCO. 8200 review of consumer-oriented services 20-1; With effect from 16 March 2020 8210 Review Review 20-1; As of March 16, 2020, Consumer Directed Services (CDS) will offer a member or their legally authorized representative the ability to hire and manage the people who provide their services within their current STAR+PLUS and STAR+PLUS Home and Community Based Services (HCBS) program. The philosophy behind CDS is that people are the best judges of the type and level of help they need and how that help should be delivered. The CDS option was in Section 531,051 of the Government Code and expanded by the 79th Texas Legislature to provide more options for members to provide their services and long-term support (LTSS). The rules for the CDS option can be found in Texas Administrative Code, Title 40, Chapter 41. A member or LAR who chooses to participate in the CDS option becomes the CDS employer of their service providers and is referred to as the CDS employer. The CDS employer is required to select and use a financial management service agency (FMSA) to provide financial management services (FMS). FMS includes help to members in managing funds linked to self-directional services. This includes the initial CDS employer orientation and permanent training related to the responsibilities of being a CDS employer. The FMSA conducts payroll files and pays employer federal and state taxes on behalf of CDS employers, screens potential employment service providers and provides ongoing support for members who opt for the CDS option. A member or LAR can choose the CDS option if: the member's program offers the CDS option; one or more program services in the member's authorized service plan are available for delivery through the CDS option; the member or LAR agrees to implement or designate the responsibilities of the CDS employer necessary for participation in the CDS option; the member or LAR shall select a Financial Management Agency (FMSA) to provide financial management services (FMS); and the member or LAR has developed and received approval from the service planning team for each service backup plan required. If a member or LAR chooses to participate in the CDS option, the member or LAR selects one FMSA to deliver FMS; with the help of the FMSA, budgets allocated in the member's authorized service plan for delivery through the CDS option; and recruits, screens, hires, trains, manages and ends service providers. As a CDS employer, a member or LAR may in writing designate a willing adult as the designated representative (DR) to assist in carrying out employer responsibilities. 8211 Consumer Directed Services Option Definitions Revision 20-1; As of March 16, 2020, the following words and terms, when used, referring to the Consumer Directed Services (CDS) option, have the following meanings. Actively involved — Involvement with a member who considers the member's service planning team to be of a quality nature on the basis of the following: perceived interactions of the person with the member; a history of advocating for the best interests of the Member; knowledge and sensitivity to the preferences, values and beliefs of the member; ability to communicate with the member; availability for the member for help or support when needed. Budget — A written projection of expenditure for each programme service provided cds option. CDS employer - The member or LAR who chooses to participate in the CDS option and is responsible for recruiting, hiring, training, managing, retaining and terminating service providers to provide program services. Designated Representative (DR) — A willing adult appointed by the CDS employer to assist or perform the required responsibilities of the employer to the extent approved by the CDS employer. The DR is not the CDS employer. The DR must be a volunteer and cannot be a paid service provider. Employee - A person employed by the member or legally authorized representative (LAR) through a service agreement to provide program services and is paid an hourly wage for those services. Employer support services — Services and items that the CDS employer must perform. These are employer and labor responsibilities, such as office equipment and supplies, support consultation, employee recruiting costs and other items approved in the Texas Administrative Code, Title 40, Part 1, Chapter 41, §41.507 and the Consumer Directed Services Handbook, Appendix XI, authorized and unauthorized expenses. Financial Management Services (FMS) — Services provided by the Financial Management Agency (FMSA) to the member or LAR, as described in Article 8214.2, FMSA Responsibilities. These services include orientation, training, support, assistance and approval of budgets, and processing of payrolls and debts on behalf of the member or LAR. Financial management services agency (FMSA) — An agency that contracts with a managed care organization (MCO) to deliver FMS. Legally authorized Representative (LAR) — A person who is legally or required to act on behalf of a STAR+PLUS or STAR+PLUS Home and Community Based Services (HCBS) member in respect of CDS, including a parent of a minor, guardian of a minor, conservator of a minor or the guardian of an adult. Service Backup Plan – A documented plan to ensure that critical program services provided through the CDS option are provided to a member when the normal delivery of the service is interrupted or there is an emergency. Service Planning Team (SPT) — A group of people who meet to discuss the member's needs, which consists of the member or LAR, the service coordinator, and any other person invited by the member or LAR. Support Advisor — An employee who provides support consultation to a CDS employer, a DR, or a member who receives services through the CDS option. Support consultation — A service that provides skills training and assistance for the implementation of CDS employer-related 8212 services available in cds option review 20-1; As of March 16, 2020, STAR+PLUS services will be available in the Consumer Directed Services (CDS): Personal Assistance Services (PAS) option; and Community First Choice (CFK) PAS or Habilitation. STAR+PLUS Home and Program Services (HCBS) available in the CDS option are: In-home respite services; Skilled nursing; Assistance in the labour market; Supported employment; Physiotherapy (PT); Occupational therapy (OT); and cognitive rehabilitation therapy (CRT); speech therapy. A member or his legally authorized representative (LAR) may choose to send all services available through the CDS option itself. The CDS option is available to members who live in their own home or family members' homes. The CDS option is not available to members living in an adult foster home (AFC) or assisted living facilities (ALFs). Choosing the CDS option does not affect a member's suitability for services. Members can choose to have the above services provided through the service delivery option of their choice. Financial management services (FMS) is a required service in the CDS option. FMS provides assistance to CDS employers for the management of funds related to self-directional services, and is provided by a financial management services agency (FMSA) contracted with the member's managed care organization (MCO). This includes initial guidance and ongoing training on the responsibilities of CDS employers and assisting and approving the CDS employer's budget. The FMSA also carries out payroll and pays employer tax on behalf of the CDS employer. A monthly administrative fee is allowed on the individual service plan (ISP) and paid by the MCO to the FMSA for FMS. If requested, an FMSA may provide support consultation, which includes additional training and support for the CDS employer in relation to their employer responsibilities outside of the ongoing support of the FMSA. 8213 Benefits and risks of the CDS Option Revision 20-1; As of March 16, 2020, the member or legally authorized representative (LAR) must be informed of and take into account the benefits and risks associated with the Consumer Directed Services (CDS) option before choosing to register. To assist the member in making an informed decision, the Managed Care Organization (MCO) service coordinator must submit information about service delivery options to the member or LAR. See section 8221, Presentation of the CDS option. 8213.1 Advantages of the CDS Option Revision 20-1; As of March 16, 2020 Below are some of the benefits of using the Consumer Directed Services (CDS) option. The member or the legally authorised representative (LAR): has greater control over who provides services and the days and times of the services are provided; benefits such as bonuses, overtime, wage increases, sick pay and insurance to direct service providers, using funds from the CDS budget and in consultation with the Financial Management Agency (FMSA); check the final pay rate for service providers within the permitted limits; can rent rent service providers, such as family members, friends and other persons they know, in accordance with the programme and CDS rules; train service providers and monitor the services provided by the service providers; may designate an eligible person as a designated representative (DR) to assist with or carry out employer responsibilities; and can use budget resources to hire a support advisor if they need help outside of FMSA's support. 8213.2 Risks and liability related to the CDS option review 20-1; As of March 16, 2020 Below are some of the responsibilities of members and possible risks associated with the consumer directed services (CDS) option. The member or legally authorized representative (LAR) is: responsible for locating escorts, backup attendants and other direct service providers, as there is no home and community support services agency (HCSSA) provider to fall back on providing services. The member or LAR may enter into a contract with an HCSSA that agrees to provide backup services, but the HCSSA is not required to enter into a contract with the member or LAR; the CDS employer in the CDS option and thus assumes all liability with regard to employment. The member or LAR retains control over the recruitment, hiring, training, management and termination of employees. The persons providing services are not employees of the Financial Management Services Agency (FMSA), the managed care organization (MCO), a state or federal agency or any other contracted provider agency. As an employer of CDS, the member or lar shall be solely responsible and liable for negligent acts or omissions of the employee(s), service providers or the designated representative (DR); responsible for dealing with all conflicts with their employees. The CDS employer may request that support consultation services be added to its service plan and budget in order to provide training and assistance to this employer's responsibility if necessary; not be able to reduce or increase the hours of service authorised by MCO by adjusting the hourly wage of the employee; the specified time limit prescribed by the FMSA should be specified. The CDS employer must keep the documentation safely for five years or more; responsible for payroll tax due to the Internal Revenue Service (IRS) and Texas Workforce Commission (TWC), and is liable if the FMSA does not pay. The FMSA assumes full responsibility for the payment of payroll tax due to the IRS; and responsible for meeting all state and federal requirements as an employer and can be held liable for the meet these requirements. 8214 Member and Financial Management Services Agency Responsibilities Revision 20-1; With effect from 16 March 2020 8214.1 Member States Responsibilities Review 20-1; With effect from 16 March 2020, the member or legally authorised representative (LAR) shall assume responsibility as the employer of the register. The The or LAR is responsible for: recruiting, hiring, training, managing and terminating direct service providers; determining wages and benefits for direct service providers within funds allocated for services chosen through the Consumer Directed Services (CDS) option; following state and federal laws, including overtime pay; evaluation of the performance of each service provider; approving, signing and submitting schedules, invoices and receipts to the Financial Management Office (FMSA) for payment to direct service providers; provide the FMSA with the necessary information to register as an agent of the member with the Internal Revenue Service (IRS) and the Texas Workforce Commission (TWC); ensure that the FMSA has verified that the applicant is eligible before hiring or retaining employment or service; resolving concerns and complaints from service providers; keeping a personnel file on each service provider; developing and implementing backup service plans for services determined by the individual's planning team to be critical to the health and safety of the individual; and to ensure the protection of individual receiving services and to preserve evidence in the event of an investigation by a Department of Family and Protective Services adult protective services of an allegation of abuse, neglect or exploitation against a CDS employee, designated representative, FMSA representative or service coordinator. The member or LAR must agree to accept financial management services (FMS) from the selected FMSA. The member or LAR must obtain an employer identification number from the applicable government agencies and may ask the FMSA for assistance to meet the requirements. The member or LAR must provide the information necessary for the FMSA to register as an agent of the member with the IRS and other appropriate government agencies. 8214.2 FMSA responsibilities review 20-1; As of March 16, 2020, a Financial Management Services Agency (FMSA) must provide financial management services (FMS) to an employer of Consumer Directed Services (CDS) or designated representative (DR), including: orienting and training the CDS employer or DR on CDS employer responsibilities for the Consumer Directed Services (CDS) option, including legal requirements of various government agencies; assisting and approving budgets for each service to be provided through CDS; complete forms necessary to obtain an employer identification number (EIN) from federal and state agencies with the CDS employer; carrying out criminal history checks and registry checks applicants; verifying the suitability of each applicant with program requirements, including Medicaid fraud exclusions, before an applicant is employed or is held by the CDS employer; register as an employer agent with the IRS and assume full liability for filing reports; Pay Pay taxes on behalf of the CDS employer, to the IRS and the Texas Workforce Commission (TWC); the receipt and processing of staff time sheets, the calculation and payment of all federal and state taxes and deductions relating to employment, and the distribution of payroll at least twice a month; the receipt and processing of invoices and receipts for payment; keeping track of all expenditure and allowances and monitoring the budget; submitting claims to the member's managed care organisation (MCO); providing written summaries and budgeting balances of wage and other expenditure at least quarterly; drawing up and submitting employer-related taxes and source forms and reports (this does not include filing income tax returns for employees); and the provision of permanent training and assistance, if necessary or requested. The FMSA must obtain employer agent status, as defined by IRS Rev. Proc., 2013-39, and perform all responsibilities as required by the IRS and other appropriate government agencies. The FMSA concludes service agreements with each of the member's direct service providers before payment is paid. An FMSA may not provide financial management services (FMS) and case management services to the same member. The FMSA must participate in all mandatory training courses given or authorized by the Texas Health and Human Services Commission. The MCO should monitor the FMSA's performance and ensure that the FMSA performs all FMSA responsibilities, including participation in mandatory training. 8220 Member Choice in the CDS option review 20-1; As of March 16, 2020, information about the Consumer Directed Services (CDS) option should be presented to the STAR+PLUS or STAR+PLUS Home and Community Based Services (HCBS) program member by the managed care organization's (MCO) service coordinator at all initial and annual planning meetings or at any time by the member. The MCO service coordinator must provide written and oral information on the benefits and requirements of the CDS option. The member chooses which services are provided through the CDS option and which will be through the agency or service responsibility option. 8221 Presentation of the CDS Option Revision 20-1; As of March 16, 2020 At the time of a member's registration in a STAR +PLUS or STAR + PLUS Home and Community Based Services (HCBS) program that provides the Consumer Directed Services (CDS) option, and at least annually thereafter, the managed care organization (MCO) service coordinator or any other person appointed by the member's program must: materials written on the CDS option to the member or legally authorized (LAR); meet the member or provide an oral explanation of the CDS option specific to the member's programme; present or make available to the member, the Texas Health and Human Services Commission (HHSC) video, The Consumer Directed Services Services accessible by visiting and fill out Form 1581, Consumer Directed Services Option Overview. A member or LAR may request an MCO service coordinator to provide additional oral and written information to the member or LAR regarding the CDS option at any time or to assist in the registration in the CDS option at any time. The MCO service coordinator must comply within five working days of receiving the request. A member or LAR who initially refuses to participate in the CDS option when presented by his service coordinator can request information about CDS at any time and choose to participate in the CDS option while receiving services through STAR+PLUS or STAR+PLUS HCBS. The MCO service coordinator is responsible for presenting the CDS option annually to all new applicants and current members who are not enrolled in the CDS option and when information is requested. The MCO service coordinator: shares an overview of the benefits and responsibilities of the CDS option by reviewing Form 1581; provide a copy of Form 1581 to the applicant or member or LAR; and informs the applicant or member of the right to choose service delivery through the CDS option the option of the agency, or the service responsibility option (SRO). For the first requests, the MCO service coordinator obtains the signature of the applicant on Form 1581 at the first contact. The MCO service coordinator signs and data the form to verify the information was submitted to the applicant. A copy of Form 1581 is placed in the file record to document that CDS information has been shared. For annual reshuffles, the MCO service coordinator shall provide the member or LAR with a copy of Form 1581 and clearly document in the file that Form 1581 has been shared with the member. When members or LARs request information about the CDS option at other times, the MCO service coordinator must provide the member with CDS information within five business days of receiving the request. The MCO service coordinator can provide the information by making a home visit or contacting the member or LAR by phone. If no home visit is made, the MCO service coordinator obtains the member's signature or LAR signature by sending Form 1581 to the member with an envelope of shipping and returns. The MCO service coordinator boards and data Form 1581 stating the information was presented. A copy of Form 1581 shall be placed in the member's file to document Form 1581. The MCO service coordinator should discuss the CDS option, as well as differences in service delivery and payment options, and allow the member or LAR to choose between provide services through the agency's option or cds option. If the member or LAR is interested in participating in the CDS option once the information on Form 1581 has been shared, the MCO Service Coordinator shall review Form 1582, 1582, Targeted responsibilities for services. The MCO

service coordinator: assesses with the member or LAR the responsibilities, risks and benefits of the CDS option; assist the member or LAR, if necessary, in completing the member's self-assessment on page 4 of Form 1582; records the choice of member or lar to participate in the CDS option and assists the member in selecting and appointing a designated representative (DR), if necessary, or registers the choice not to participate in the CDS option; obtain the dated signature of the DR if the member or LAR chooses to appoint a DR; and characters and dates Form 1582. If a member or LAR (the CDS employer) cannot complete the consumer's Self-Assessment, a person designated by the CDS employer as the CDS employer's DR must be able to complete the consumer's self-assessment for the member receiving services to participate in the CDS option. 8222 Choice of Membership and registration in the CDS option revision 20-1; As of March 16, 2020, a member or legally authorized representative (LAR) who decides to participate in the Consumer Directed Services (CDS) option, with the help of the service coordinator of the managed care organization (MCO), must fill out the following forms: (1) Form 1582, Consumer Directed Services Responsibilities (2) Form 1583, Employee Qualification Requirements; (3) Form 1584, consumer choice; (4) Form 1585, Recognition of responsibility for exemption from nursing license for certain services through consumer directed services, or Form 1733, employer and employee recognition of exemption from nursing license for certain services provided through consumer directed services, if required by the program's policy of the member; and (5) Form 1586, confirmation of information regarding support consultation services in the Consumer Directed Services (CDS) Option, if the service is available in the member's program. A member or LAR who chooses to participate in the CDS option must complete the self-assessment in Form 1582 and, if applicable, complete any assessment required by the member's program. A member or LAR who cannot complete the self-assessment must appoint a designated representative (DR) to participate in the CDS option. The MCO service coordinator presents the information on Form 1582 and allows the member or LAR to choose between the CDS option or the Agency Option (AO). The MCO service coordinator develops the member's service plan according to the policy and CDS option rules. 8222.1 Choose the CDS option and an FMSA revision 20-1; As of 16 March 2020 If the member or legally authorised representative (LAR) chooses and can participate in the consumer services (CDS) option, the MCO service coordinator moves to Form 1583, Employee Qualification Requirements and Form 1584, Consumer Participation Choice. The MCO service coordinator: offers Form Form information about the additional responsibilities of the employer are in the CDS option and which may or may not be hired in the CDS option; divide form 1584 indicating the selection of the CDS option by the applicant, member or LAR; obtains the signature of the applicant, the member or lar on Form 1583 and Form 1584, where applicable; characters and dates of the forms; and helps the member or LAR to choose a financial management services agency (FMSA). The MCO service coordinator presents a list of MCO-contracted FMSAs and home and community support servicesgencies (HCSSA) providers. The member or LAR must choose: an FMSA to offer CDS financial management services (FMS); and an HCSSA provider to provide all other STAR+PLUS Home and Community Based Services (HCBS) program services that are not delivered under the CDS option. The MCO service coordinator develops the individual service plan (ISP) according to STAR+PLUS and STAR+PLUS HCBS program policies and CDS option rules. 8222.2 The CDS option revision 20-1 decreases; As of March 16, 2020 If the member or the legally authorized representative (LAR) rejects the Consumer Directed Services (CDS) option after viewing the self-assessment tool on Form 1582, Consumer Directed Services Responsibilities, the service coordinator of the managed care organization (MCO): the signature of the applicant, member or LAR on Form 1584, Consumer Participation Choice, indicating his or her selection of service delivery options; and characters and dates Form 1584. The MCO service coordinator must ensure that the member understands that the CDS option is always available and that the member can call the MCO service coordinator to request a change to the CDS option at any time. Form 1584 is signed by the member at any time a different service delivery option is chosen. 8223 Designated representative review 20-1; As of March 16, 2020, the member or legally authorized representative (LAR) has the option to appoint a designated representative (DR) to assist in the responsibilities of being a CDS employer in the Consumer Directed Services (CDS) option. If a CDS employer decides to appoint a DR after the Financial Management Services Agency (FMSA) has been selected, the FMSA will assist the CDS employer in appointing a DR. A CDS employer may designate a willing adult as dr to assist or to perform CDS employer responsibilities. The CDS employer maintains the responsibility and accountability for decisions and actions of the DR. If the CDS boss chooses to appoint or change a DR, the CDS Boss must complete Form 1720, Appointment of Appropriate Representative. The person referred to by the member or if DR is designated, be prepared to serve as a member or lar dr to participate in the CDS option; or are actively involved with the member; and complete the self-assessment in Form 1582, Consumer Directed Services Services and any assessment required by the member's programme. A DR may not: sign or represent himself as the CDS employer; paid to carry out employer responsibilities; be an employee of the CDS employer; employ a spouse of the CDS employer; or provide a program service to the member. The CDS employer must inform the FMSA by fax or telephone within two working days of the appointment or modification of a DR. If the CDS employer informs the FMSA by telephone, the CDS employer must fax or email a copy of Form 1720 to the FMSA within five working days of the appointment or modification of a DR. If a CDS employer decides to revoke the appointment of a DR, the CDS employer must: fill form 1721, Withdrawal of Appointment of Appropriate Representative; and, within two days of the effective date of withdrawal, provide a copy of the completed form to the person's DR, FMSA, and case manager/service coordinator. Based on documentation provided by the FMSA on a CDS employer's inability to fulfill the employer's responsibilities, the personal service planning team may recommend that the CDS employer designate a DR to assist in or to perform responsibilities of CDS employers. 8230 Developing the individual service plan in the CDS option revision 20-1; As of March 16, 2020, service planning for a member who chooses to participate in the Consumer Services Directed (CDS) option will be completed in accordance with the rules and requirements of the member's program in the same way as when services are provided through a program provider. Service planning includes: determining the member's needs; determining service levels; to justify changes to the service plan; maintaining costs and cost limits; review of services; and obtaining approval for planned services. The Managed Care Organization (MCO) service coordinator must comply with the rules and requirements of the member's program if the member's services or a request for services is recommended for: denial; reduction; suspension; termination. The MCO service coordinator must provide a written or oral explanation of an action recommended by a service planning team. The procedure for applying for a fair trial must be given orally and in accordance with the member's programme requirements. All financial and non-financial requirements for the eligibility of STAR+PLUS and STAR+PLUS Home and Community Based Services (HCBS). All existing Medicaid eligibility requirements apply in the CDS option. CDS is not a service; it is a service delivery option. The MCO service coordinator completes all currently required for STAR+PLUS HCBS program services, including Form H2060, Needs Assessment Questionnaire and Task/Hour Guide, Form H2060-A, Addendum to Form H2060 and Form H2060-B, Addendum for Needs Assessment, if applicable. The member using the CDS option must have a backup plan to all authorized services that are critical to the health and safety of the member without service interruption, even if there are unexpected personnel changes. The CDS employer or designated representative (DR) must develop and approve the MCO service coordinator for each service backup plan required to participate in the CDS option. See Section 8231, Service Backup Plans. The MCO service coordinator follows program policies when completing denials or terminations, service reductions, and suspensions. The MCO service coordinator must ensure that the CDS employer fully understands the reasons for actions taken regarding the Individual Service Plan (ISP) and STAR+PLUS or STAR+PLUS HCBS program services, as well as actions that may affect the member's participation in the CDS option. If the CDS employer or DR hires a nurse to provide services, nurses must work within their licensing requirements described in the Texas Board of Nursing regulations (Texas Administrative Code, Title 22, Part 11), including registered nurse (RN) or doctor supervision, plan of care development for nurses, depending on the level of nursing hired, and RN or doctor delegation , as indicated. In the CDS option, an RN must develop the care nursing plan that determines the required hours of nursing and how many, if any, of the nursing hours can be provided by an approved professional nurse (LVN) and the same RN responsibilities mentioned in the above paragraphs. The RN and LVN must recognise the nursing rules, including that an LVN must practice under the supervision of an RN, by completing Form 1747, Recognition of Nursing Requirements. The RN can be used through a contract with a home health care agency or private scheme. The same expectation of cooperation exists between the MCO RN service coordinator and the RN who develops the plan of care in the CDS option. 8231 Service Backup Plans Review 20-1; As of March 16, 2020, the managed care organization (MCO) must discuss with the CDS employer or designated representative (DR) the services provided through Consumer Directed Services (CDS) that are critical to the health and safety of the member. The MCO must require the CDS employer or DR to develop a service backup plan to ensure the health and safety of the member when regular service providers are not available to provide services or in an emergency. The CDS employer or DR must develop a backup plan and document the plan on Form 1740, Service Backup Plan, to provide all authorized personal without guaranteeing service interruption. The CDS employer or DR, with the help of the MCO service coordinator (if necessary), completes Form 1740. The service backup plan should list the steps that the CDS employer or DR will take if the regular service provider is not running. The service backup plan may include the use of paid service providers, including, service providers, such as family members, friends or non-programme services, or interruption (if included in the ISP). The CDS employer or DR is responsible for implementing the service backup plan in the employee's absence. Service backup plans are submitted by the member, LAR or DR to the MCO service coordinator. The MCO service coordinator/service planning team (SPT) approves the plans as viable if necessary in the event that a service provider is absent. The MCO or SPT must approve each service backup plan and any revision(s) before the CDS employer or DR is implemented. The MCO approves the service backup plan by signing, dating and returning a copy of the plan to the CDS employer and DR, if applicable. The CDS employer or DR is required to: budget sufficient resources in the CDS option budget to execute a service backup plan; review and revise each service backup plan annually; revise a service backup plan if: the member is experiencing a problem in the deployment; whether there are changes in the availability of resources; redistribution of resources that are not used to run a service backup plan; and provide a copy of the initial and revised service backup plans and budgets to the Financial Management Services Agency (FMSA) within five business days of approval of a plan by the SPT. The FMSA should: Assist a CDS employer or DR, as requested, in reviewing budgets to meet the service backup plan strategies approved by the member's SPT; revised, validating and approving revised budgets in accordance with §41,511, Texas Administrative Code, with respect to budget revisions and approval; documented, budgeted permitted costs associated with implementing service backup plan strategies; and keep a copy of service backup plans received from the CDS employer or DR. 8232 Service Planning Team Responsibilities Revision 20-1; As of March 16, 2020, a member's personal service planning team will consist of individuals required or permitted by the member's program. A Consumer Directed Services (CDS) employer must participate in and participate in the member's service planning meetings. The designated representative of a CDS employer (DR) may also attend the meeting with the approval of the CDS employer. A CDS employer or DR must provide documentation regarding services, services and participation in the CDS option when requested by a managed care organization (MCO) or MCO service coordinator. A CDS employer or DR must request a change to a service or the addition of a service for delivery via the CDS option, the person-oriented (SPT) provide documentation of circumstances requiring a review of the individual service plan (ISP). The MCO and STAR+PLUS or STAR+PLUS Home and Community Based Services (HCBS) program SPT members are the person-centered SPT for the member who selects the CDS option. Select. MCO convenes the SPT as required by the STAR+PLUS or STAR+PLUS HCBS program policy and obtains approvals from SPT members where applicable. The MCO and SPT also help to resolve issues and concerns related to the member's participation in the CDS option. The Financial Management Agency (FMSA) should send a quarterly report to the employer and MCO service coordinator of CDS and MCOs and inform the MCO of issues or problems, including: allegations of abuse, neglect, exploitation or fraud; concerns about the health or safety of the member; non-delivery or longer interruptions in services; non-compliance with the responsibilities of CDS employers; non-compliance with service backup plans; or over- or underutilization of services or resources allocated in the ISP for the provision of services to the member through the CDS option and in accordance with the requirements of the STAR+PLUS or STAR+PLUS HCBS programme. The member or the legally authorised representative (LAR) is required to participate in service planning meetings and provide requested documentation relating to services and services. The member or LAR shall provide documentation to support requests for a review of the ISP. The FMSA may also participate in the member's service planning at the request of the member or LAR, and if agreed by the FMSA. The FMSA shall provide information on the member's participation in the CDS option within three days of receipt of a request for information from the member or LAR, DR, MCO or other interested parties. Mco and SPT members shall, as appropriate, participate in the approval of backup plans, develop corrective action plans, if necessary, and recommend suspension or termination of the CDS option. See section 8231, service backup plans, and section 8244, corrective action plans. 8233 CDS Employer Support Services in the CDS Option Revision 20-1; As of March 16, 2020, an employer of Consumer Directed Services (CDS) or designated representative (DR) may budget CDS employer support services and start-up costs through the services provided by one or more employees in the CDS option. Cds employer support services include work-related costs, employer-related costs and support consultation services. CDS employer support services do not include unauthorized expenses listed in Appendix XI, authorized and unauthorized expenses, in the Consumer Directed Services Handbook. Start-up costs should be: budgeted for purchases projected before the delivery of services through the CDS option; and made up of the budgeted unit rate for services scheduled for delivery via the CDS option within three months after the introduction of the CDS option. A CDS employer or DR may provide authorised, necessary and reasonable services, goods or items for employment contracts, including: recruitment costs, budgeting; obtaining a report on the criminal history report history report the Texas Department of Public Safety; taking on a job-specific training; cardio-pulmonary resuscitation training; first aid training; deliveries necessary for an employee or provider of the service to perform a task, if not available through the member's program or any other source and the purchase is permitted through the member's programme; non-taxable employee benefits; and services, goods and items specifically approved by the member's programme as an employer support service or as authorised expenditure included in Appendix XI. A CDS employer or DR may provide employer-related services, goods or property necessary to meet the responsibilities of CDS employers, including: basic office equipment, which may contain a basic fax device for submitting documents to the Financial Management Services Agency (FMSA); mailing costs; costs related to the making of copies; file folders and envelopes; and services, goods and items specifically approved by the member's programme as an employer support service or as authorised expenditure included in Appendix XI. Support consultation, if available through the member's program, is an optional service that is available to a member participating in the CDS option. Support consultation is given to a CDS employer, DR, or a member who receives services through the CDS option, if that member will be the CDS employer within six months of the opening of support consultation services. Support consultation is provided by a person who meets the qualifications of a support advisor. A support advisor may be a contractor for the CDS employer or an employee or contractor of an FMSA. Support consultation should provide a level of training, assistance and support that does not duplicate or replace the services of the FMSA, the Service Coordinator of managed care organization (MCO) or other available programme or non-programme services or resources. Support consultation provides practical skills training and assistance to successfully manage service providers for authorized program services provided through the CDS option. This includes skills training and assistance for: recruiting, screening and hiring of employees; developing and documenting job descriptions; checking the suitability and qualifications of employment; completing documents necessary to: employ a person; retain a contractor or supplier; and the management of service providers; effective communication, troubleshooting and documenting CDS employer responsibilities in the CDS option; development, review and implementation of service backup plans; performing comply with the member's programme and this section; and the development of continuous decision-making skills for employer-related and employment-related situations. A CDS employer or DR can budget and initiate the support consultation services while the member participates in the CDS option. Before Before of the service, the CDS employer or DR must identify the person or persons (the CDS employer, the DR or the member within six months of the creation of the CDS employer) in order to receive the service and set specific targets for the service; obtain approval of the objectives set for the service by the member's service planning team; develop a budget for aid consultation; and obtaining the approval of the FMSA budget. If the member's service planning team allows support consultation, the team must: approve the funds, duration, and frequency of the service; help develop objectives and ensure that the activities necessary to achieve the objectives through support consultation meet this department; the objectives for support consultation and the person or persons receiving the service (the member, the employer or dr) approve; and end the service when the goals are achieved. A CDS employer or DR can budget up to 10 percent of their CDS budget for CDS employer support services. A CDS employer or DR may not spend more than $600 per year or more than $50 per month for CDS employer support services if less than 12 months remain in the service plan. 8240 Introduction and transition to the CDS option review 20-1; With effect from 16 March 2020 Within five working days of receipt of a completed Form 1584, Consumer Participation Choice, by an eligible member or legally authorised representative (LAR), or after receipt of Form 1584 and within five business days of determining the suitability of an applicant who signs up for program services, a managed care organization (MCO) service coordinator must provide the following documentation to the Financial Management Services Agency (FMSA) : Form 1584, the individual service plan (ISP); date on which the CDS employer can incur costs to start up activities and incur recruitment and recruitment costs; date on which the CDS employer may begin the provision of programme services through the service providers of the CDS employer; the number of units, the approved rate or the amount permitted in the ISP for each service to be supplied through the CDS option; total resources allowed for each program service to be provided through the CDS option; and the authorized schedule of service delivery by day, week, month or other time frame specific to the service, if not listed on the above forms. Within five working days of determining eligibility for the STAR+PLUS or STAR+PLUS Home and Community Based Services (HCBS) program, new applicants who choose the CDS option will be referred to the FMSA they have selected to start initiation process. Within five working days of receipt of the completed Form 1584, current STAR+PLUS and STAR+PLUS HCBS program members who choose the CDS option will be referred to the FMSA they selected to start the CDS initiation process. The MCO service coordinator provides the FMSA with the documentation: Form 1584; Form 1582, responsibilities for consumer-oriented services; and the ISP. The MCO service coordinator must provide the FMSA with the authorized schedule of service delivery per day, week, month, or other time frame specific to the service, if it is not listed on the forms above. Some applicants may have anticipated the availability of the CDS option and may choose to go directly to the CDS option. The MCO service coordinator should stress that the applicant assumes all responsibility for arranging his self-directed services. MCO service coordinators should carefully coordinate transition activities in the transition of applicants or members to and from the CDS option. 8241 Introduction and orientation of the member as employer review 20-1; With effect from 16 March 2020, a CDS employer and the designated representative (DR) shall, where applicable, complete the initial face-to-face orientation of the Financial Management Services Office (FMSA) in the place of residence of the member or institution of the choice of the member or legally authorised representative (LAR); a copy of Form 1736, documentation of employer orientation by financial management services agency, to be completed and kept, upon completion of the orientation; Form 1735, Employment Agreement of the Agency for Employers and Financial Management, with the programme addendums, where applicable; form 1726, fill out relationship definitions in consumer directed services; if required by the member's program, complete Form 1733, employer and employee exemption from nursing license for certain services provided through Consumer Directed Services, or Form 1585, Recognition of responsibility for exemption from nursing license for certain services provided through consumer directed services; Form 1728, confirmation of liability; submit to the FMSA within five working days of the date of the first orientation completed original forms specified in this section; and keep copies of the completed documentation required by this section. Upon receipt of the CDS referral from the service coordinator of the managed care organization (MCO), the FMSA completes the original CDS employer orientation with the member, LAR or DR, if applicable, in the place of residence or setting of the member's or LAR's choice. The FMSA provides an overview of the CDS option, including the rules and requirements of the applicable government agencies, and the roles of the CDS employer and the FMSA. During the first face-to-face orientation, the FMSA must also: explain the roles, rules and responsibilities that apply to a CDS employer, provider, FMSA, MCO and government agencies, the CDS employer budget based on the authorised service plan; the recruitment process, including documents and forms to be completed for new employees; completed; managing paper and electronic schedules, expiry dates, payday schedules and paying out salary checks for employees; revision and departure with the CDS employer and DR, where applicable, a printed document clearly indicating the FMSAs: normal hours of use; key persons to get in touch with issues or questions and how to contact them; and the complaints procedure, including the submission of a complaint to the FMSA or the FMSA; form 1735 and required addendums, with an emphasis on the control and policy requirements of the member's program, including: service definitions; qualifications of the supplier; required documentation to be kept in the home; training requirements for service providers; program staff who will be reviewing the CDS employer records; and, where applicable, nursing requirements as described on Form 1747, recognition of nursing requirements; and the CDS employer and dr, if applicable, review and leave, printed information on reporting allegations of abuse, neglect and exploitation. The FMSA provides the CDS employer or DR with a printed or electronic copy of the HHSC CDS Option Employer Manual. At the end of the orientation, the FMSA and the CDS employer must complete Form 1736, Documentation of employer orientation by financial management services agency. The FMSA shall receive a completed Form 1735 with required annexes signed and dated by the CDS employer or DR prior to the introduction of the CDS option. The CDS employer or DR signs and submits all required forms to participate in the CDS option and returns the forms to the FMSA within five working days of the date of the first orientation. The CDS employer and FMSA shall notify the MCO service coordinator when all initiation activities have been completed. The MCO must ensure that the FMSA performs all FMSA responsibilities, including providing guidance to CDS employers. 8242 Employer and employee confirmation of exemption from nursing licensing for certain services provided through CDS review 20-1; As of March 16, 2020 the Financial Management Services Agency (FMSA) assists the Consumer Directed Services (CDS) employer or designated representative (DR) in completing the CDS employer and employee recognition of exemption from nursing licensing requirements for certain services provided through CDS. Tasks prohibited to delegate delegation are described in the Texas Administrative Code §225.13, Taken Prohibited From Delegation. The employee acknowledges that, if the person providing the service, they have not been: refused a license under Chapter 301 or 302, Occupation Code; or a license issued under Chapter 301, Occupation Code, which shall be repealed or suspended. The FMSA verifies potential service providers selected by the CDS employer or DR to meet the qualifications and other requirements of STAR+PLUS or STAR+PLUS Home and Community Based Services (HCBS) for the CDS employer or DR DR service provider. 8243 allow CDS revision 20-1; As of March 16, 2020 When the CDS employer and financial management services agency (FMSA) informs the Service Coordinator of the Managed Care Organization (MCO) that the CDS services are ready to begin, the MCO service coordinator negotiates a start date for services. The MCO Service Coordinator revises Form H1700-1, Individual Service Plan (Pg. 1), and changes the applicable authorizations to the FMSA. For current members, the individual service plan (ISP) year remains the same. The same procedures shall be followed for any other transfer of agencies. It is the responsibility of the CDS employer and the FMSA to ensure that expenditure for the year remains within the permitted amount. The MCO is responsible for the timely payment of FMSA claims filed on behalf of the CDS employer, as well as for the payment of the monthly service fee, which the FMSA pays for its services. 8244 Corrective Action Plans Revision 20-1; With effect from 16 March 2020, a written Action Plan for Corrective Action (CAP) may be required from an employer of Consumer Directed Services (CDS) or designated representative (DR) if the CDS employer or DR: hires an ineligible service provider; submit incomplete, incorrect or late documentation of the provision of the service; does not follow the budget; does not meet the program requirements relating to the CDS option; does not meet other responsibilities of CDS employers. The CDS employer or DR must provide a written CAP to the person required by the plan within 10 working days of receipt of a CAP request. CAPs can be requested in writing by the Financial Management Services Agency (FMSA), Managed Care Organization (MCO), Texas Health and Human Services Commission (HHSC) staff or service planning team (SPT) member. The written CAP must contain the reason why the CAP is required; measures to be taken; the person responsible for each action; and the date on which the action is to be completed. The CDS employer or DR may request assistance from the: FMSA or others in the development or implementation of a CAP, if the plan relates to the responsibilities of the CDS employer; and MCO, if the CAP is related to the rules or requirements of the STAR+PLUS Home and Community Based Services (HCBS). Form 1741, action plan for corrective measures, is used to document the CAP. 8244.1 Termination of cds option revision 20-1; As of March 16, 2020, an employer of Consumer Directed Services (CDS) may at any time request voluntary termination of participation in the CDS option and receive services through a program agency provider. A member can also terminate participation in the CDS option in accordance with the requirements of the member's program and Texas Administrative Code §41.407, Termination of participation in the CDS option. After the CDS option ends, the member must wait 90 days before switching to another service Option. A member's Managed Care Organization (MCO) service coordinator convenes the member's service planning team (SPT) on matters that may warrant an immediate termination of the member's participation in the CDS option. When reviewing the information, the SPT may recommend that participation in the CDS option be terminated immediately if: the health or safety of the member is immediately endangered by the member's participation in the CDS option; the designated representative (DR) has been convicted of an offence under Chapter 32 of the Penal Code or an offence prohibiting employment as set out in the Texas Health and Safety Code, §250.006(a) and (b); or HHSC or any other government agency with the applicable regulatory authority recommends that participation in the CDS option be terminated immediately. If a CDS employer or designated representative (DR) does not perform and successfully complete the following steps and interventions, the SPT may recommend that a member's SPT terminate participation in the CDS option in accordance with the member's program requirements: eliminate any risk to the member's health and safety; successfully providing programme services through CDS; to meet the responsibilities of CDS employers; successfully implement corrective action plans; or appointing a DR or accessing other available supports to assist the CDS employer in meeting CDS employer responsibilities. Before recommending a financial management agency (FMSA) to involuntarily terminate participation in the CDS option to a member's MCO service coordinator, the FMSA must: provide documentation to the member's MCO service coordinator of additional and permanent training and support provided by the FMSA when a CDS employer or DR is not connected to the responsibilities of the CDS employer; assistance requested by the CDS employer or DR to develop and implement a corrective action plan; provide documentation in accordance with this section of a corrective action plan requiring the CDS employer or DR of the CDS employer or DR; and notify the MCO service coordinator in writing of the requirements of the member's program when recommending that a member's participation in the CDS option be terminated. Upon receipt of a recommendation for involuntary termination of the FMSA or any other Party, the member's MCO service coordinator shall: assist in providing support and developing and implementing a corrective action plan regarding non-compliance with programme and CDS requirements; document interventions used by the CDS employer or DR to eliminate non-compliance with for the delivery of program services through the CDS option; and convenes the SPT to consider: recommendations regarding the member's participation in the CDS option; recommend additional measures to protect the health and safety of the member in the CDS option; and, if necessary, make revisions to the member's service plan. If the SPT recommends that participation in the CDS option be discontinued, the member's MCO service coordinator should document the reasons for the recommendation; the conditions and the time limit laid down by the SPT of the member which the member must meet before the member is re-registered for the CDS option; justifying a time limit for termination exceeding the minimum requirement of 90 days; and, where applicable, the conditions and time frame set by a hearing officer as a result of a fair trial that upholds the termination. When a member's participation in the CDS option is terminated, the MCO service coordinator must take steps and interventions in accordance with the requirements of the member's program to: ensure continuity of the provision of program services provided through the CDS option; and document agreements made for the delivery of program services that were provided through the CDS option to be provided by the member program provider or other resources. 8244.2 Re-enrolment in the CDS option revision 20-1; As of March 16, 2020 after termination of participation in the Consumer Directed Services (CDS) option, a member or legally authorized representative (LAR) must re-apply for registration in the CDS option by notifying the member's managed care organization (MCO) service coordinator. If a member or LAR wants to re-enroll in the CDS option, the MCO service coordinator must review the reason why the member was suspended or terminated from the CDS option; check that the member has complied with the minimum period of 90 days and the conditions laid down by the member's service planning team (SPT) or a hearing officer, if applicable; check how any problem that contributed to the suspension or termination has been resolved; and refer the request for re-registration in the CDS option to the member's SPT and follow the requirements of the member's program, including: reviewing the member's service plan and re-enrolling the member in the CDS option after approval; and giving a refusal and providing information regarding requesting a fair trial if the request is not approved. If approved for re-enrolment, the FMSA must: provide an initial orientation in accordance with this section, after the re-registration of the member in the CDS option if the current CDS employer or DR has not received initial guidance; and notify the CDS employer DR and the member's MCO service coordinator in writing within two working days of a repetition of prior non-compliance or additional non-compliance with requirements of program of the member or section during the member's participation in the CDS option. 8245 Budget review 20-1; As from 16 March 2020 The CDS employer or designated representative (DR), with assistance obtained from financial management services (FMSA) or others, should: develop a first and annual budget for each STAR+PLUS service and STAR+PLUS Home and Community Based Services (HCBS) to be delivered through the CDS option; project expenditure of resources allocated in the Individual Service Plan (ISP) for the effective period of the ISP; use a workbook approved by the managed care organization (MCO) or the applicable budget workbooks available through Texas Health and Human Services Commission (HHSC) on budget to pay workers in accordance with minimum wage legislation and all other applicable basic wage requirements; if necessary, to seek assistance from the FMSA; each budget to the FMSA for the revision of the member's budgetary wage expenditure and the verification that the applicable budget workbooks are within the approved budget. The FMSA should work with the CDS employer or DR to resolve problems preventing the adoption of budget plans; and obtain written approval for each FMSA budget for the implementation of the budget and the introduction of services through the CDS option. An FMSA must: check out the cds employer's budgeted payroll decisions; check that each applicable budget workbook falls within the approved budget; and informs the CDS employer in writing of the approval or disapproval of the CDS employer's budget and work with the CDS employer or DR to resolve problems that prevent the budget from being approved. Budget revisions and approval A CDS employer or DR must make budget revisions if: a change in the individual service plan (ISP) affects the financing of a program service provided through the CDS option; a budget before the ISP's end date is or will be exceeded; units, unit rate or amount of the allocated funds have been amended; an amount paid for one or more services, goods or items shall affect the approved budget; changes are made to a service backup plan; resources budgeted for a service backup plan are not used or needed; whether the FMSA, the MCO service coordinator, the personal service planning team (SPT) or an HHSC representative requires a review. The CDS employer or DR must submit budget revisions to the FMSA for approval. Revised budgets can only be implemented after the FMSA has been approved in writing. The FMSA must assist the CDS employer or DR in making budget changes as requested or required by the member, validate the budget and grant written approval to the or DR. The MCO evaluates ISP changes requested by the CDS employer and participates in the SPT meetings to resolve issues when the CDS employer or DR does not follow the budget or meets the budget requirements for CDS options. 8300 Service Responsibility Option (SRO) Description Revision 20-1; With effect from 16 March 2020 2020 Responsibility Option (SRO) is a service delivery option that allows the member or the legally authorized representative (LAR) to manage most daily activities. This includes monitoring the employee providing personal assistance services and respite services. The member or LAR determines how services are provided. SRO leaves the company data to the contracted provider of the member's managed care organization. The rules for the SRO can be found in Texas Administrative Code, Title 40, Chapter 43. For a comparison of all available service delivery features, see Annex XVII, It's Your Choice: Deciding how to manage your personal assistance services. 8310 SRO Roles and Responsibilities Review 20-1; As of March 16, 2020, Form 1582-SRO, Service Responsibility Option Specifies Roles and Responsibilities, the roles and responsibilities assigned to the member or legally authorized representative (LAR), provider and managed care organization (MCO). The member, provider and MCO receive and sign Form 1582-SRO stating that it agrees to accept the responsibilities of the service responsibility option (SRO). 8311 Managed Care Organization Responsibilities Revision 20-1; As of March 16, 2020, the intake, referral and assessment procedures for members or legally authorised (LARs) provided through the service responsibility option (SRO) will be handled in the usual manner. The managed care organisations (MCOs) are responsible for: ensuring that the member or LAR has the opportunity to make an informed choice by an objective and balanced assessment of the options; and monitoring the quality of service and service. Once the assessment is complete, the MCO is required to: inform the member or LAR of all options for the management of eligible services; and view Annex XVII, It's your choice: Decide how to manage your personal assistance services, with the member or LAR to determine if the SRO is an appropriate choice. In addition, the responsibilities of the MCO are: presenting all service delivery options; documenting the choice of member or LAR on Form 1584, Consumer Participation Choice; providing a list of contracted SRO agencies; explaining SRO rights, responsibilities and resources to the member or LAR; to present the list of MCO contracted providers and the support consultation provider to the member or LAR; making a reference to the provider(s) selected by the member, LAR or representative; process the member or lar's request to change service delivery options; redevelopment of the individual service plan when a member's needs change; serve as a resource if the member has health or safety problems, problems related to the associated or other service-related problems; convening the meeting of the service planning team in cases where the member has: health and safety problems; has difficulty selecting or tracking companion; or has other issues relating to services that cannot be resolved in any other way; monitoring services in accordance with Section 8322, Monitoring. 8312 Office responsibilities Review 20-1; As of 16 March 2020 The agency contracted with the managed care organisation (MCO) is the employer consumer directed services (CDS) of the supervisor and handles the company data (e.g. paying taxes and doing payroll). The agency also orients attendees on policies and standards before sending attendees to members' homes. The Agency: discusses and negotiates possible backup plans for those times when the supervisor is absent from work; sends a maximum of three escorts, including those recommended by the member, to assess the member; explains to the selected supervisors that the agency is the CDS employer of record and that the member is the daily manager; the member offers time sheets of the agencies and orients the member on the process for submitting rosters, including how often rosters should be filled in; receives and processes associated rosters; sends new supervisors within the required time frame to interview at the request of the member or legally authorised representative (LAR) request; and orients the member or LAR on the corresponding evaluation process of the agency, including forms and the schedule for the evaluation of the supervisors. 8313 Member States responsibilities Revision 20-1; As of 16 March 2020, the legally authorised representative (LAR) or representative shall be responsible for most of the day-to-day management of the supervisor's activities, starting with the interview and selection of the person who will be the supervisor. To participate in the service responsibility option (SRO), the member must be able to perform all management tasks as described below, or it may identify a representative to assist or perform these management tasks on behalf of the member. The member is responsible for: choosing the SRO; choose the SRO service and support provider(s); meeting with the SRO support provider within 14 days of the SRO selection; coordination with the agency's supervisor as part of the service planning process by: negotiating the type, frequency and schedule of quality assurance contacts; discussing any concerns about care management; requesting on-the-spot assistance in orienting a new supervisor, if desired; and negotiate the preparation of a backup plan for when the supervisor cannot get to work; the selection of personal counsellor(s) of candidates (including someone who recommends the person to the agency's supervisor or someone who has completed the agency's pre-employment screening); notify the supervisor of the chosen person within 24 hours; if the servant informs of his intention to quit; if the attendant stops; or if the member wishes to dismiss the supervisor; training of the how the approved tasks can be carried out safely in the appropriate manner; supervise the personal supervisor; ensure that the supervisor performs only the tasks permitted in the Individual Service Plan (ISP) and only works the number of hours allowed in the ISP; comply with the agency's wage and attendance policy; evaluation of the supervisor's performance at the time designated by the Agency; assessing, approving and signing the employee timesheets after the supervisor has completed them; ensure that workers' schedules are submitted within the time limits of the workers designated by the Agency; notify the Agency as soon as possible if the personal supervisor will be absent and a replacement is required; taking responsibility for liability risk if the member or supervisor is injured while performing duties under the training and supervision of the member; using the following complaints procedures: If the agency does not fulfil the expected responsibilities, you should address these issues directly with the Agency. If the agency and member or LAR are unable to resolve the issues, the member or LAR should contact the managed care organization (MCO). If problems and problems are still not resolved, the member or LAR can select another agency. The member or LAR must contact the MCO to move from one agency to another. The MCO will make all necessary arrangements for the transfer. inform the MCO and/or the supervisor of any health or safety problems or problems with the person concerned (the member or lar may request a meeting of the service

planning team (SPT) at any time); and notify the MCO and the regulator if a change to the agency's option of Consumer Directed Services (CDS) is desired. An SPT meeting will be held to plan the change. 8320 Managed Care Organization (MCO) Procedures Revision 20-1; As of March 16, 2020 The service responsibility option (SRO) is not a service; it is a service delivery option. All financial and non-financial eligibility criteria, including unmet need and non-hiring policies, will continue to apply to each program area. Unless otherwise stated in this section, MCO procedures will not be affected by the member's choice for SRO. Fill out all forms currently required, including the assessment of functional needs on Form H2060, Needs Assessment Questionnaire and Task/Hour Guide, Form H2060-A, Addendum on Form H2060 and Form H2060-B, Needs Assessment Addendum. Continue to identify all caregivers who currently meet the needs of the 8321 Initial authorisation for services revision 20-1; As of March 16, 2020, the decision of the member or legally authorised representative (LAR) to receive services through the service responsibility option (SRO) does not change the way the initial services are permitted. See Article 3300, administrative procedures, for specific information. 8322 Review of monitoring As of March 16, 2020 All monitoring for service responsibility option (SRO) members is done by the managed care organization (MCO) according to the mandate for its specific services. In the face of health and safety problems, MCO staff shall discuss the problems with agency staff; talk to the member or the legally authorised representative (LAR) to determine whether the problems can be resolved; and convene a meeting of a service planning team if the issue cannot be resolved. Since the member or LAR is now jointly responsible for the service, the MCO must, among other control requirements, monitor the members' or LAR's: satisfaction with the SRO; and the ability to meet SRO requirements. If it is clear that the member or lar has difficulty in managing the SRO responsibilities, the staff of the MCO should consult the agency's staff; and advise the member or LAR on the possibility of returning to the agency's option. 8323 Presentation of the SRO review 20-1; As of March 16, 2020, members or legally authorized representatives (LARs) must be offered the service responsibility option (SRO) annually by the managed care organization (MCO) and can request a transfer to the SRO at any time. In addition, the SRO should be submitted to current members or LARs at each annual reassessment or upon request. If the member or LAR is interested in transferring to the SRO, the member or LAR must sign Form 1582-SRO, Service Responsibility Option Roles and Responsibilities. The MCO must ensure that the member or LAR understands the responsibility it bears. The MCO should send: Form H2067-MC, Managed Care Programs Communication, to the Agency to advise the agency on the selection of the member or LAR; inform the Agency that the member or LAR are in contact with the Training Agency; request the Agency to advise the MCO with Form H2067-MC when the transition planning is complete; and negotiate a start date with the member and the agency. 8400 Option review of the Agency 20-1; With effect from 16 March 2020 8410 Description Revision 20-1; From 16 March 2020 Under the agency option, the contracted care organisation (MCO) is responsible for the management of the day-to-day activities of the supervisor and all company data. Most members or legally authorized representatives (LARs) select the agency's option model because of the simplicity and ease of receiving services. For example, under this option, the Agency, not the member or lar, is responsible for: locating qualified supervisors(s) for the provision of services; Negligent or omissions of the data subject(s) and assumes liability for such acts; dealing with all conflicts with the supervisor(s); all business data relating to the provision of services; and providing basic training for the supervisor(s). Section 9000, Usage Review Purpose Revision 19-1; As of June 3, 2019, Utilization Review (UR) is a within the Medicaid Children's Health Insurance Program (CHIP) Services Department of the Texas Health and Human Services Commission (HHSC). UR was created by Senate Bill 348, 83rd Legislative Session, 2013. This bill amended Section 533.00281 of the Texas Government Code to allow HHSC to review the use of the STAR+PLUS Home and Community Based Services (HCBS) Program. HHSC has expanded the scope of UR with the assessment of STAR Kids Medically Dependent Children Program (MDCP) services and state plan services provided in STAR Kids. Star+PLUS managed care organizations (MCOs) must make information including, but not limited to, documents, reviews, notes and authorizations related to STAR+PLUS members available at UR's request. STAR+PLUS MCOs must participate and provide the appropriate staff for reviews performed by UR at that division's request. Section 10000, State Plan Long Term Services and supports review 20-1; As of March 16, 2020 10100 Long-term Services and supports review 17-5; Starting September 1, 2017, Texas Medicaid provides a range of long-term services and supports (LTSS) to STAR+PLUS members. Managed care organizations (MCOs) authorize LTSS in a way that reflects a member's ongoing need, based on a person-centered assessment, and a person-centered service plan. State plan LTSS is available to all STAR+PLUS members who meet functional and/or medical need for the services. Services include Day Activity and Health Services (DAHS), Personal Assistance Services (PAS), Community First Choice (CFK) for members who meet the suitability of the level of care and services provided by a nursing home. 10110 Day Activity and Health Services Revision 17-5; As of September 1, 2017 Day Activity and Health Services (DAHS) is a Medicaid state plan service available to STAR+ PLUS members who can benefit from a structured and comprehensive program designed to meet the needs of adults with functional disabilities through an individual plan of care by providing health, social and related support services in a protective environment. Eligibility for the service is limited to members who need the service because of a chronic medical condition and are able to benefit therapeutically from the service. DAHS provides services in a facility environment, under the supervision of a nurse. Services include nursing and nursing delegated tasks, physical rehabilitation, nutrition, social activities and transportation to and from the facility when another means of transport is not available. 10111 Restrictions Revision 17-5; September 1, 2017, Day Activity and Health Services (DAHS) is limited to no more than 10 hours per day and 230 hours per month, according to the Medicaid State Plan, and is typically allowed for three to six hours a day. This limit can be exceeded with additional permission from managed care (MCO). The authorisation for DAHS must be related to the member's chronic medical condition in order to be considered medically necessary and the member must have one or more functional limitations and a doctor's assessment indicating the potential for receiving therapeutic benefit from DAHS. Consent regarding a primary diagnosis of mental disorders, intellectual disabilities or related disorders is prohibited by the State Plan. 10120 Day Activity and Health Services Providers Revision 17-5; As of September 1, 2017 day activity and health services (DAHS) will be delivered in a Texas Health and Human Services System license facility and in the community. In order to deliver DAHS, a facility must be in possession of a current license, be accredited and controlled by the managed care organization (MCO) and hold an MCO contract. DAHS facilities are responsible for: Nursing services: Complete a member's nursing assessment, help with prescription medications, guidance regarding health needs and supervision of delegated tasks and personal assistance services. Develop interventions to stabilize, improve or prevent complications due to the condition in accordance with doctor orders and included in the individual plan of care. Help with activities of daily life that take place while the member receives DAHS. Physical rehabilitation services, including restorative care, and group and individual exercises, including a range of exercises. Food services: A midmorning and midafternoon snack; Preparation of foods necessary for special diets; and nutritional therapy and nutrition education for the member and his/her family. Transportation to and from the facility, to and from the facility on an activity outing, and to and from a facility approved to provide therapies if the member requires additional services on days of presence in the DAHS facility. The provider must: coordinate the use of other means of transport within the community; make every effort to have family members transported; maintenance and operation of facility vehicles, including liability insurance. Vehicles used by the plant must be able to comply with the Texas Department of Public Safety's vehicle inspection requirements; and have sufficient staff to ensure the safety of the transported members. Activities and other support services: Activities offered at the facility should be meaningful, fun, therapeutic and educational. A provider must offer at least three different planned activities in at least one or more of the following Exercise; Games; Educational or reality orientation; and/or Crafts. A provider must offer at least one of the following activities monthly, at cost to the provider: Travel or special events; or Cultural enrichment. 10130 Assessment for day activity and health services Revision 17-5; Effective Effective 1, 2017 The potential for therapeutic benefit should be determined by a doctor's assessment and requires a doctor's assignment. The functional need for day time activity and health services (DAHS) is established by the service coordinator of the managed care organization (MCO) using Form H2060, Needs Assessment Questionnaire and Task/Hour Guide, and Form H2060-A, Addendum by Form H2060 or Form H6516, Community First Choice Assessment and Form H2060-A. A DAHS facility nurse must complete a DAHS assessment or the mco's equivalent process for each STAR+PLUS member in the facility. The DAHS assessment of whether the equivalent process can be carried out by the facility nurse, based on the member's condition at the time of the initial assessment. The DAHS facility nurse completes a DAHS assessment or the equivalent process of the MCO at the facility or at the member's home. DAHS ratings should be performed at least when: members need an initial assessment for prior approval by a STAR+PLUS MCO; members switch to a new facility (operated by the new facility); reauty; and the DAHS nurse stipulates that a member must be reassessed. 10140 Reassessment of day activity and review of health services 17-5; As of September 1, 2017, a reassessment for day activity and health services (DAHS) by a doctor is required for continued admission at least every 12 months. The Service Coordinator of the Managed Care Organization (MCO) is reassessed at least annually by the service coordinator of the managed care organization (MCO): A member is reassessed by the facility nurse at regular intervals. In addition, the facility nurse assesses the member for nursing, physical rehabilitation and nutritional services when: a member enters the facility for the first time; switching from another DAHS facility; whether a member's condition changes resulting in the need for a new service plan due to changes in dietary restrictions, medications or other services provided by the facility. If the change in condition is required, the facility nurse coordinates with the member's service coordinator or doctor for a doctor assessment. 10150 Authorisation for day-time activity and review of health services 20-1; With effect from 16 March 2020 to allow day activity and health services (DAHS), the managed care organisation (MCO) must obtain a doctor's assessment and complete the following forms: Form H2060, Needs Assessment Questionnaire and Task/Hour Guide, and Form H2060-A, Addendum to Form H2060; or form H6516, Community First Choice Assessment and Form The documentation required by the MCO may not be dated more than 90 days before the application for authorisation. MCOs can issue temporary permits if the doctor's assessment and all forms are not submitted. Temporary authorizations are valid for at least 30 days, but expire after 60 days. Authorizations should be updated when the is assessed by their doctor and all forms are submitted to match the 90-day deadline between the date of assessment and authorization. DAHS authorisations should reflect the member's ongoing needs and should typically be valid for 12 months, unless the member experiences a significant change in condition or is admitted to a hospital or nursing facility, transfers between facilities or transfers to a new MCO. If a permit is issued for less than 12 months, the MCO may not require an assessment of a new physician unless the member experiences a change in condition, as described in the STAR+PLUS contract(s) with respect to assessment instruments, or if the change is related to changes in dietary restrictions, medications, transportation needs or other services provided by the facility. 10160 Reautification of day activities and review of health services 20-1; As of March 16, 2020, providers of day care and health services (DAHS) must be reautified by a managed care organization (MCO) at least every 12 months in accordance with the Texas Medicaid state plan. If a member moves to another facility, a new permit from the acquiring facility must be obtained before the service is provided. Failure to obtain a permit may result in non-payment or payback. If a member experiences a significant change in condition or is admitted to a hospital, she may need the assessment of a new doctor. The assessment of the DAHS facility (Form 3050, DAHS Health Assessment/Individual Service Plan, or the equivalent of the MCO) and the physician's assessment should be updated based on the member's current condition. If the member's physician's assessment, diet and medication needs, and functional ability have not changed since the previous DAHS license, the doctor may use a shortened form for the doctor's assessment, if permitted by the MCO. An MCO may allow the doctor's assessment to be kept with the provider, rather than submitted to the MCO, if the MCO conducts periodic audits of provider files. MCOs can provide temporary reautments if the doctor's assessment and all forms are not prepared or submitted at the same time. Temporary reautments expire 60 days after receipt by the facility. Reauthorizations can be searched at any time. The reautification may not exceed a period of 12 months. 10170 Transfer between the review of facilities 17-5; As of September 1, 2017 If a member chooses to switch to another Day Activity and Health Services (DAHS) facility in the same or moves to another part of the State, the obtaining facility must complete an assessment and obtain the required documentation from the managed care organization (MCOs) within 14 days for continued authorization. If the acquiring facility is unable to obtain the necessary documentation within 14 days, the MCO may provide a temporary to ensure continuity of care. The MCO may not need a new doctor's assessment if an assessment has been carried out in the past 12 months. The acquiring facility should request documentation relating to the member, including reviews and forms of the member's former facility or MCO service coordinator. 10180 Transfer between MCOs Revision 17-5; As of September 1, 2017 10181 New MCO Same Service Area Overhaul 17-5; As of September 1, 2017 If a member transfers managed care organizations (MCOs) into the same service area, the existing license for day activity and health services must be up to the earliest of the following actions: authorisation expires; six months have elapsed; or the MCO has assessed the member and issued a new licence. 10182 New MCO Different Service Area Overhaul 17-5; As of September 1, 2017 If one member moves to another service area and another managed care organization (MCO) and has an existing license for Day Activity and Health Services (DAHS), the new MCO must assist the member in locating an in-network DAHS facility and primary care provider. The new MCO must fill out the required forms (Form H2060, Needs Assessment Questionnaire and Task/Hour Guide, and Form H2060-A, Addendum on Form H2060, or Form H6516, Community First Choice Assessment and Form H2060-A). The new facility should work with the new MCO to complete the mco's required documents and forms. Article 11000, Nursing Facility Services Revision 20-1; As of March 16, 2020 11100 CPWC Benefit for NF residents enrolled in STAR+PLUS or a Medicare-Medicaid Plan Revision 20-1; As of March 16, 2020 Custom power wheelchairs (CWC's) are a benefit to STAR+PLUS/Medicare-Medicaid Plan (MMP) members residing in a Medicaid enrolled nursing facility (NF) when the CPWC is medically necessary and authorized prior to by the Texas Health and Human Services Commission (HHSC) or its designee. CPWC is a Medicaid benefit for Medicaid-only NF residents, as well as NF residents who are dually eligible for Medicare and Medicaid. Admission requirements The managed care organisation (MCO) must ensure that the following criteria are met to determine whether the CPWC benefit is eligible for NF residents. The MCO must ensure that the resident: qualifies for and receives Medicaid services, including dual-eligible NF residents, in a licensed and certified NF that has a Medicaid contract with HHSC; is 21 years of age or older; has a signed declaration or written order from an attending physician proving the CPWC is medically necessary; has a and dated evaluation of physical or occupational therapy to address functional mobility and a safety assessment that includes an evaluation of the occupant's ability to operate the chair safely; and has completed a chair assessment and signed by an approved professional or physiotherapist and a qualified qualified Professional (QRP) documents that the customer is able to safely operate an electric wheelchair and all his medically necessary components and equipment. Tests should be conducted in an electric wheelchair to demonstrate the ability to navigate independently through the typical obstacles in the environment and functionally operate the powerized accessories in a safe manner. The QRP must be employed or contracted by the supplier of sustainable medical equipment (DME). The QRP is not required to be contracted directly with the MCO, but must be enrolled in Texas Medicaid as an executive provider under a DME provider group. The QRP must be present when assessing the seating, assembly, training and delivery of the CPWC. The evaluation should show that the resident is unable to ambulate more than 10 feet independently; unable to operate a manual wheelchair or operate other ambulation devices on its own; without cognitive impairment that would affect the ability to manipulate controls or address other safety problems for the occupant or others; cannot be placed in a standard wheelchair; has a mobility status that would be compromised without the requested CPWC; and a reasonable expectation that the resident will benefit from the use of this chair for a period of at least six months to five years. Required elements of a CPWC A CPWC is defined as a professionally manufactured wheeled mobility system consisting of a power base and a custom seating system and provides motorized mobility on wheels and body support especially for persons with reduced mobility. The power mobility base can contain programmable electronics and can use alternative input devices. The wheelchair must be medically necessary, adapted and manufactured to meet the individualised needs of the occupant and be intended for the exclusive and continuous use of the occupant. For safety, all seats must be equipped with a stop switch for use by the customer sitting in the seat. Parts of the modified seating system may be fully or partially usable by the occupant for whom the electric wheelchair has been adapted and manufactured. This means that at least one of the parts of the seating system can only be usable by that occupant. In order to be considered tailor-made, the chair must be specifically measured to the needs of the occupant. Custom seats can include a custom-made seat cushion and/or back cushion or a cast chair. The resident must have a documented condition requiring custom seating which, but is not limited to, one or more of the poor trunk control; contractions of elbows and/or shoulders; muscle poasticity; imbalance by shoulders and/or back; kyfose, lordosis or other skeletal deformity; lack of flexibility in the pelvis or spine. Cast chair-billable labor to create should not exceed 15 hours. Tilt into space possibilities. The The must have a condition that meets the medical need for a tilt in space, including, but not limited to, one or more of the following: documented weak upper extremity strength or a condition that leads to weakened upper limbs; severe spasticity; hemodynamic problems; quadriplegia; excess extensortoon; the need to rest in a lounger position two or more times a day when the occupant cannot switch between the bed and the wheelchair unaided; and/or at risk of skin breakdown due to the inability to reposition in the chair to relieve pressure areas. For a combination power tilt and reclining seating system (reclining capabilities), the occupant must demonstrate the need to rest in a recumbent position two or more times a day when the occupant cannot transfer between the bed and the wheelchair without assistance and/or the risk of skin degradation due to an inability to move in the chair to relieve pressure areas. Power Elevating Been Lifts. A power height function includes a special motor and related electronics with or without variable speed programmable, allowing the leg rest to be increased and lowered independently of the reclining and/or tilting of the seat system. It contains a switch control that may or may not be integrated with the power tilt and/or reclining control(s). The resident must meet the criteria for lying options. The resident must have documented limitations with upper extremity functioning that would limit their ability to manual uplifting leg rests. The resident must have a condition with one of the following: A musculoskeletal disorder, such as flexion contractions of the knees or the placement of a brace that prevents 90-degree flexion. Significant edema of the lower limbs that requires leg height. Hypotensive episodes that require frequent positioning changes. Required need to maintain anatomically correct positioning and reduction of exposure to the skin scissors. Power Seat Elevation System. A power seat height system is used to raise and lower the customer in their seating position without changing the seat angles to provide different amounts of additional vertical access when the occupant does not have the ability to stand or pivot transfer without assistance. It may cover one or more of the following: facilitating independent transfers, uphill transfers and transfers over uneven seating heights to and from the wheelchair; and Increase customer range in cases of limited range and range of motion in the shoulder, arm and/or hand. The CPWC must be: designed to help the resident to be independently mobile in environment (this includes surfaces inside and outside the facility); designed to meet the medical and physical needs of the resident and to prevent or minimise further deterioration; for the exclusive use of the resident for whom he and the personal property of the resident for whom it is permitted. It becomes the personal property of the estate of the resident after death. Prior authorizations and billing The MCO/MMP is responsible for the prior authorisation and reimbursement of PCCs. If, for whatever reason, a resident changes MCO/MMP (i.e. choice, moves out of the service delivery area, etc.), and the prior permit has already been approved, but the seat has not yet been delivered to the NF occupant, the MCO granting the first permit is responsible for the reimbursement of the CPWC. This is in accordance with the Uniform Managed Care Contract, Section 5.06, Cover Span. Where the MCO receives a prior application for authorisation from a contracted DME provider to build a CPWC for an NF resident, the MCO is required to respond with a decision of approval, refusal or amendment within three working days of receipt of the request. Medicare does not cover PCCs for skilled nursing (SNF) residents. MCOs may not refuse NF CPWC claims or previous authorization requests, nor require a Medicare Explanation of Benefit (EPO) for NF residents with two eligible NFs, in accordance with Uniform Managed Care Manual (UMCM) Chapter 2.0, Claims Manual, Section VII, Claims Processing Requirements, F. STAR+PLUS and STAR Kids Services for Dual-Eligibles. STAR+PLUS MCOs and MPs should ensure that staff processing CPWC requests for prior consent and claims are informed of this benefit for NF residents with two eligible nf. STAR+PLUS MCOs and MMP's should ensure staff processing CPWC prior authorization requests and claims are informed of this benefit for dual-eligible NF residents. MCO systems must have the functionality to prevent the request of a Medicare EPO or the denial of a CPWC for a reason related to the resident with Medicare as their primary insurance. Denial notices should include answers that are specific and individualized, reference criteria described in this policy, and the process and timelines for appealing the decision. See chapter 3.21 of umcm. After approval by the MCO of the prior permit application, the MCO must instruct the provider to proceed with the construction of the chair and request that the claims be billed directly through the MCO portal upon delivery of the seat to the NF occupant. Specific billing codes should be used to identify the type of power base and each accessory or component. To be eligible for Medicaid reimbursement, the member must stay on a Medicaid NF at the time of assessment and at the CPWC delivery. The MCO/MMP must make a clean claim within 30 days. will be required to pay providers interest at an 18 percent annual rate if a claim, or part of a claim, remains unassessed after the 30-day claims processing deadline. The MCO is responsible for seat adjustments and adjustments. The MCO/MMP is responsible for the prior authorization and reimbursement of changes, as described below. CPWC changes are the replacement of components due to changes in the Condition. Any changes within the first six months following the delivery of the chair shall be considered as part of the purchase price. Parts that no longer function as they were originally designed are not considered changes. Changes to a CPWC after the first six months after delivery must be sent for a prior permit application due to a change in the needs, capabilities of the resident, or physical or mental status that was unknown or not expected. The MCO will request the following documentation for use in the prior authorisation process: any changes to the resident's mobility needs; the original delivery date; the serial number of the current equipment; and the cost of the requested change(s). The MCO/MMP is responsible for prior authorization and reimbursement of CPWC adjustments, as described below. Adjustments require labor only and do not include the addition, modification or replacement of parts or supplies needed to complete the adjustment. Adjustments are permitted after the first six months after the delivery of the chair. Adjustments prior to the first six months are considered as part of the purchase price. If necessary, up to one hour of work can be requested. Adjustments do not require purchase of supplies, as this is not defined as a repair. The MCO/MMP is responsible for the prior consent and reimbursement for medically necessary CPWC replacement applications on or after five years from the original date of purchase. The MCO/MMP shall be responsible for prior authorisation and reimbursement of replacement seats before five years after the original date of purchase if the CPWC no longer meets the resident's needs. Other circumstances that would justify seat replacement before the expiry of five years after the date of purchase are listed below: Serious damage was caused by no debt to the occupant. If it is found that the chair has been damaged as a result of abuse by the staff of the NF, the NF shall be responsible for replacing the chair. CPWC was stolen and a police report is provided to document the theft. The following items are not an advantage and cannot be charged additionally: Additional accessories such as tire pumps, color upgrades, gloves, backpacks, USB ports, and flags. (These items are not considered medically necessary and this list is not all-inclusive.) Attendant control switch. Elevators or platform lifts. In all other circumstances of the above mentioned, the NF is responsible for routine maintenance and repair, including the battery and battery charger replacement of the occupant's CPWC. Appendix Annex I, voor toekomstig gebruik aanhangsel II, richtlijnen voor het invullen van formulier H1746-A, MEPD Referral Cover Sheet Appendix III, Medicaid Type Program Codes for STAR+PLUS Home and Community Based Services and Community First Choice Appendix IV, Reserved for Future Use Appendix V, V, voor toekomstig gebruik appendix VI, STAR+PLUS-onderzoeksgrafiek appendix VII, afkortingen revisie 18-2; Vanaf 3 september 2018 worden de volgende afkortingen gebruikt in het STAR+PLUS-programma. Acroniem Beschrijving AA Adaptive Aids ADL Activiteit van Daily Living AFC Adult Foster Care AL Assisted Living ALF Assisted Living Facility AO Agency Option APS Adult Protective Services CAP Corrigerende Actie Plan CARE Client Assignment and Registration System CAS Community Attendant Services CBA Community Based Alternatives CCAD Community Care for the Aged and Disabled CCP Comprehensive Care Program CDS Consumer Directed Services CFC Community First Choice CFR Code of Federal Regulations CHIP Children's Health Insurance Program CLASS Community en Support Services CMPAS Client Managed Personal Attendant Services CMS Claims Management System CMS Centers for Medicare and Medicaid Services CNA Certified Nursing Assistant COLA Cost of Living Adjustment CRU Central Representation Unit CSHCN Children with Special Health Care Needs CSIL Community Services Interest List DAC Disabled Adult Child DAHS Day Activity and Health Services DBMD Doaf Blind with Multiple Disabilities DDS Disability Determination Services DDU Disability Determination Unit DER Data Entry Representative DFPS Department of Family and Protective Services DBMD Do blind with Multiple Disabilities DDS Disability Determination Services DDU Disability Determination Unit DER Data Entry Representative DFPS Department of Family and Protective Services DID Bepaling van intellectuele handicap DIU Data Integrity Unit DME Duurzame Medische Apparatuur DOB Datum van geboorte DOD Datum van overlijden DR aangewezen vertegenwoordiger DSHS Department of State Health Services ERS ERS Emergency Response Service Inschrijving Resolutie Services FBR Federale Benefit Rate FC Family Care (Titel XX) FFS Fee-for-Service FH Fair Hearing FHO Fair Hearings Officers FMSA Financial Management Services Agency GR General Revenue HCBS Home and Community Based Services HCS Home and Community-based Services HCSS Home and Community Support Services HCSSA Home and Community Support Services Agency HDM Home Delivered Meals HEART Health and Human Services Enterprise Administrative Report and Tracking System HHS Health and Human Services HHSC Texas Health and Human Services Commission HICAP Health Information Counseling and Advocacy Program HIPAA Health Insurance Portability and Accountability Act HIPP Health Insurance Premium Payment Program HMA Health Maintenance Activities IADL Instrumental Activity of Daily Living ICF-IID Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions IDD Intellectual of Developmental Disability IDT Interdisciplinary Team ILM Interest List Management IME Incurred Medical Expense ISP Individual Service Plan LAR Legally Authorized Representative LCSW Licensed Social Worker LIDDA Local Intellectual and Developmental Disability Authority LOC Level of Care LOS Level of Service LTC Long Term Care LTC-R Long-term Care Regulatory LTSS Long-term Services and Supports LVN LVN Beroepsverpleegkundige MAO Medische Hulp Alleen MBI Medicaid Buy-In MC Managed Care MCO Managed Care Organization MCCO Managed Care Compliance & Operations MDCP Medically Dependent Children Program MDS Minimum Data Set Med ID Medicaid Identification Card MEPD Medicaid for the Elderly en mensen met een handicap MERP Medicaid Estate Recovery Program MESAV Medicaid Eligibility Service Authorization Verification MFP Money Volgt de persoon MHM Minor Home Modificaties MMP Medicare-Medicaid Plan MN Medische noodzaak MN / LOC Medische noodzaak en Niveau van zorg MSHCN Leden met speciale gezondheidszorg behoeften NF Verpleegkundig Faciliteit OT Ergotherapie PACE Programma van all-inclusive zorg voor ouderen PAS Persoonlijke Bijstand Services PASRR Preadmission Screening en Resident Review PCN Patient Control Number PCP Huisarts PCS Personal Care Services PDN Private Duty Nursing PES Program Inschrijving Ondersteuning PHC Primary Home Care PNA Persoonlijke Behoeften Allowance POC Plan of Care PPECC Voorgeschreven Pediatrische Extended Care Center PPS Premies Payable System PSU Program Support Unit PT Fysiotherapie QIT Gekwalificeerd Income Trust QMB Gekwalificeerde Medicare Begunstigde R&B Room en Board RN Registered Nurse RSDI Retirement and Survivors Disability Insurance RUG Resource Utilization Group SA Service Area SAS Service Authorization System SC Service Code SC Service Coordinator SCSA Significant Change in Status Assessment SDX State Data Exchange SG Service Group SLMB Specified Low-Income Medicare Beneficiaries Supplemental Nutrition Assistance Program SO State Office SOC Start of Care SOLQ State On-Line Query SPMI Severe and Persistent Mental Illness STAR+PLUS HCBS programma State of Texas Access Reform PLUS Home and Community Based Services program SRO Service Responsibility Option SSA Social Security Administration SSI Supplemental Security Income SSN Social Security Number SSPD Special Services to Persons with Disabilities ST Logo Therapy STAR State of Texas Access Reform STAR+PLUS State of Texas Access Reform Plus STS Supplemental Transition Support TAC Texas Administrative Code TANF Temporary Assistance to Needy Families TAS Transition Assistance TDI Services Texas Department of Insurance THSteps-CCP Texas Health Steps – Uitgebreide Care Program TIERS Texas Integrated Eligibility Redesign System TMHP Texas Medicaid & Healthcare Partnership TOA Type of Assistance TP Type Program TPR Third-Party Resource TW Texas Works TxHmL Texas Home Living UAP Unlicensed Assistive Person UMCC Uniform Managed Care Contract UMCM Uniform Managed Care Manual WTPY Wire Third Party Query Appendix VIII, Maandelijkse inkomens/resourcelimieten appendix IX, tijdberekening appendix X, STAR +PLUS HCBS Kostenlimieten Appendix XIV, bepaling van de status van hoge behoeften voor de STAR + PLUS HCBS Program Revision 17-1; Met ingang van 1 maart 2017 een entering the STAR+PLUS Home and Community Services (HCBS) program is designated as having a high needs status as: the individual is on fan care; the individual has highly skilled nursing needs, such as tracheotomy care, wound care, suction or feeding tubes; and/or the person will exceed the cost limit for the individual service plan and have needs that require special services or service delivery, and community support/resources have not been identified. Appendix XV, Services available from other government agencies Appendix XV-A, Department of State Health (DSHS) Appendix XV-C, Texas Veterans Commission (TVC) Appendix XV-D, Texas Department of Housing and Community Affairs (TDHCA) Appendix XV-E, Department of Family and Protective Services (DFPS) Appendix XV-F, Rehabilitation Technology Resource Center Appendix XIIIV, MutualLy Exclusive Services Appixend XIX, Nursing Facility Counter Logic Appendix XXI, Reserved for future use appendix XXII, reserved for future use Appendix XXIII, reserved for future use Appendix XXIV Minimum Standards for STAR +PLUS AFC Homes and Home Providers Appendix XXV, Community First Choice Support Management Appendix XXVII, Reserved for Future Use Appendix XXIX, Emergency Response Service Provider Requirements and Service Initiation Requirements 9-2017 An Emergency Response Services (ERS) provider contracted with a managed care organization (MCO) must meet meet with an emergency response services (ERS) provider contracted with a managed care organization (MCO) : have an emergency monitoring capacity 24 hours a day, seven days a week; and are equipped to provide verifiable data using technology capable of producing a printed recording of the type of alarm code (test, accident or emergency); subscriber number per unit; date; and the time of the activated alarm in seconds. An ERS provider that has a contract with an MCO must meet the following requirements for initiating services prior to the service delivery. Secure responders who: Go to the member's house if an alarm call is made to a provider; and take appropriate measures, including contacting public service personnel, on the basis of the situation. Try to secure the names of at least two responders of a member on or before the provider initiates services. The exceptions are as follows: If the provider can secure the name of only one responder of a member, the provider must: designate the public service staff instead of the member's second responder; and document the reason why the provider can protect the name of only one responder. If a provider has the names of unable to secure a member, the provider must: designate the staff of the public service instead of the responders of the member; and send written notification to the service coordinator of the inability to secure the names of any responders within 14 days of initiating services. Manage an orientation to a responder according to the following requirements: A responder in person, by phone, or in about the responder's responsibilities on or before the date the responder is first contacted by the provider and asked to respond to an alarm call; Document the following orientation information: responder name and phone number; the name of the member; date the responder is protected; date of orientation; orientation method; and topics covered; and make sure a responder receives written procedures on how to respond to an alarm call and document the date the procedures were provided to the responder. The provider can send the written procedures to the responder. Replace a responder according to the following requirements: A provider must protect a replacement responder when a member's responder is no longer able to participate. If a member has two responders, a provider must secure a second responder within seven days of being aware that the member no longer has two responders. If a member has one responder, a provider must secure a replacement responder within four days of the member's only responder being unable to participate. If a provider cannot secure replacement responders, the provider must: designate the public service staff instead of the replacement responders; and the case manager within 14 days of the provider's decision that it cannot secure a replacement responder, written notification. A provider must document the provider's date: became aware that a responder could no longer participate; and have secured a replacement responder. Keep a record of the names of current responders for each member. Keep documentation of initiating the service in a member's file. A responder must meet the following service requirements. Install the equipment according to the following requirements: During a first home visit, an installer must: install and make a first test of the equipment; ensure that the equipment has an alternative power source in the event of a power failure; to install within the limits laid down in the manufacturers' installation instructions; and, if necessary, the purchase of an extension cord; connect and leave an extension cord of a phone no more than 50 feet between the wall jack and the equipment; and securely stick the extension cord against the wall or floor to avoid danger to a member. An installer is not required to: adjust the physical environment in a member's home to make it compatible with the equipment; arrange or pay for the movement of the telephone; or buy or install electrical extension cords. An installer may not use an electric extension cord when installing equipment. A provider must document the equipment, including the: reason for the delay; date when the provider expects it to install the equipment or the specific reason why the provider cannot anticipate a date; and description of the ongoing efforts of the supplier to install the equipment, if applicable. The training of a member on the use of the equipment must include: demonstrating how the equipment works; Have the member activate an alarm call; The member shall explain that: the member must participate in a system check every month; the member must contact the provider if: his telephone number or address changes; or change one or more of its responders; the member shall not intentionally abuse or damage the equipment; a responder may, if necessary, enter a member's house by force; the procedures for filing a complaint against a supplier; and Obtaining a signed release for coercive entry. The expiration dates for initiating services are as follows: The provider must start services within 14 days of the service's effective date; and If a member is not available during the time limits, the provider must initiate services within 72 hours or document a reason for delay. An ERS provider that has a contract with an MCO must document any failure when initiating services on the expiration date. The documentation must include: The reason for the delay; Either the date when the provider expects it to initiate services or specific reasons why the provider cannot anticipate a date for initiating a service; and a description of the provider's ongoing efforts to initiate services. A provider must keep documentation of initiating services in a member's file. Annex XXX, Relocation Function Appendix XXXI, STAR +PLUS members who move from an NF in one service area to the community in another Service Form Health and Human Services Program Support Unit personnel must use all forms as published, without review. With the exception of Forms H2060 and 4800-D, Managed Care Organization (MCO) employees can develop their own forms unless otherwise stated in the form instructions. Forms developed by MCO must contain at least all elements in the form. ES = Spanish version available. Form Title 0003 Authorization to Provide Information 1023 Request for Services Funded by General Income 1025 Request for Information Medicare Advantage Coordination 1027 Caregiver Status Questionnaire ES 1131 Individually Identifiable Health Information Fax Transmittal 1578 Qualified Income Trust (Q IT) Copayment Agreement ES 1579 Referral for Relocation Services ES 1580 Texas Money Follows the Person Demonstration Project Informed Demonstration Consent for Participation ES 1581 Consumer Directed Services Option Overview ES 1582 Consumer Services Directed Services Responsibilities ES 1582-SRO Service Responsibility Roles and Responsibilities ES 1583 Employee Qualification Requirements ES 1584 Consumer Participation Choice ES 1585 Recognition of responsibility for exemption from nursing licensing for certain services provided through Consumer Directed Services ES 1586 Recognition of support consultation services information in consumer-oriented consumer-oriented services (CDS) Optie ES 1720 Benoeming van een aangewezen vertegenwoordiger ES 1721 Intrekking van de benoeming van de aangewezen vertegenwoordiger ES 1735 Werkgevers- en Dienstendienstovereenkomst ES 1740 Service Backup Plan ES 1741 Corrigerend actieplan ES 1747 Erkenning van verpleegkundig eisen 1826-D Case Information Release 2059 Samenvatting van client's Need for Service 2110 Community Care Intake 2110-A Community Care Intake Nursing Facility Diversion Slot Screening 2115 Conflict of Interest Notification 2119 Residential Care, Adult Foster Care of Assisted Living Contribution Erkenning ES 2327 Individueel/Lid en Provider Overeenkomst 2327-A Kamer en bestuur wijziging van de Individuele en Provider Overeenkomst 2330 Assessment and Service Plan Goedkeuring voor Adult Foster Care 2442 Kennisgeving van Rentelijst Release Closure ES 3050 DAHS Health Assessment / Individuele service plan 3055 Arts's Orders (DAHS) 3632 Intrekking bevestiging ES 4116 State of Texas Aankoop Voucher 4800-D Fair Hearing Request Samenvatting 4800-DA 4800-D Addendum 4807-D Actie genomen op hoorzitting besluit 8001 Medicaid Estate Recovery Program Ontvangstbevestiging ES 8604 Transition Assistance Services (TAS) Beoordeling en autorisatie H0025 HHSC Aanvraag voor Voter Registration ES H1010 Texas Works Aanvraag voor Bijstand - Uw Texas Benefits (Engels en Spaans) ES H1027-A Medicaid Eligibility Verification H1097 Affidavit for Citizenship/Identity ES H1200 Application for Assistance - Your Texas Benefits H1200-A Medical Assistance Only (MAO) Recertification ES H1200-EZ Application for Assistance - Aged and Disabled (Large Print) H1270 Data Integrity SAVERR Notification H1350 Opportunity to Register to Vote H1700-1 Individual Service Plan (Pg. 1) H1700-2 Individual Service Plan (Pg. 2) ES H1700-3 Nursing Service Plan ES H1700-A Rationale for STAR+PLUS HCBS Program Items/Services H1700-A1 Certification of Completion/Delivery of STAR+PLUS HCBS Program Items/Services ES H1700-B Non-STAR+PLUS HCBS Program Services H17 46-A MEPD Referral Cover Sheet H1746-B Batch Cover Sheet H2053-B Health Plan Selection ES H2060 Needs Assessment Questionnaire and Task/Hour Guide ES H2060-A Addendum to Form H2060 ES H2060-B Needs Assessment Addendum ES H2062 STAR + PLUS Waiver Activiteit Record H2064 Gap in Inschrijving voor Medicaid Managed Care Leden H2065-D Kennisgeving van Managed Care Program Services ES H2067-MC Managed Care Programma's Communicatie H2111 Interest List Kennisgeving - HCBS ES H2118 STAR +PLUS HCBS Program Interest List – Bevestiging van voortdurende interesse ES H3034 Disability Determination Socio-Economisch Rapport ES H3035 Medical

Information Release/Disability Determination ES H3675 Application Acknowledgement ES H3676 Managed Care Pre-Enrollment Assessment Authorization H4800 Hearing Request Summary H4800-A Fair Hearing Request Summary (Addendum) H4803 Notice of Hearing H4807 Action Taken on Hearing Decision H6516 Community First Choice Assessment ES Upcoming Form Revisions The forms below have been recently revised and will publish on the date listed. DO NOT use these forms until the published date. Date form No 18-2 and title dictionary Revision 18-2; As of September 3, 2018 Acute care — Preventive care, primary care and other medical care led by a healthcare provider for a relatively short-lived condition. Agency option (AO) — A service delivery option where the provider is responsible for managing the day-to-day activities of the supervisor and all company data. Applicant - A person who has applied for Medicaid benefits. Delegate — Any person or entity acting on behalf of the person and with the person's written consent. Centers for Medicare and Medicaid Services (CMS) - The federal agency that administers Medicare and Medicaid. Code of Federal Regulations (CFR) - The codified federal regulations that govern most federal programs, including Medicaid. Community First Choice (CFK) option — Personal assistance services; habilitation services focused on the acquisition, maintenance and improvement of skills; emergency services; and support management provided in a community setting for eligible Medicaid members in the STAR PLUS Home and Community Based Services program who have received an institutional level of care (LOC) provision. Community Living Assistance and Support Services (CLASS) — A non-head waiver from the 1915(c) that provides home and community services to people with intellectual or developmental disabilities. Consumer Directed Services Employer - A member or legally authorized representative (LAR), parent, or court appointed guardian who chooses to participate in the CDS option and is therefore responsible for hiring and retaining service providers to provide program services. Consumer Directed Services (CDS) — A service delivery option where a member or LAR employs and retains service providers and directs the delivery of eligible STAR+PLUS Home and Community Based Services (HCBS) program services. A member participating in the CDS option is required to use a financial management office (FMSA) chosen by the member or LAR to provide financial management services. Days — A calendar day, unless otherwise specified in the text. A calendar day includes weekends and holidays. Deafblind with multiple disabilities (DBMD) — A waiver of non-protagonists from 1915(c) providing home and community services to persons who are deaf, blind and have a third disability. — Closing of an application with a determination of ineligibility. Designated Designated (DR) — A willing adult appointed by the CDS employer to assist or perform the required responsibilities of the employer to the extent that the employer has acknowledged. A DR, usually a family member, is not a paid service provider and is at least 18 years old. Eligibility Date — The first date meets all the eligibility criteria, as described in Section 3240, star+plus home and community-based services program requirements. Employee (a.k.a. service provider) —— A person hired, trained and managed by the employer to provide services authorized by the MCO. Enrollment Broker — A contracted entity that helps individuals select and enroll in a managed care organization (MCO). If requested, the enrollment broker can also assist the member in choosing a primary care physician (PCP). Family member - A person who is related by blood, affinity or entitlement to an individual. Financial Management Services (FMS) — Assistance to members who manage funds related to the self-directional services. The service includes initial orientation and permanent training related to responsibilities of being an employer and complying with legal requirements for employers. Financial management services agency (FMSA) — An agency that provides contracts with the MCO to deliver FMS to members who choose the CDS option. Health Maintenance Activity (HMA) — A task that can be exempted from delegation on the basis of a registered nursing assessment that allows the member to remain in an independent living environment and goes beyond daily activities due to the higher skill level required to perform. Home and Community-based Services (HCS) — A 1915(c) waiver that provides home and community services to individuals with intellectual or developmental disabilities as cost-effective alternatives to institutional care. Individual Service Plan (ISP) — Identifies and documents an individualized and person-centered plan in which a member is enrolled in the MCO-managed STAR+PLUS HCBS program with the necessary help, identifies his or her preferences, strengths and health and well-being needs to develop short-term goals and action steps to ensure that personalized outcomes are achieved within the most integrated environment by using identified support and services. The ISP is supported by the results of the member's programme-specific assessment and must meet the requirements of 42 CFR §441.301. Individual Service Plan (ISP) Service Tracking Tool - This tool is developed at least annually by the member, the MCO and family members to MDCP services determined by documenting the member's team and budget related to the provision of the services. The total cost of the member's budget provided on this instrument shall be lower than the fixed cost ceiling. This is also known as Form 2604. Intellectual and developmental development (IDD) — A disability with the onset during the development period that includes limitations in both intellectual and adaptive functioning, which includes many daily conceptual, social and practical skills. IDD can start at any time, until the age of 22 years. It usually lasts during someone's life. Interdisciplinary Team (IDT) — All persons/entities involved in the planning of the member's care plan (POC). This usually includes the member, the member's authorised representative, the service coordinator, the general practitioner, etc. Legally authorized Representative (LAR) — A person legally authorized to act on behalf of a member, including a parent of a minor, guardian of a minor, administrator of a minor or the guardian of an adult, as defined by state or federal law, including Texas Occupations Code §151,002(6), Texas Health and Safety Code §166,164, and Texas Estates Code Chapter 752. Long-term services and support (LTSS) — Services, including primary care, day care and health services, and the STAR+PLUS HCBS program, which helps members live in the community. Managed Care Compliance & Operations (MCCO) — A unit within the Medicaid/Children's Health Insurance Program (CHIP) Division of HHSC responsible for administrative and operational aspects of the management of the Medicaid managed care programs. Managed care organization (MCO) — An established health maintenance organization or Approved Non-Profit Health Corporation (ANHC) that provides health care. In accordance with Chapter 843 of the Texas Insurance Code, it is currently licensed as such in the state of Texas. Medicaid Estate Recovery Program (MERP) - A program that requires Texas Health and Human Services Commission (HHSC), as the State Medicaid agency, to recover the cost of Medicaid long-term care benefits received by certain Medicaid recipients. For more information, see the MERP website at . Medical Necessity (MN) - The medical criteria that a person must meet for admission to a Texas nursing facility (NF), as defined in Texas Administrative Code, Title 40 §19.2401. Member — A person who is registered and receives services through a STAR+PLUS MCO. Money Follows the Person (MFP) – A process that is used when a member in a Medicaid-certified NF who asks to move to the community is Medicaid-eligible and approved for the STAR+PLUS HCBS program before leaving the NF. Mutually exclusive services — Two or more services that cannot be authorised for the same person during the same period. Plan of Care (POC) — A care plan developed by the MCO its members with acute care and LTSS. The POC is not the same as the ISP. Program Support Unit (PSU) — An HHSC unit with employees who HCBS programme, as described in Section 3300, administrative procedures. Provider — A person with an appropriate license, facility, agency, institution, organization or other entity, and its employees and subcontractors, who has a contract with the MCO for the provision of covered services to members of the MCO. Responsible Party — A person who: assists and/or represents an applicant or member in the application or eligibility rescheduling process; or is familiar with the applicant or member and his or her financial affairs and functional condition. Service coordinator — The MCO employee who is primarily responsible for providing service coordination and care management to STAR+PLUS members. Service Responsibility Option (SRO) — A service delivery option that allows the member to manage most daily activities. This includes the supervision of the person who provides personal counsellors (PAS). The member determines how services are provided. It leaves the business data to a provider of the member's choice. Social Security Administration (SSA) - U.S. government agency founded in 1935 by President Franklin D. Roosevelt, the SSA administers social insurance programs in the U.S. The agency includes a wide range of Social Security services, such as disability, retirement and survivor benefits. STAR Kids – Managed care program for recipients under the age of 21 who receive SSI, SSI-related Medicaid, and/or 1915 (c) waiver services. STAR +PLUS Home and Community Based Services (HCBS) program – Authority granted to the state of Texas to provide community-based LTSS that help members to live in the community rather than an NF. STAR + PLUS program – The Texas State Access Reform Plus Medicaid managed care program in which HHSC contracts with MCOs to provide, regulate, and coordinate preventive, primary, acute and long-term care-covered services to adults with disabilities and elderly people 65 years and older who are eligible for Medicaid through the SSI program and/or the MAO program. Children under the age of 21 who are eligible for Medicaid through the SSI program can voluntarily participate in the STAR+PLUS program. The STAR+PLUS program is the overarching designation that includes both the STAR+PLUS services and the STAR+PLUS HCBS program. STAR+PLUS program specialist — The responsible employee, together with Managed Care Compliance & Operations, for STAR+PLUS policy development. STAR + PLUS Services – Authority granted to the State of Texas to provide Medicaid State Plan acute care, Primary Home Care (PHC), and Day Activity and Health Services (DAHS) through a managed care delivery system statewide. Additional Security Income (SSI) - Federal Income Supplement Program general tax revenues (not social security taxes) designed to help the elderly, the blind and disabled little or no income by providing cash to meet the basic needs for food, clothing and shelter. Support Advisor — An employee who provides support consultation to an employer, a DR, or a member who receives services through the CDS option. Support Consultation — An optional service provided by a support advisor and provides a level of assistance and training that goes beyond FMSA support management through FMS or CFCs. Support consultation helps a CDS employer meet the cds option's required employer responsibilities and successfully manage the delivery of program services. Texas Administrative Code (TAC) - A compilation of all state rules in Texas. Termination — Closure of an ongoing case as a result of the determination of ineligibility. Texas Health and Human Services Commission (HHSC) - Administrative agency within the executive branch of the State of Texas established under Texas Government Code Chapter 531. HHSC is the only state agency in charge of administration and oversight of the Texas Medicaid program, including Medicaid managed care. Texas Medicaid & Healthcare Partnership (TMHP) - The Texas contractor manages Medicaid provider enrollment and fee-for-service processing claims. TMHP is responsible for the processing of Medical Necessity and Level of Care (MN/LOC) Assessments for the waivers. Third-Party Resource (TPR) – Any person, entity or program that is or may be liable to pay for, or provide, medical assistance or support to a recipient under the approved state Medicaid plan, or as part of their health care plan without paying. TxMedCentral - A secure Internet bulletin board that the state and MCOs use to share information, as described in Section 5110, TxMedCentral Naming Convention and File Maintenance. Unlicensed Assistive Person (UAP) - A paraprofessional who assists people with physical disabilities, mental disabilities and other health care needs with their daily life activities (ACLs) and provides bedside care. A UAP can perform nursing duties only in specific situations, such as governed by the Texas Administrative Code (TAC) for the Texas Board of Nursing, Title 22, Part 11, Rules 224 and 225. Upgrade - An existing STAR+PLUS member requesting STAR+PLUS HCBS program services or if the MCO determines that the member would benefit from the STAR+PLUS HCBS program and receive services after you meet the ela elm elm elity criteria. Revisions 20-2, Various amendments revision notification 20-2; As of October 1, 2020, the following changes(s) have been made: Revised title change 1143.1.3 STAR+PLUS Personal Assistance Services (PAS) Statement of Need (PSON) Adds a section describing the implementation of a PSON policy. 3621.1 Expiration Report For expiring individual service plans Adds a section describing the time limits for viewing and updating the ISP report. 6420 Approval of AIDS and medical supplies clarifies language related to the type of provider that sends supporting documentation for adaptive devices and medical supplies. Clarifies language regarding MCO communications. 6630 Minor Home Modification Service Cost Limit Adds 'Minor' to the title. Adds Texas Administrative Code (TAC) and handbook credentials and clarifies language regarding exceeding the lifetime benefit without prior approval of HHSC. 6710 Employment Assistance clarifies language from the Rehabilitation Act 1973. 7310 Service Coordination tasks related to Respite Care Clarified language regarding respite permits. 7500 Home Delivered Meals adds a TAC reference and clarifies language regarding meal delivery and requirements. Form 1580, Form 1580-S (Spanish) and Instructions Texas Money Follows the Person Demonstration (MFPD) Project Informed Consent for Participation Changes implemented in August 2020 include adding additional verification to the signature; review of the complaint email box; and the removal of demonstration services, the reference and case manager of Mathematica Policy Research and state-supported references from the living center and dual language. HHSC Deleted Policy Updates HHSC 16-03-002 released 3-17-16 Individual Service Plan Expiration Scan Call Review Process Removes if the information is included in section 3621.1. 20-1, Various amendments revision notification 20-1; As of March 16, 2020, the following changes have been made: Revised title change 3413 STAR+PLUS Home and Community Based Services Program member that transitions from one MCO to another within the same service area Removes dual-information language, adds examples, and removes incorrect time limits. 3520 Money Follows the Person Demonstration Changes the title of Section 3521 to Money Follows the Person Demonstration Introduction and removes language indicating MFPD has ended. Adds sections 3522, 3522.1, 3522.2, 3523, 3524, and 3525 that describe MFPD eligibility, enrollment, and tracking. 3611.1 Immediate suspension of services removes or Reduces from the title and clarifies language. 3631.5 Unable to obtain doctor signature Adds a new section and procedure when unable to obtain the doctor's signature. 5220 Money Follows the Person Demonstration Entitlement Tracking and Service Authorization System Online Data Entry Clarified language and adds four examples. 6230 Nursing Services in Assisted Living Facilities Corrects a Reference and Link to Texas Administrative Code (TAC) Title 26, §553.41. 6530 Deadlines for initiation of dental services clarifies language. 7110 Introduction a reference and link to TAC Title 26, Chapter 553. 7121 AFC Homes with Four or More Residents and Members Corrects a reference and link to TAC Title 26, Chapter 553. 8000 Service Delivery Options Renumbers sections and reviss all sections to to Language. 10150 Authorization for day activity and health services clarifies language. 10160 Reauthorization of Day Activity and Health Services Changes the title and adds language. 11000 Nursing Facility Services adds Section 11100, CPWC Benefit for NF residents enrolled in STAR+PLUS or a Medicare-Medicaid Plan, regarding custom power wheelchairs. 19-3, Various amendments revision notification 19-3; As of December 2, 2019, the following changes have been made: Revised title change Section 4000 Complaints, Internal MCO Appeals and State Con Fair Hearings corrects the titles of Form 4800-D, Summary of Fair Hearing Request and Form 4807-D, action under hearing decision, in various sections. 19-2, Appendix XVI revised revision notice 19-2; As of September 6, 2019, the following changes have been made: Revised title change appendix XVI Long Term Services and Supports Codes and Modifiers Updates the information effective September 1, 2019. HHSC policy updates The purpose of this section is to make the most up-to-date policies and procedures readily available through a single resource. Memoranda with policy or procedural information will be placed on this list at the time of distribution. They remain on the list until the information is fully included in the handbook. Release Date Title 06-24-16 HHSC 16-06-003, Medicaid Type Program Identification for STAR+PLUS Home and Community Based Services and Community First Choice Attachment: TP Code ME Waiver and CFC 06-20-16 HHSC 16-06-002, Policies and procedures for reassessment of Community First Choice Services 02-29-16 HHSC 16-02-001, Community First Choice Fair Hearing Processes 01-12-16 HHSC 16-01-001, Form H2060, Needs Assessment Questionnaire, completion requirements for STAR+PLUS HCBS members receiving Community First Choice Services 01-06-16 HHSC 15-12-005, Home and Community Based Services Notification STAR+PLUS Waiver End Date 01-06-16 HHSC 15-12-003, Personal Assistance Services, Emergency Response Services and Protective Oversight for HCBS STAR+PLUS Waiver Members 12-04-1 15 HHSC 15-12-002, Nurse Assessment, Training and Supervision of Delegated Tasks for Community First Choice and Personal Care Services in Managed Care 11-19-15 HHSC 15-11-001 , Authorizations for Community First Choice Personal Assistance Services or Habilitation 08-26-15 HHSC: 15-08-001, Processing Medical Necessity/Level of Care Assessments for Community First Choice (CFC) Services or Upgrading CFC Recipients to HCBS STAR+PLUS Waiver 07-27-15 HHSC: 15-07-004, Secure File Transfer Protocol Names Convention for Community First Choice Assessments 07-23-15 HHSC: 15-07-002, Support Management in Community First Choice Attachment: Community First Choice Support Management Handout: Community First Choice Support Handout (Spaans) 07-09-15 HHSC: 15-07-001, Psychological Testing for Community Community Choice Eligible in STAR+PLUS 05-07-15 HHSC: 15-05-001, STAR+PLUS policies and procedures for community first choice services attachment: STAR+PLUS Community First Choice Process Flows Attachment: Responsible Entities in the CFC Assessment Process SPW Service Authorization System (SAS) Updates The purpose of this section is to make the latest SPW SAS updates readily available through a single source. Memoranda with SPW SAS update information will be placed on this list at the time of distribution. They remain on the list until the information is fully included in the SPW SAS Help file. File.

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