SPH, Section 3000, Waiver Eligibility and Services

Revision 18-2; Effective September 3, 2018

3100 Ancillary Member Resources

Revision 18-2; Effective September 3, 2018

3110 Medicaid, Medicare and Dual-Eligibles

Revision 18-2; Effective September 3, 2018

3111 Dual-Eligible Members

Revision 18-2; Effective September 3, 2018

Managed care organizations (MCOs) are required to contact all members upon enrollment. If there is a need identified or a request from the member, the MCO will assess the member in developing an appropriate plan of care (POC). MCOs are expected to provide innovative, cost-effective care from the beginning in order to prevent or delay unnecessary institutionalization.

STAR+PLUS Medicaid-only members are required to choose an MCO and a primary care provider (PCP) in the MCO's network. These members receive all covered services, both acute care and long-term services and supports (LTSS), from the MCO.

Members who receive both Medicaid and Medicare (dual-eligible) choose an MCO, but not a PCP, because dual-eligible members receive acute care from their Medicare providers. STAR+PLUS does not impact Medicare eligibility or services. The STAR+PLUS MCO only provides Medicaid LTSS to dual-eligible members.

3112 Medicaid Eligibility

Revision 18-2; Effective September 3, 2018

At the time of the initial application for the STAR+PLUS Home and Community Based Services (HCBS) program, Program Support Unit (PSU) staff must obtain information on the applicant's Medicaid and/or financial status. PSU staff must also obtain verification of the applicant's current eligibility for an appropriate type 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 determination process.

Refer to [Section 3114](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3114), Applicants with Medicaid Eligibility, for Medicaid programs appropriate for STAR+PLUS HCBS program financial eligibility status.

Medicaid eligibility may have already been determined and must be used unless there have been changes in the applicant's financial situation. Applicants who currently have [Form H1200](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1200-application-assistance-your-texas-benefits), Application for Assistance – Your Texas Benefits, on file with the Texas Health and Human Services Commission (HHSC) may not need to complete a new Form H1200. PSU staff must check with the Medicaid for the Elderly and People with Disabilities (MEPD) specialist regarding the need for a new Form H1200.

See [Appendix V](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/appendices/appendix-v-medicaid-program-actions), Medicaid Program Actions, to determine if a program transfer by MEPD will be required. See also [Section 3230](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3230), Financial Eligibility, for additional information regarding financial eligibility.

**Note:** The completion or signing of an application for an applicant or member does not automatically authorize a person to receive protected health information from PSU staff or the managed care organization (MCO) regarding that applicant or member. See [Section 2119](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-2000-sph-legal-requirements#2119), Personal Representatives, for individuals who may receive or authorize the release of an applicant's or member's individually identifiable health information under Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

3113 Transmittal of Form H1200 or Form H1200-EZ

Revision 18-2; Effective September 3, 2018

When transmitting [Form H1200](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1200-application-assistance-your-texas-benefits), Application for Assistance – Your Texas Benefits, or [Form H1200-EZ](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1200-ez-application-assistance-aged-disabled), Application for Assistance – Aged and Disabled, to Medicaid for the Elderly and People with Disabilities (MEPD), Program Support Unit (PSU) staff fax Form H1200 or Form H1200-EZ to MEPD. Texas Health and Human Services Commission (HHSC) staff retain the original Form H1200 or Form H1200-EZ with the applicant's valid signature in the case record. The original form must be kept for three years after the case is denied or closed. Staff must also retain a copy of the successful fax transmittal confirmation in the case record.

If HHSC staff are co-housed with MEPD, the original Form H1200 or Form H1200-EZ is hand-delivered to the MEPD specialist and HHSC staff retain a copy of the form in the case record. If unusual circumstances exist in which the original must be mailed to the MEPD specialist after faxing, HHSC staff must mark "DUPLICATE" on the top of the form and retain a copy of the form in the case record. Scanning Form H1200 or Form H1200-EZ and sending by electronic mail is prohibited.

3114 Applicants with Medicaid Eligibility

Revision 18-2; Effective September 3, 2018

At the time of the initial intake for the STAR+PLUS Home and Community Based Services (HCBS) program, Program Support Unit (PSU) staff must obtain information on the applicant's Medicaid and/or financial status. PSU staff must obtain verification of the applicant's current eligibility for an appropriate type Medicaid program from Medicaid for the Elderly and People with Disabilities (MEPD) specialist or through inquiry in the Texas Integrated Eligibility Redesign System (TIERS).

To be financially eligible for the STAR+PLUS HCBS program, refer to the mandatory population described in [Section 3221](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3221), Mandatory Groups.

Applicants who receive Supplemental Security Income (SSI) are financially eligible for Medicaid and do not require a financial determination; the Social Security Administration (SSA) has already made this determination.

Applicants receiving services through Community Attendant Services (TIERS TP14) are not automatically eligible for the STAR+PLUS HCBS program. MEPD specialists must be consulted for these applicants. Applicants who currently have [Form H1200](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1200-application-assistance-your-texas-benefits), Application for Assistance – Your Texas Benefits, on file with the Texas Health and Human Services Commission (HHSC) may not need to complete a new Form H1200.

3115 Applicants Without Medicaid Eligibility

Revision 18-2; Effective September 3, 2018

The Code of Federal Regulations, Section 42 CFR 431.10, specifies that Medicaid eligibility must be determined by a single state agency. The Texas State Plan designates the Texas Health and Human Services Commission (HHSC) as the sole agency with the authority to make eligibility determinations for medical assistance only (MAO) cases.

Financial eligibility for non-Supplemental Security Income (SSI) STAR+PLUS Home and Community Based Services (HCBS) program is determined exclusively by the Medicaid for the Elderly and People with Disabilities (MEPD) specialist. Program Support Unit (PSU) staff must not:

* screen applicants from referral to MEPD due to apparent financial ineligibility; or
* deny applications or recertifications based on financial eligibility criteria unless notified by the MEPD specialist of financial ineligibility.

If the applicant's individual income exceeds the SSI federal benefit rate (FBR) per month, the applicant applies for Medicaid through HHSC by completing [Form H1200](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1200-application-assistance-your-texas-benefits), 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 may apply for MAO with HHSC. See [Appendix VIII](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/appendices/appendix-viii-monthly-incomeresource-limits), Monthly Income/Resource Limits, for the current SSI FBR.

3116 Monthly Income Below the Supplemental Security Income Standard Payment

Revision 18-2; Effective September 3, 2018

An applicant in the community (with no ineligible spouse) who has income less than the Supplemental Security Income (SSI) federal benefit rate must apply for SSI through the Social Security Administration (SSA). Texas Health and Human Services Commission (HHSC) staff cannot determine financial eligibility for these individuals except for cases in which the SSI application for disability has been pending for more than 90 days and a decision is made by HHSC Disability Determination Unit (DDU) staff.

If there is a question whether the applicant should apply for SSI or for medical assistance only (MAO), Program Support Unit (PSU) staff may consult the regional Medicaid for the Elderly and People with Disabilities (MEPD) specialist.

3117 Coordination with Medicaid for the Elderly and People with Disabilities Staff

Revision 18-2; Effective September 3, 2018

Program Support Unit (PSU) staff must inform the applicant or member without pre-existing Medicaid coverage and/or her or his authorized representative (AR) that the Medicaid for the Elderly and People with Disabilities (MEPD) specialist will complete a financial eligibility (Medicaid) determination. PSU staff must encourage the applicant, member or AR to cooperate with the MEPD specialist and to provide all verifications necessary in a timely fashion.

Any information, including information on third-party insurance, obtained by PSU staff must be shared with the MEPD specialist to prevent the applicant or member from having to provide the information twice.

PSU staff must inform the MEPD specialist of the request for the STAR+PLUS Home and Community Based (HCBS) program according to regional procedures. For those applicants or members already on an appropriate type of Medicaid program, PSU staff must obtain a copy of the most recent:

* [Form H1200](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1200-application-assistance-your-texas-benefits), Application for Assistance – Your Texas Benefits;
* [Form H1200-A](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1200-a-medical-assistance-only-mao-recertification), Medical Assistance Only (MAO) Recertification; or
* [Form H1010](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1010-texas-works-application-assistance-your-texas-benefits), Texas Works Application for Assistance – Your Texas Benefits

An applicant for the STAR+PLUS HCBS program who has medical assistance only (MAO) coverage type Medicaid services may only receive the STAR+PLUS HCBS program after a program transfer to Medicaid waivers is completed by the MEPD specialist. When 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 staff must also send an email to the MEPD specialist that includes the following information:

* the applicant’s name;
* applicant’s Medicaid identification (ID) number;
* individual has MAO coverage-type Medicaid, which will require a program transfer; and
* name and telephone number of the PSU staff contact.

The MEPD specialist will make the necessary changes to allow the MA coverage-type Medicaid individual to receive the STAR+PLUS HCBS program.

Identification of MAO Coverage-Type Medicaid

PSU staff can check TIERS to determine a member’s coverage type. In TIERS, the coverage type on the Search/Summary screen is displayed with the preface of MAO.

An application form is not required for members receiving Supplemental Security Income (SSI).

If a STAR+PLUS HCBS program applicant's or member's application for SSI disability has been pending more than 90 days, the Texas Health and Human Services Commission's (HHSC’s) Disability Determination Unit (DDU) staff may determine disability, pending the Social Security Administration (SSA) determination. The SSI decision must be adopted when it is received from SSA. In order for DDU staff to make a disability determination, DDU staff require [Form H3034](https://hhs.texas.gov/laws-regulations/forms/3000-3999/form-h3034-disability-determination-socio-economic-report), Disability Determination Socio-Economic Report, [Form H3035](https://hhs.texas.gov/laws-regulations/forms/3000-3999/form-h3035-medical-information-releasedisability-determination), Medical Information Release/Disability Determination, and a copy of the Medical Necessity and Level of Care (MN/LOC) Assessment. If additional records are necessary, the MEPD specialist is notified.

3117.1 Income and Resource Verifications for Medicaid for the Elderly and People with Disabilities

Revision 18-2; Effective September 3, 2018

Any information, including information on third-party insurance, obtained by Program Support Unit (PSU) staff must be shared with the Medicaid for the Elderly and People with Disabilities (MEPD) specialist to prevent the applicant or member from having to provide the information twice. Any information obtained by managed care organization (MCO) staff must be immediately forwarded to PSU staff so it can be passed on to the MEPD specialist.

Inform medical assistance only (MAO) applicants of the importance of providing the most complete packet possible to the MEPD specialist. Explain that failure to submit the required documentation to the MEPD specialist could delay completion of the application or cause the application to be denied.

Ensuring the following items are included greatly facilitates the financial eligibility process:

* Bank accounts – bank name, account number, balance and account verification (for example, a copy of the bank statement)
* Award letters showing the amount and frequency of income payments
* Life insurance policy – company name, policy number, face value or a copy of the policy
* A signed and dated [Form 0003](https://hhs.texas.gov/laws-regulations/forms/0-999/form-0003-authorization-furnish-information), Authorization to Furnish Information
* Confirmation that Medicaid Estate Recovery Program information was shared with the applicant by checking the appropriate box on [Form H1746-A](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1746-a-mepd-referral-cover-sheet), MEPD Referral Cover Sheet
* Preneed funeral plans – name of the company, policy or plan number and a copy of the preneed agreement
* Correct and up-to-date telephone numbers
* Power of Attorney or Guardianship – copy of the legal document

PSU staff must inform the MEPD specialist of the request for the STAR+PLUS Home and Community Based Services (HCBS) program, according to regional procedures. PSU staff should obtain a copy of the most recent [Form H1200](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1200-application-assistance-your-texas-benefits), Application for Assistance – Your Texas Benefits, for those applicants or members already on an appropriate type of Medicaid program. Form H1200 is not required for members receiving Supplemental Security Income (SSI).

If a STAR+PLUS HCBS program applicant's or member's application for SSI disability has been pending more than 90 days, the Texas Health and Human Services Commission (HHSC) Disability Determination Services (DDS) staff may determine disability, pending the Social Security Administration (SSA) determination. The SSI decision must be adopted when it is received from SSA. In order for DDS staff to make a disability determination, DDS staff require [Form H3034](https://hhs.texas.gov/laws-regulations/forms/3000-3999/form-h3034-disability-determination-socio-economic-report), Disability Determination Socio-Economic Report, [Form H3035](https://hhs.texas.gov/laws-regulations/forms/3000-3999/form-h3035-medical-information-releasedisability-determination), Medical Information Release/Disability Determination, and a copy of the Medical Necessity and Level of Care (MN/LOC) Assessment. If additional records are necessary, the MEPD specialist will be notified.

3117.2 MAO Applicants Not Previously Certified in TIERS

Revision 18-2; Effective September 3, 2018

A new application is defined as an application for a Medicaid for the Elderly and People with Disabilities (MEPD) household not previously certified in the Texas Integrated Eligibility Redesign System (TIERS).

Once staff determine applicants being referred to MEPD for a financial determination do not have any prior certifications in TIERS, [Form H1746-A](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1746-a-mepd-referral-cover-sheet), MEPD Referral Cover Sheet, and [Form H1746-B](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1746-b-batch-cover-sheet), Batch Cover Sheet, must be used to send [Form H1200](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1200-application-assistance-your-texas-benefits), Application for Assistance – Your Texas Benefits, [Form H1200-EZ](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1200-ez-application-assistance-aged-disabled), Application for Assistance – Aged and Disabled, or [Form H1010](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1010-texas-works-application-assistance-your-texas-benefits), 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 containing more than one Form H1746-A being sent to DPC.

3117.3 Unsigned Applications

Revision 18-2; Effective September 3, 2018

Unsigned applications received by the Medicaid for the Elderly and People with Disabilities (MEPD) specialist are returned to the sender. Texas Health and Human Services Commission (HHSC) staff must ensure applications are signed prior to referring to the MEPD specialist; if not, HHSC staff are required to obtain signatures when unsigned applications are returned.

The application forms are:

* [Form H1200](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1200-application-assistance-your-texas-benefits), Application for Assistance – Your Texas Benefits;
* [Form H1200-EZ](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1200-application-assistance-your-texas-benefits), Application for Assistance – Aged and Disabled;
* [Form H1200-A](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1200-a-medical-assistance-only-mao-recertification), Medical Assistance Only (MAO) Recertification; and
* [Form H1010](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1010-texas-works-application-assistance-your-texas-benefits) – Texas Works Application for Assistance – Your Texas Benefits.

If the MEPD specialist receives an unsigned application from HHSC with [Form H1746-A](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1746-a-mepd-referral-cover-sheet), MEPD Referral Cover Sheet, the MEPD specialist returns the application to HHSC with an annotation on the cover form (Form H1746-A) that the application is unsigned and must be signed before HHSC can establish a file date. Once HHSC staff receive an unsigned application from the MEPD specialist, it is the responsibility of HHSC staff to coordinate with applicants or members in getting applications signed and returned to the MEPD specialist for processing.

Sending unsigned applications delays the MEPD and HHSC eligibility processes and could adversely affect service delivery to applicants or members.

3117.4 Medicaid Eligibility Decisions Pending Past the Program Due Date

Revision 18-2; Effective September 3, 2018

For most Medicaid for the Elderly and People with Disabilities (MEPD) applications, eligibility decisions are due by the 45th day. However, applications for individuals under age 65 may require a 90-day time frame to allow the agency to obtain a disability determination. This applies when the person's age is less than 65 and the person does not receive Retirement, Survivors and Disability Insurance (RSDI), Supplemental 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 eligibility component criteria.

For other case actions (for example, program transfers), the MEPD specialist may require time to verify income and resources. This is especially true if the previous case was community-based or included an individual declaration of income/resources. Program Support Unit (PSU) staff may inquire about these cases once they have been pending more than 45 days.

A list of individuals to contact when PSU staff are attempting to determine the status of MEPD case actions that have passed the MEPD program due dates can be found in [Appendix III](https://hhs.texas.gov/laws-regulations/handbooks/appendices/appendix-iii-starplus-medicaid-elderly-and-people-disabilities-mepd-management-team), Medicaid for the Elderly and People with Disabilities (MEPD) Management Team. PSU staff must not contact the MEPD specialist until the MEPD due date has passed.

Once the deadline has passed, PSU staff may contact the program manager's administrative assistant at the number provided in the right-hand column of the list. Do not contact the program manager directly.

3118 Address Changes for Supplemental Security Income Recipients

Revision 18-2; Effective September 3, 2018

Program Support Unit (PSU) staff must not send address change requests for Supplemental Security Income (SSI) recipients to the Document Processing Center (DPC) in Midland. PSU staff must inform the individual or her or his responsible party to contact the Social Security Administration (SSA) to request the residence address change. The address change will be reflected in the Texas Integrated Eligibility Redesign System (TIERS) after SSA makes the change.

PSU staff must also send an email to the Enrollment Resolution Services (ERS) mailbox to notify ERS of the request for a change in address.

3120 Other Available Services

Revision 18-2; Effective September 3, 2018

3121 Prescription Drugs

Revision 18-2; Effective September 3, 2018

Prescription drugs are not part of the managed care organization's (MCO's) array of services. STAR+PLUS Medicaid-only members continue to have prescriptions filled by any pharmacist participating in the Texas Health and Human Services Commission (HHSC) Vendor Drug Program (VDP). They will receive unlimited medically necessary prescriptions instead of the traditional three prescriptions per month limit. Drug coverage through VDP is limited to the state's formulary and may not cover all of the prescribed medications required for the individual.

Medicare prescription drug coverage (Medicare Part D) is insurance 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 expenses. Members who are eligible for both Medicaid and Medicare (dual-eligible) receive the majority of their drugs through Medicare Part D.

The MCO must inform individuals requesting the STAR+PLUS program of 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 must be explained to the applicant:

* If a member is considered dual-eligible (receiving both Medicare and Medicaid), the member obtains prescriptions first through Medicare Part D or, for certain prescribed drugs excluded from Medicare Part D, through the VDP.
* Drug coverage through Medicare is limited to each drug plan's formulary and may not cover all of the prescribed medications required for the member. Prescriptions not covered by Medicare Part D may be paid by the Medicaid VDP; however, the Medicaid Vendor Drug formulary does not cover certain prescription drugs and over-the-counter medications.
* Members who participate in Medicare Part D are responsible for purchasing any medications and copayments for medications not covered through Medicare Part D or the Medicaid VDP.
* Members not participating, or those choosing private insurance over Medicare Part D, are also responsible for purchasing medications and copayments for medications not covered by Medicare Part D or the Medicaid VDP.
* Members eligible for both Medicare and Medicaid can receive assistance with prescription costs through the Low Income Subsidy program. These members pay little or no premiums and no deductibles. Drug copayment amounts could range from $1 to $5.

Federal law prohibits the use of STAR+PLUS program funds for Medicare Part D prescriptions, copayments and costs. STAR+PLUS program funds may not be authorized for prescriptions, copayments and costs if the member is eligible for Medicare Part D and chooses private insurance rather than participation in Medicare Part D. Non-covered medications cannot be billed through the STAR+PLUS program as medical supplies or adaptive aids.

Copayments for prescriptions covered by the Veterans Benefits Administration may be authorized 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 costs as an incurred medical expense if they:

* reside in the community and have a qualified income trust (QIT); or
* receive assisted living (AL) or adult foster care (AFC) services.

For a member whose current Medicaid identification card does not include the statement "can receive more than three prescriptions," pharmacists may verify the STAR+PLUS program eligibility 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 staff register the member on the system within two days after the member's enrollment record is registered for STAR+PLUS Program services.

Pharmacists must check the member's Your 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 incurred medical expenses. Refer to [Section 3123](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3123), Incurred Medical Expenses.

3122 Over-the-Counter Drugs

Revision 18-2; Effective September 3, 2018

The STAR+PLUS Home and Community Based Services (HCBS) program does not pay for over-the-counter drugs, with or without a prescription or statement from a physician or health professional. Over-the-counter drugs are generally considered medications that may be sold to a customer without a prescription and do not require the direct supervision of a physician or health professional. Common over-the-counter medications include pain relievers, decongestants, antihistamines, cough medicines, vitamins, minerals and herbal supplements. This list is not all inclusive.

Medications, including over-the-counter drugs not covered through the Texas Health and Human Services Commission (HHSC) Vendor Drug Program (VDP), Medicare Part D or other third-party resources (TPR), cannot be paid for by the STAR+PLUS HCBS program. Refer to [Section 3121](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3121), Prescription Drugs, for additional information.

3123 Incurred Medical Expenses

Revision 18-2; Effective September 3, 2018

Incurred medical expenses (IMEs) are out-of-pocket expenses a medical assistance only (MAO) member can incur for necessary medical services. IMEs include the cost of medically necessary (MN) items not covered by Medicaid, such as Medicare Part D premiums.

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 (such as premiums, enhanced premiums, prescription drug 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:

* reside in the community and have a Medicaid copayment as a result of a qualified income trust (QIT); or
* reside in an adult foster care (AFC) home or assisted living facility (ALF).

Members who wish to use IMEs to pay for Medicare Part D costs should report these costs to the Medicaid for the Elderly and People with Disabilities (MEPD) specialist so the costs can be included in the calculation of copayment for the STAR+PLUS HCBS program. The member's statement of Medicare Part D expenses is acceptable. No written documentation is required from the member to support the declaration. The arrangement for payment of the prescriptions is between the member and the pharmacist.

Some drugs are not covered by Medicare Part D, Medicaid or private drug coverage. In order for these non-formulary drugs to be considered as IMEs, a member must request an exception from the Medicare Part D plan for the drugs. The member is expected to use the procedure for requesting an exception, as required by her or his Medicare Part D plan. The member can submit the results of the requested exception directly to the MEPD specialist. If an exception is not requested, the non-formulary drugs are not allowable IMEs and the cost will be the responsibility of the member.

The MEPD specialist applies the IME policy during the certification process to all new members who meet the above criteria. MEPD also reviews Medicare costs and IMEs once every six months as part of the regular case monitoring, or whenever the member makes a request to update IME costs. The member or her or his authorized representative (AR) may identify and request IMEs by contacting the MEPD specialist.

3124 Medical Transportation

Revision 18-2; Effective September 3, 2018

STAR+PLUS Home and Community Based Services (HCBS) program members, as recipients of Medicaid, are eligible to use the Medicaid medical transportation system for Medicaid-covered medical appointments. The Medicaid medical transportation system is accessed by calling the local agency 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 (AL) providers are responsible for scheduling transportation for the residents.

The local medical transportation contractors have procedures regarding service area limitations, schedules for traveling to certain areas and requirements on the amount of notice 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 eligibility for participants who are living in an AFC/ALF. In cases of difficulties in scheduling, or questions about eligibility for transportation, participants should contact the managed care organization to intercede on the participant's behalf with the local Medicaid medical transportation system.

3125 STAR+PLUS Home and Community Based Services Program Members Requesting Non-Managed Care Services

Revision 18-2; Effective September 3, 2018

The STAR+PLUS Home and Community Based Services (HCBS) program is required to provide all of the services (excluding hospice) needed to enable the member to live safely in the community. Therefore, Community Care for Aged and Disabled (CCAD) services cannot be authorized for STAR+PLUS HCBS program members. STAR+PLUS HCBS program members requesting additional services must be referred to the managed care organization's (MCO’s) service coordinator.

3126 STAR+PLUS Members Requesting Non-Managed Care Services

Revision 17-1; Effective March 1, 2017

Members receiving STAR+PLUS services are potentially eligible to receive a variety of services from the Texas Health and Human Services Commission (HHSC). For specific information, see:

* [Section 3126.1](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3126.1), Community Care for Aged and Disabled Services; and
* [Section 3126.2](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3126.2), In-Home and Family Support Program Services.

3126.1 Community Care for Aged and Disabled Services

Revision 18-2; Effective September 3, 2018

If members meet program requirements, STAR+PLUS services members are eligible to receive the following Community Care for Aged and Disabled (CCAD) services:

* adult foster care (AFC);
* residential care;
* emergency response services (ERS);
* home-delivered meals; and
* special services to persons with disabilities.

Members may also be eligible for family care if the managed care organization (MCO) has denied their request for personal attendant services due to the:

* lack of practitioner's statement of 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 activity and health services (DAHS);
* community attendant services (CAS);
* primary home care (PHC); and
* assisted living (AL).

An individual requesting CCAD services should be added to any applicable interest lists at the time of the request, in order to protect the date and time of the request. Prior to processing an application, the CCAD case manager must verify the service array does not include a service equivalent of the Title XX service requested. The CCAD case manager may view the STAR+PLUS Program Health Plan Comparison Charts and value-added services on the HHSC website at:  [https://hhs.texas.gov/services/health/medicaid-and-chip/programs/starplus/comparison-charts](https://hhs.texas.gov/services/health/medicaid-chip/programs/starplus/starplus-comparison-charts).

Value-added services offered by an MCO are extra services approved by HHSC. Value-added services will vary by MCO. HHSC staff are not required to wait for appeal decisions from MCOs to process requests for Title XX services if the service requested is not a value-added service on the member’s plan. Once released from the Title XX interest list, the CCAD case manager verifies the applicant’s MCO does not offer an equivalent service as a value-added service and proceeds with the eligibility determination 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 CCAD case manager refers the member to the MCO.
* yes, and services were approved, the CCAD case manager refers the member to the MCO to initiate service delivery.
* yes, and services were not approved or the member doesn't know if he or she was approved, the CCAD case manager contacts Program Support Unit (PSU) staff. Once PSU staff confirm services were not approved, the application can be processed.
* unsure, the CCAD case manager refers the member to PSU staff. PSU staff will contact the MCO to inquire about the request.

Once released from the interest list, CCAD case managers may proceed to determine eligibility. Process applications for individuals who are enrolled in STAR+PLUS Services managed care only if they meet the criteria outlined above. Do not authorize Title XX services for anyone receiving the STAR+PLUS Home and Community Based Services (HCBS) program.

3127 Health Insurance Premium Payment Program

Revision 18-2; Effective 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 deductibles for Medicaid-covered services provided by Medicaid providers. HIPP individuals also can receive Medicaid benefits (provided by a Medicaid-enrolled provider) not covered by their employer-sponsored health insurance.

In order to qualify for HIPP, an employee must either be Medicaid eligible or have a family member who is Medicaid eligible. The reimbursement may pay for individuals and their family members to receive employer-sponsored health insurance benefits when it is determined the cost of insurance premiums and administration are less than the cost of projected Medicaid expenditures.

Individuals who participate in the HIPP program may participate in STAR+PLUS and remain enrolled in HIPP.

3200 Eligibility

Revision 18-2; Effective September 3, 2017

3210 Service Areas

Revision 18-2; Effective September 3, 2018

STAR+PLUS services are currently available statewide, broken down by service delivery areas:

|  |
| --- |
| Bexar Service Area: Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina and Wilson counties |
| Dallas Service Area: Collin, Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwell counties |
| Harris Service Area: Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller and Wharton counties |
| El Paso Service Area: El Paso and Hudspeth counties |
| Hidalgo Service Area: Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy and Zapata counties |
| Jefferson Service Area: Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler and Walker counties |
| Lubbock Service Area: Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Lynn, Potter, Randall, Swisher and Terry counties |
| 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 and Washington counties |
| 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 and Wood counties |
| 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 and Zavala counties |
| Nueces Service Area: Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kennedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio and Victoria counties |
| Tarrant Service Area: Denton, Hood, Johnson, Parker, Tarrant, and Wise counties |
| Travis Service Area: Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis and Williamson counties |

3220 Eligible Groups

Revision 18-2; Effective September 3, 2018

3221 Mandatory Groups

Revision 18-2; Effective September 3, 2018

The following groups of individuals must receive services through STAR+PLUS. The program designations are used in the following list.

* Supplemental Security Income (SSI) recipients, Texas Integrated Eligibility Redesign System (TIERS) TA 01, TA 02 and TA 22 — Individuals age 21 or over who qualify for this needs-tested program administered by the Social Security Administration (SSA) (full Medicaid recipients).
* Pickle Amendment Group, TIERS TP 03 — Individuals age 21 or over who would continue to be eligible for SSI benefits if cost of living increases (COLAs) were deducted from their countable income.
* Disabled Widow(s) or Widower(s), TIERS TP 21 — Widow(s) or widower(s), age 60-65 and with a disability, who:
  + were denied SSI benefits because of entitlement to early aged widow's or widower's benefits;
  + are ineligible for Medicare; and
  + would continue to be eligible for SSI benefits in the absence of those early aged widow's or widower's benefits 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 a disability, who:
  + are ineligible for Medicare and were denied SSI due to an increase in widow's or widower's benefits as a result of the relaxing of disability criteria; and
  + would continue to qualify for SSI with the exclusion of the Retirement, Survivors and Disability Insurance (RSDI) benefit and all COLA increases.
* Disabled Adult Children, TIERS TP 18 — Adults over age 21 with a disability that began before age 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 age 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 — Individuals age 18 to the 65th birth month who meet eligibility requirements defined in Texas Administrative Code, Title 1 Part 15, Chapter 366, Subchapter D.
* STAR+PLUS Home and Community Based Services (HCBS) program recipients who are medical assistance only (MAO), TIERS TA 10 (ME-Waiver) — Individuals who are eligible for STAR+PLUS because they participate in the STAR+PLUS HCBS program.
* Most nursing facility (NF) residents, TIERS TP 38 or TA06 (SSI) or TP 17 (MAO) — Most individuals residing in an NF.

The TIERS TA 10 identifier also designates individuals in Home and Community-based Services (HCS), Medically Dependent Children Program (MDCP) and Community Living Assistance and Support Services (CLASS). Because HCS, CLASS and MDCP individuals are excluded from STAR+PLUS, if a TIERS TA 10 recipient is identified as receiving one of these excluded services, contact the Program Support Unit (PSU) and provide the details for disenrollment from STAR+PLUS.

3222 Excluded Groups

Revision 17-1; Effective March 1, 2017

For excluded groups, refer to Texas Administrative Code (TAC) [§353.603 (link is external)](http://texreg.sos.state.tx.us/public/readtac%24ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=1&pt=15&ch=353&rl=603), Member Participation.

3223 Hospice Services in STAR+PLUS

Revision 18-2; Effective September 3, 2018

Hospice services may be delivered in a variety of settings, including nursing facilities (NFs). STAR+PLUS members must not be denied services or disenrolled due to receipt of hospice services. Hospice provides services related to terminal illness that are not available under the STAR+PLUS program. For example, hospice providers are able to administer pain control medications 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 Financial Eligibility

Revision 18-2; Effective September 3, 2018

STAR+PLUS Home and Community Based Services (HCBS) program applicants who are not already Medicaid eligible are required to complete [Form H1200](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1200-application-assistance-your-texas-benefits), Application for Assistance – Your Texas Benefits, in order to be evaluated for financial eligibility. The completed application form must be sent to the Medicaid for the Elderly and People with Disabilities (MEPD) specialist by close of business of 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, in order to be evaluated for financial eligibility. The completed application form must be sent to the MEPD specialist by close of business of 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.

Applicants have 30 days from the mail date of the application to complete, sign and return Form H1200. After 30 days, the application must be denied for failure to return the information needed to determine financial eligibility. Before denying the application, Program Support Unit (PSU) staff must check first to make sure the application form was not mailed directly to the MEPD specialist.

If denial is necessary, document "Your application is being denied because you failed to return the application form mailed to you on [date]" in the comments section of [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services.

See [Section 3112](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3112), Medicaid Eligibility, for additional information regarding financial eligibility for the STAR+PLUS HCBS program.

3231 Income Diversion Trust

Revision 18-2; Effective September 3, 2018

An applicant who has a qualified income trust (QIT) may be determined eligible for the STAR+PLUS Home and Community Based Services (HCBS) program even though her or his income is greater than the special institutional income limit, if the applicant also meets all other eligibility criteria. Income converted to the trust does not count for purposes of determining financial eligibility by Medicaid for the Elderly and People with Disabilities (MEPD) specialists; however, the total income (including income diverted to the trust) is considered for the calculation of 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 equals or exceeds the total cost of her or his individual service plan (ISP).

Financial eligibility for an applicant with a QIT is determined by the MEPD specialist. He or she is informed that any funds deposited into the trust must be used as copayment for the cost of services delivered. The MEPD specialist calculates the amount of income available from the trust for copayment and provides the amount to Program Support Unit (PSU) staff. PSU staff notify the managed care organization (MCO) via [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-starplus-communication), Managed Care Programs Communication.

For an applicant who is financially eligible based on a QIT, the eligibility based on the ISP cost limit is determined before considering the use of funds from the trust for the purchase of services. Funds from the trust determined to be 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 after eligibility is determined to avoid the possibility of "purchase" of STAR+PLUS HCBS program eligibility. A member with a QIT copayment that covers all STAR+PLUS HCBS program costs receives the benefit of contracted rates as opposed to private pay rates.

First, a plan of care (POC) is developed by the MCO without consideration of the trust. Then, if the individual is eligible for the STAR+PLUS HCBS program based on the cost limit, the excess funds from the trust (the monthly income in excess of the institutional income limit and allowable deductions for a spouse's needs and medical expenses) are allocated to pay for services identified on [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-spw-pg-1), Individual Service Plan (Pg.1), as the STAR+PLUS HCBS program. The ISP total, and therefore the amount of the authorizations to providers, is reduced by the amount of excess funds. The member must pay the provider directly for the amount of services equivalent to the amount of excess funds. Use of the trust fund is documented on [Form H1700-B](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-b-non-hcbs-starplus-waiver-services), Non-STAR+PLUS HCBS Program Services. Continuing Medicaid eligibility through the STAR+PLUS HCBS program is contingent upon payment of the QIT copayment to the provider(s).

Refer to [Section 3236](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3236), Copayment and Room and Board, and [Section 3232](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3232), Payments from the Qualified Income Trust, for specific PSU and MCO procedures related to QIT copayments.

3232 Payments from the Qualified Income Trust

Revision 18-2; Effective September 3, 2018

Applicants or members with a qualified income trust (QIT) are responsible for a copayment in adult foster care (AFC), assisted living (AL) or the at-home setting. The managed care organization (MCO) must clearly explain to the applicant or member the funds from the QIT determined to be available for copayment must be used to purchase the STAR+PLUS HCBS program. Payments are made directly to the AFC, AL or other provider.

For applicants or members residing in AFC or AL settings, the copayment amount is usually applied to the cost of AFC or AL first. If copayment funds remain after being applied to the cost of AFC or AL, the remaining funds must 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 to purchase PAS, nursing or medical supplies. The MCO calculates the type and amount of payment the applicant or member will make directly to the service provider using the following steps:

* The MCO develops the individual service plan (ISP) showing the total requested services and total cost of the ISP without consideration of the amount of services the QIT copayment will purchase.
* Once the ISP has been 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 to be purchased from the trust. The units of service are determined by dividing the monthly copayment amount by the unit rate for the service and rounding the result to the next lower half unit. The MCO documents the amount of services the member must pay directly to the provider(s) and obtains the applicant's or member's agreement. Refer to [Section 3234](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3234), Qualified Income Trust Copayment Agreement, for specific details about documenting the agreement.
* The MCO develops a second [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-spw-pg-1), Individual Service Plan (Pg.1), to reflect the amount of services reduced by the QIT copayment amount. The second Form H1700-1 is annotated in the top 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 amount of services to be purchased. This amount is subtracted from the total authorized amount to determine the new service units to be authorized and the new ISP total. [Form H1700-B](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-b-non-hcbs-starplus-waiver-services), Non-STAR+PLUS HCBS Program Services, is used to document the specific services provided through the QIT.
* The amounts on the adjusted ISP are entered into the Service Authorization System Online (SASO). The total available QIT copayment 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 lives in an AFC or AL setting, the calculated QIT copayment amount will be reflected in the Copayment screens in SASO. Refer to the information in [Section 3233](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3233), Available QIT Copayment Amount Exceeds the Daily Rate for AFC or AL, if the available QIT copayment amount is sufficient to fully pay for AFC or AL. The copayment amount for services other than AFC or AL is documented on [Form 1578](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1578-qualified-income-trust-qit-copayment-agreement), Qualified Income Trust (QIT) Copayment Agreement, and [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services.
* The adjusted ISP and Form 1578 are sent to the service provider(s). The provider will review the adjusted ISP and attachments to determine the acceptance of a referral.
* Form H2065-D is used to notify the member and provider(s) of the amount of copayment to be made directly to the provider(s). QIT copayment amounts to the MCO contracted provider are shown 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; Effective September 3, 2018

If the available qualified income trust (QIT) copayment amount exceeds the daily rate for adult foster care (AFC) or assisted living (AL), the monthly AFC or AL copayment amount must be calculated using the exact number of days in each month (28, 30 or 31 days).

Example: The available QIT copayment amount is $1,400 monthly. The member is authorized as 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 organization (MCO) may complete [Form 1578](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1578-qualified-income-trust-qit-copayment-agreement), 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 any of the months the member has been notified of in advance, Form 1578 must be sent to reflect the new copayment amounts for each month. The MCO must maintain a copy of each Form 1578 in the member's folder.

If any QIT copayment amount remains after the monthly copayment amount is calculated for the AFC or AL setting, the remaining copayment amount is applied to services delivered by the in-home provider. In these cases, the AFC or AL provider, in-home provider, member and trustee must be notified of the amounts to be collected from the member based on 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 delivered by the provider. In May, the member has $92.42 remaining to pay for services delivered by the provider.

Failure to pay the required QIT copayment could result in termination of services. Refer to [Section 3235](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3235), Refusal to Pay Qualified Income Trust Copayment.

3234 Qualified Income Trust Copayment Agreement

Revision 18-2; Effective September 3, 2018

The managed care organization (MCO) completes [Form 1578](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1578-qualified-income-trust-qit-copayment-agreement), Qualified Income Trust (QIT) Copayment Agreement, and documents the:

* service purchased;
* amount available for copayment;
* unit rate;
* units purchased; and
* monthly copayment amount for the specific services.

The units to be purchased must be converted to a monthly amount if that service is not already reported in a monthly format. The monthly copayment amount cannot exceed the total amount for that service for a month. If there are additional copayment funds after the first service is calculated, the copayment is applied to a second (or third) service, if necessary. For persons residing in adult foster care (AFC) or assisted living (AL) settings, the copayment amount is usually applied to the cost of AFC or AL. If copayment funds remain after being applied to the cost of AFC or AL, the remaining funds must be applied to other services such as nursing, personal assistance services (PAS) or medical supplies. For persons at home, the copayment is first used to purchase PAS, nursing or medical supplies.

[Form H2060](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-needs-assessment-questionnaire-taskhour-guide), Needs Assessment Questionnaire and Task/Hour Guide, [Form H2060-A](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-a-addendum-form-h2060), Addendum to Form H2060, [Form H2060-B](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-b-needs-assessment-addendum), Needs Assessment Addendum, or other individual service plan (ISP) attachments should not be modified since 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; Effective September 3, 2018

There are 1,400 units (hours) of personal assistance services (PAS) included in the initial individual service plan (ISP). The available copayment amount is $1,250, and divided by $10.86 (PAS hourly rate) it equals 115.101 units; rounded down to the next lower half unit equals 115. (If the units were 115.633, it would be rounded down to 115.5.) On [Form 1578](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1578-qualified-income-trust-qit-copayment-agreement), Qualified Income Trust (QIT) Copayment Agreement, in the Service Purchased by QIT Copayment column, enter PAS; in the Monthly Copayment Amount Available column, enter $1,250; in the Unit Rate column, enter 115 units; and in the Monthly Copayment Amount for Units Purchased, enter $1,248.90 (115 units multiplied by $10.86).

Next, calculate the annual amount of units to be purchased through QIT by multiplying the monthly units by 12. For example, 115 units multiplied by 12 months equals 1,380 annual units to be purchased through QIT. Subtract this amount from the total authorization to determine the units to be authorized on the adjusted [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-spw-pg-1), Individual Service Plan (Pg. 1). For example, 1,400 units minus 1,380 equals 20 units of PAS to enter on the adjusted ISP.

After determining the amount of copayment to be paid to the service provider(s), the managed care organization (MCO) discusses the copayment with the applicant or member and the trustee of the trust. After explaining the requirements, the applicant, member or authorized representative (AR) and the trustee must sign Form 1578. A copy of the signed agreement is given to the applicant, member and/or AR and the trustee.

Services cannot begin until Form 1578 is signed, indicating the applicant's or member's agreement to pay the required copayment. A copy of Form 1578 is sent to the service provider(s) along with the ISP. If an applicant or member refuses to sign the adjusted ISP or the copayment agreement, services are denied for failure to pay the required copayment.

3235 Refusal to Pay Qualified Income Trust Copayment

Revision 18-2; Effective September 3, 2018

The trustee of the qualified income trust (QIT) must pay the QIT copayment directly to the provider by the 10th day of the month, or not later than 10 days after STAR+PLUS Home and Community Based Services (HCBS) program services have started in situations when services did not start on the first day of the month.

If the trustee refuses to pay the copayment for services, the provider must notify the managed care organization (MCO) via [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-starplus-communication), Managed Care Programs Communication, within **two business days**. The MCO must contact the trustee to learn the reason for refusal to pay. The MCO must also:

* write a letter to the member and the trustee explaining the consequences of continued failure to pay; and
* notify the Medicaid for the Elderly and People with Disabilities (MEPD) specialist that the trustee has refused to make the copayment.

If the copayment is not fully paid within 30 days of the due date, the MCO initiates denial.

If the Home and Community Support Services (HCSS) provider does not deliver sufficient services to use the copayment amount, the HCSS provider must refund any remaining copayment to the trustee and notify the member and MCO via Form H2067-MC.

Example: The provider collected a $400 QIT copayment to purchase 36.5 hours of PAS, but only 15 hours were delivered because the member went out of town. The provider must refund the dollar amount difference between 36.5 hours and 15 hours. The MCO must notify the MEPD specialist of the refund.

Refer to [Section 7100](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-7000-sph-waiver-program-services#7100), Adult Foster Care, for procedures related to failure to pay copayment.

3236 Copayment and Room and Board

Revision 18-2; Effective September 3, 2018

Members who are determined to be financially eligible based on the special medical assistance only (MAO) institutional income limit may be required to share in the cost of STAR+PLUS Home and Community Based Services (HCBS) program services. The method for determining the member's copayment is documented on the Medicaid for the Elderly and People with Disabilities (MEPD) copayment worksheet for the STAR+PLUS HCBS program.

The copayment amount is the member's remaining income after all allowable expenses have been deducted. The copayment amount is applied only to the cost of services funded through the STAR+PLUS HCBS program and specified on the member's individual service plan (ISP). The copayment must not exceed the cost of services actually delivered. Members must pay the cost-sharing amount directly to the provider contracted to deliver authorized STAR+PLUS HCBS program services.

To determine the room and board amounts for members residing in adult foster care (AFC) or assisted living (AL) settings, apply the following post-eligibility calculations:

* for individuals, the room and board amount is the Supplemental Security Income (SSI) federal benefit rate (FBR) minus the personal needs allowance;
* for SSI couples, the room and board amount is the SSI FBR [for a couple] minus the personal needs allowance for an individual multiplied by two; or
* for couples with incomes that exceed the SSI FBR for couples, the room and board amount is the couple's income minus the personal needs allowance for an individual multiplied by two. This amount cannot exceed double the room and board amount for an individual.

Some individuals will be responsible for contributing toward the cost of STAR+PLUS HCBS program services. This is referred to as copayment and/or room and board charges. The copayment amount is not a factor in determining the individual's eligibility for services.

The MEPD specialist calculates the copayment and deducts allowable incurred medical expenses for individuals whose eligibility is based on the special institutional income limits, or for individuals who have a qualified income trust (QIT). Refer to [Section 3123](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3123), Incurred Medical Expenses, and [Appendix XXII](https://hhs.texas.gov/laws-regulations/handbooks/medicaid-elderly-people-disabilities-handbook/appendices/appendix-xxii-home-community-based-services-waiver-program-co-payment-worksheets), §1915(c) Waiver Program Co-Payment Worksheets, of the *MEPD Handbook*.

SSI recipients, including SSI recipients who also receive Retirement, Survivors and Disability Insurance, are not required to make a copayment and no copayment calculation is necessary for them. STAR+PLUS HCBS program members who reside in AFC or AL settings may be required to pay a copayment.

The managed care organization (MCO) must clearly explain to the applicant, if it is determined the applicant must pay a monthly copayment that the copayment amount must be paid directly to the AFC or AL provider. All STAR+PLUS HCBS program members, including SSI recipients, are required to 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 board charge. If the member fails to pay the agreed-upon room and board charge and/or copayment, the member could be terminated from the STAR+PLUS HCBS program.

Program Support Unit (PSU) staff notify the member and MCO of new copayment amounts to be collected on [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services.

Refer to [Section 3232](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3232), Payments from the Qualified Income Trust, and [Section 3234](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3234), Qualified Income Trust Copayment Agreement, for specific QIT copayment procedures.

3237 Determining Room and Board Charges

Revision 18-2; Effective September 3, 2018

All STAR+PLUS Home and Community Based Services (HCBS) program members must pay the room and board charges to be eligible for assisted living (AL). Room and board cannot be waived, but an AL facility (ALF) may choose to accept an individual for a lower amount. STAR+PLUS HCBS program policy does not direct the facility to accept or reject the individual.

The room and board charge for an individual is fixed at the amount remaining after subtracting $85 from the Supplemental Security Income (SSI) federal benefit rate (FBR). FBR current amounts are found in [Appendix VIII](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/appendices/appendix-viii-monthly-incomeresource-limits), Monthly Income/Resource Limits, which is updated when the FBR changes.

For couples where both partners are residing in an adult foster care (AFC) or AL settings, $170 is subtracted from the couple's income so each member of the couple keeps $85 a month for personal needs and the remainder is the room and board charge for the couple. Due to the difference in income between couples and individuals, the amount of room and board charge for a couple depends on 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 is less than the current FBR for an individual doubled, the room and board charge is for the monthly income minus the $170 for personal needs.
* For couples whose income exceeds twice the SSI FBR for an individual, the full room and board charge for two individuals is required.

The AFC or AL participant will keep $85 a month for personal needs.

3238 Determining Copayment Amounts

Revision 18-2; Effective September 3, 2018

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](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-starplus-communication), Managed Care Programs Communication, or [Form H1746-A](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1746-a-mepd-referral-cover-sheet), MEPD Referral Cover Sheet, and a copy of the completed MEPD Waiver Program Copayment Worksheet to Program Support Unit (PSU) staff indicating the amount available for the monthly ongoing copayment. PSU staff forward this information to the managed care organization (MCO) by posting [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, to TxMedCentral.

3239 Copayment Changes

Revision 18-2; Effective September 3, 2018

A member's copayment may change during the time he is receiving the STAR+PLUS Home and Community Based Services (HCBS) program, typically due to a change in income or medical expenses. Copayment changes must always be effective on the first day of the month. If the copayment is increasing, Program Support Unit (PSU) staff must send the member and managed care organization (MCO) notification on [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, and the increase is effective the first day of the month after the expiration of the adverse action period. The MCO is responsible for notifying the provider.

If the first day of the month occurs before the end of the adverse action period, the copayment increase is effective the first day of the subsequent month. Decreases in copayment require Form H2065-D notification, but can be effective 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 staff. MEPD specialists inform PSU staff of fraud referrals and determine whether any corrections are necessary to the member's copayment based on a change in the amount available for copayment. PSU staff post [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-starplus-communication), Managed Care Programs Communication, to inform the MCO of any change in the copayment amount.

Underpayments by the member that 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 copayment that was underpaid. PSU staff are not responsible for determining if the underpayment is made to the MCO. The underpayment is not retroactively considered in the copayment calculation. The MEPD specialist notifies PSU staff if the ongoing copayment amount increases. If the amount does increase, PSU staff must post Form H2065-D notifying the MCO of the increase in the monthly copayment amount. The increase in copayment is effective the first day of the month after the expiration of the adverse action period indicated on Form H2065-D.

Refunds due to the member require a new copayment calculation be completed. The copayment may be calculated to allow the refund to be deducted from the member's next copayment amount due to the provider or the member may be given a reimbursement by the adult foster care/assisted living (AFC/AL) provider if there are no future copayments. The MCO determines if the AFC/AL provider should submit a negative billing. The effective date of the decrease in copayment is the first of the month after Form H2065-D is sent.

Example: The member's ongoing copayment is $100 per month. The MEPD specialist determines a copayment amount of $75 should have been effective February 1. A refund of $25 per month for the months of February, March, April and May total $100. PSU staff find out about the new amount on May 20 and immediately post Form H2065-D notifying the MCO. The MCO contacts the provider of the member's new copayment amounts: June – $0, July – $50, August – $75, ongoing.

3240 STAR+PLUS Home and Community Based Services Program Requirements

Revision 18-2; Effective September 3, 2018

The STAR+PLUS Home and Community Based Services (HCBS) program is provided by virtue of authority granted to the state of Texas to allow delivery of long-term services and supports (LTSS) that assist members to live in the community in lieu of a nursing facility (NF). To be eligible for services under STAR+PLUS HCBS program, the following criteria must be met:

* medical necessity (MN) (see [Section 3241](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3241), Medical Necessity Determination);
* services under the established cost limits (see [Section 3242.1](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3242.1), Maximum Limit);
* the member's unmet need for at least one STAR+PLUS HCBS program (see [Section 3242.2](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3242.2), Unmet Need for at Least One Waiver Service); and
* full Medicaid coverage.

3241 Medical Necessity Determination

Revision 18-2; Effective September 3, 2018

A STAR+PLUS Home and Community Based Services (HCBS) program applicant or member must have a valid medical necessity (MN) determination before admission into the STAR+PLUS HCBS program. The determination of MN is based on a completed Medical Necessity and Level of Care (MN/LOC) Assessment. The applicant's or member's individual service plan (ISP) cost limit is calculated based on the MN/LOC Assessment information.

The managed care organization (MCO) completes and submits MN/LOC Assessments to 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 RUG is a measure of nursing facility (NF) staffing intensity and is used in the STAR+PLUS HCBS program to:

* categorize needs for applicants or members; and
* establish the ISP cost limit.

When TMHP processes an MN/LOC Assessment, a three-alphanumeric digit RUG appears in the Level of 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 will result with a BC1 code instead of a RUG value. An MN/LOC Assessment resulting with a BC1 code does not have all of the information necessary for TMHP to accurately calculate a RUG for the member. Code BC1 is not a valid RUG to determine STAR+PLUS HCBS program eligibility.

The MCO nurse must correct the information on 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 correct information to TMHP.

For applicants or members needing a Medicaid eligibility financial decision, Program Support Unit (PSU) staff must notify the Medicaid for the Elderly and People with Disabilities (MEPD) specialist that the applicant or member meets MN. This notification can be by telephone or may be documented on [Form H1746-A](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1746-a-mepd-referral-cover-sheet), MEPD Referral Cover Sheet, which PSU staff send to the MEPD specialist. The MEPD specialist may view the SASO or LTC Online Portal to confirm that the applicant or member has met the MN criteria.

3241.1 Medical Necessity Determination for Applicants Residing in Nursing Facilities

Revision 18-2; Effective September 3, 2018

During the initial contact with the applicant or member, Program Support Unit (PSU) staff must explore the applicant's or member's status in the nursing facility (NF) and determine whether the applicant or member has a current medical necessity (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 regarding plans for submittal of the MN/LOC Assessment may be necessary. PSU staff must make every effort to determine if authorizing the MCO to complete the MN/LOC Assessment is necessary and to avoid duplication of submittal to Texas Medicaid & Healthcare and Partnership (TMHP) for an MN determination.

Approved MNs for NF residents may be verified through the Service Authorization System Online (SASO). In this situation, the MCO must not complete a new MN/LOC Assessment. The MN on record will be accepted as a valid MN. The MCO should 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 is applying for Medicaid as a resident in the NF and is concurrently applying for the STAR+PLUS Home and Community Based Services (HCBS) program, the NF should complete the MDS. The MCO is instructed not to complete a new MN/LOC Assessment with the pre-enrollment assessment. PSU staff must notify the MCO that MN exists by entering the Resource Utilization Group (RUG) and expiration date in Section A, Item 6, of [Form H3676](https://hhs.texas.gov/laws-regulations/forms/3000-3999/form-h3676-managed-care-pre-enrollment-assessment-authorization), Managed Care Pre-Enrollment Assessment Authorization. If the NF refuses to complete the MDS in a timely manner, PSU staff must authorize the MCO to complete the MN/LOC Assessment on the applicant or member by entering N/A in Section A, Item 6, of Form H3676 and posting to TxMedCentral in the MCO's XXXSPW folder using the appropriate naming convention.

A different situation exists when a STAR+PLUS HCBS program applicant or member enters the NF on Medicare. PSU staff must authorize the MCO to complete the MN/LOC Assessment, as described above, to expedite receiving an MN and avoid a delay for the applicant's or member's return to the community.

A denied MN decision resulting from an MN/LOC Assessment the MCO submitted is not used to deny a STAR+PLUS HCBS program applicant who has a current valid NF MDS. The NF MDS and RUG are used in the STAR+PLUS HCBS program eligibility determination.

An MN record must be located in the SASO so the individual service plan (ISP) registration does not suspend. The SASO MN record must match the ISP effective end date and must have an active MN period covering the entire ISP period. The MN/LOC Assessment end date must be adjusted to match the ISP end date, if necessary.

3241.2 Medical Necessity Determination for Applicants Not Residing in Nursing Facilities

Revision 18-2; Effective September 3, 2018

For STAR+PLUS Home and Community Based Services (HCBS) program applicants not living in nursing facilities (NFs), the medical necessity (MN) determination 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) doing the pre-enrollment home health assessment.

The MCO must electronically submit the MN/LOC Assessment to TMHP after it has been signed by the physician. A copy of the MN/LOC Assessment is filed in the member's case file.

3242 Individual Cost Limit Requirement

Revision 18-2; Effective September 3, 2018

3242.1 Maximum Limit

Revision 17-1; Effective March 1, 2017

The cost of the STAR+PLUS Home and Community Based Services (HCBS) program cannot exceed 202 percent of the cost of care the state would pay if the member was served in a nursing facility (NF). For initial eligibility, the STAR+PLUS HCBS program applicant must have an individual service plan (ISP) developed that is at or below 202 percent of what it would cost to provide services in an NF.

For initial applications, the total cost of services for an applicant's ISP must be equal to or below the individual's ISP cost limit. Applicants exceeding the cost limit cannot elect to receive reduced services for entry to the program if this would pose a risk to the individual's health, safety and welfare.

3242.2 Unmet Need for at Least One STAR+PLUS Home and Community Based Services Program Service

Revision 18-2; Effective September 3, 2018

The Code of Federal Regulations (CFR) specifies individuals are not eligible to receive  the STAR+PLUS Home and Community Based Services (HCBS) program unless they have a need for at least one STAR+PLUS HCBS program service. Therefore, the Texas Health and Human Services Commission (HHSC) cannot approve any individual service plan (ISP) which has $0.00 as the “Total Est. Waiver Cost” at the bottom of [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-spw-pg-1), Individual Service Plan (Pg. 1). When Program Support Unit (PSU) staff receive an ISP from the managed care organization (MCO) with a $0.00 STAR+PLUS HCBS program cost, the following activities occur.

Within **two business days**:

PSU staff post [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-starplus-communication), Managed Care Programs Communication, to the appropriate XXXSPW folder in TxMedCentral, using the appropriate naming convention. This will inform the MCO to verify if the ISP, which has no services, is accurate.

* If the ISP was submitted incorrectly:
  + the MCO must resubmit a corrected ISP within **two business days** (for example, the ISP posted correctly but is missing services); and
  + PSU staff must honor the original postdate if the MCO posts the corrected ISP within **two business days** of notification by PSU staff; or
* If the ISP was submitted correctly:
  + the MCO must post Form H2067-MC informing PSU the ISP reflects the member's needs; and
  + PSU staff:
    - begin denial procedures for these cases by completing [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services;
    - mail the original Form H2065-D to the member;
    - post Form H2065-D to TxMedCentral in the XXXSPW folder, using the appropriate naming convention;
    - fax or mail a copy of Form H2065-D to the Medicaid for the Elderly and People with Disabilities (MEPD) specialist, if applicable; and
    - email a copy of Form H2065-D to HHSC Enrollment Resolution Services (ERS)with Form H2067-MC, explaining that Form H2065-D was signed, dated and sent to the applicant.

3300 Administrative Procedures

Revision 18-2; Effective September 3, 2018

Program Support Unit (PSU) staff operate in each Texas Health and Human Services Commission (HHSC) STAR+PLUS managed care service area (SA). PSU staff provide support necessary for the coordination of long-term services and supports (LTSS), including the STAR+PLUS Home and Community Based Services (HCBS) program, for members who transfer in and out of STAR+PLUS SAs. PSU staff are also the point of contact for the coordination and monitoring of members transitioning from:

* nursing facilities (NFs) to the community, and
* the Medically Dependent Children Program (MDCP) to the STAR+PLUS HCBS program.

Responsibilities of PSU staff include:

* acting as an intermediary in relaying communications between Community Care Services Eligibility (CCSE) staff and the managed care organization (MCO);
* receiving requests for services from CCSE staff performing intake tasks;
* coordinating the application process for the STAR+PLUS HCBS program for NF residents who wish to transition to the community;
* assisting applicants with enrollment through the enrollment broker to select an MCO and primary care provider (PCP), if necessary;
* coordinating with Medicaid for the Elderly and People with Disabilities (MEPD) specialists regarding Medicaid eligibility, as appropriate;
* sending service authorizations ([Form H3676](https://hhs.texas.gov/laws-regulations/forms/3000-3999/form-h3676-managed-care-pre-enrollment-assessment-authorization), Managed Care Pre-Enrollment Assessment Authorization) to the MCO to do STAR+PLUS HCBS program assessments for non-members;
* serving as the primary contact for transitions in and out of STAR+PLUS SAs;
* assisting CCSE case managers in processing applications for non-Medicaid services by verifying the MCO denied the equivalent service under STAR+PLUS (see [Section 3510](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services), Money Follows the Person and Managed Care);
* assisting MCO members requesting placement on an interest list for services excluded from managed care (see [Section 3222](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3222), Excluded Groups);
* removing members in STAR+PLUS counties from the STAR+PLUS HCBS program interest list and processing their applications;
* assisting members who are aging out of MDCP and/or Texas Health Steps/Comprehensive Care Program in transferring to the STAR+PLUS HCBS program (see [Section 3420](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3420), Individuals Aging Out of Children's Programs);
* coordinating continuity of care for members suspended or disenrolled from STAR+PLUS;
* approving the STAR+PLUS HCBS program based upon eligibility;
* making Service Authorization System Online (SASO) entries as required for actions involving STAR+PLUS HCBS program members;
* handling the administrative claims process;
* researching and requesting disenrollment when the member is enrolled inappropriately;
* denying eligibility for the STAR+PLUS HCBS program; and
* handling requests for Medicaid fair hearings for applicants or members who are denied STAR+PLUS HCBS program eligibility.

3310 Intake and Enrollment

Revision 18-2; Effective September 3, 2018

When Community Care Services Eligibility (CCSE) receives a request for the STAR+PLUS Home and Community Based Services (HCBS) program, CCSE intake staff must assess whether the request for services should be forwarded for processing to the:

* appropriate Texas Health and Human Services Commission (HHSC) unit;
* HHSC enrollment broker;
* Program Support Unit (PSU) staff; or
* appropriate managed care organization (MCO).

Use the chart below to determine how to process requests for services in STAR+PLUS.

| **Type of Individual** | **Enrolled with a STAR+PLUS MCO?** | **How does CCSE handle this request?** |
| --- | --- | --- |
| Full Medicaid recipient applying for the STAR+PLUS HCBS program | No. | Forward the intake request to the enrollment broker. Supplemental Security Income (SSI) or other full Medicaid program recipients never go on the STAR+PLUS HCBS program interest list, whether they are enrolled with STAR+PLUS or not.  The enrollment broker determines what is preventing MCO enrollment and takes action to resolve the issue, which may include referral to the Health and Human Services Commission (HHSC) or contact with the individual. |
| Full Medicaid recipient applying for the STAR+PLUS HCBS program | Yes. | Refer the recipient to the MCO for the STAR+PLUS HCBS program. This individual will never go on the interest list. |
| Medically Dependent Children Program (MDCP) member who is turning age 21 | No. MDCP is excluded from STAR+PLUS. | A quarterly report is emailed to the PSU supervisor identifying individuals who are turning age 21 within the next 18 months and who receive MDCP and/or PDN. See the procedures for transition from MDCP to the STAR+PLUS HCBS program in [Section 3420](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3420), Individuals Aging Out of Children's Programs. These individuals never go on the interest list. |
| Medical assistance only (MAO) applicant for the STAR+PLUS HCBS program | No. | Staff receiving the intake will place the individual on the STAR+PLUS HCBS program interest list. |
| Nursing facility (NF) resident applying for the STAR+PLUS HCBS program | Yes. | The resident must be referred to the MCO for an upgrade to the STAR+PLUS HCBS program. |
| NF resident applying for the STAR+PLUS HCBS program | No. | All Money Follows the Person (MFP) individuals are placed on the interest list by intake staff and immediately assigned. The community services interest list (CSIL) assignment automatically generates an email notifying PSU staff of the referral. |

When CCSE intake staff determine a request for the STAR+PLUS HCBS program should be forwarded to PSU staff for processing, they must submit an email to HHSC Star Plus Waiver Interest List.

The email should 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 staff are unable to obtain all data elements from the applicant, the referral will still be processed by PSU staff so that access to the STAR+PLUS HCBS program interest list will not be denied. Although CCSE intake staff routinely provides the initial four demographic data, there may be times when an individual requesting services is unable to furnish the date of birth. If this information is not included in the referral, PSU staff must obtain it as the date of birth is required for entry to the Community Services Interest List (CSIL) system.

PSU state office staff will monitor the interest list mailbox and process the referrals within **three business days** by placing the individual on the STAR+PLUS HCBS program interest list, using the original date CCSE intake staff referred the request to PSU staff.

Because of member choice issues, MCOs are prohibited from contacting non-members without the authorization from PSU staff to complete 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 staff:

* complete Section A of [Form H3676](https://hhs.texas.gov/laws-regulations/forms/3000-3999/form-h3676-managed-care-pre-enrollment-assessment-authorization), Managed Care Pre-Enrollment Assessment Authorization; and
* post Form H3676 in the XXXSPW folder to TxMedCentral in the MCO folder, following the naming convention instructions in [Section 5110](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-5000-sph-automation-and-payment-issues-starplus#5110), TxMedCentral Naming Convention and File Maintenance.

**Note:** When PSU staff check the Texas Integrated Eligibility Redesign System (TIERS) for enrollment, the designation on the *Individual – Managed Care* screen of “Candidate Eligible” is not verification of enrollment. When enrollment is complete, the *Individual – Managed Care* screen will display “Enrolled.”

**Note:** CCSE intake screeners must provide information about the Program of All-Inclusive Care for the Elderly (PACE) to individuals during the intake and referral process when the individual requesting services is determined to be age 55 years or older and resides in a PACE service area. PACE services are available in designated areas of El Paso, Amarillo/Canyon and Lubbock.

CCSE intake screeners must be aware of the PACE service areas and referral procedures. Additional information on PACE can be found at: <https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/program-all-inclusive-care-elderly-pace>.

3311 Interim Services for Individuals Awaiting Managed Care Enrollment

Revision 18-2; Effective September 3, 2018

While awaiting enrollment in managed care, individuals are entitled to receive services from the Community Care for Aged and Disabled (CCAD) program. Referrals to CCAD must be made for all full Medicaid recipients. Case managers may assess these individuals for services if it appears services can be authorized and delivered prior to enrollment.

3311.1 Interest List Procedures

Revision 18-2; Effective September 3, 2018

Requests from Supplemental Security Income (SSI) or other full Medicaid program recipients must be assigned immediately. Program Support Unit (PSU) staff must use the Community Services Interest List (CSIL) database to track full Medicaid recipients who are not SSI eligible, as well as non-Medicaid individuals who have expressed interest in the STAR+PLUS Home and Community Based Services (HCBS) program. Interest List Management (ILM) Unit staff will record the date and time of the expressed interest. If the individual is first on the list and the service area (SA) is releasing names from the interest list, ILM staff may immediately release and assign the individual to the appropriate PSU staff.

PSU staff must also use CSIL database to track nursing facility (NF) residents who are not SSI eligible and express an interest in the STAR+PLUS HCBS program. When PSU staff receive the request for community transition to the STAR+PLUS HCBS program, PSU staff will check CSIL to see if the NF resident is already on the STAR+PLUS HCBS program interest list. If not, and the individual is not SSI eligible, PSU staff will add and immediately release the individual from the STAR+PLUS HCBS program interest list.

PSU staff manage activities related to the STAR+PLUS HCBS program interest list, including:

* placing individuals on the interest list;
* performing annual contacts when individuals are on the interest list for a year or more;
* releasing individuals from the interest list;
* tracking STAR+PLUS HCBS program slots allocated for use by individuals who are not mandatory participants; and
* confirming that individuals on the interest list are viable STAR+PLUS candidates before release by:
  + verifying all contact information is correct,
  + checking the Service Authorization System Online (SASO) and the Texas Integrated Eligibility Redesign System (TIERS) to determine the Medicaid eligibility status, and
  + verifying the individual still wants the STAR+PLUS HCBS program.

PSU state office staff are responsible for sending [Form H2111](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2111-interest-list-notification-hcbs-spw), Interest List Notification - HCBS-SPW, or Form H2111-S (Spanish), within **three business days** of placing individuals on the interest list. Additionally, PSU staff will open a case record in the Texas Health and Human Services (HHS) Enterprise Administrative Report and Tracking System (HEART), upload copies of the completed forms and immediately close the HEART case record.

PSU staff are required to perform annual contacts for individuals on the STAR+PLUS HCBS program interest list to verify the current address and confirm continued interest in the program. If PSU staff are unable to reach the individual by telephone during the annual contact, PSU staff must send [Form H2118](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2118-hcbs-spw-confirmation-continued-interest), STAR+PLUS Home and Community Based Services (HCBS) Program Interest List Confirmation of Continued Interest, or Form H2118-S (Spanish), to the address on file within **one business day** of the attempted contact date. If no response is received from the individual within 30 days of the date of the letter, PSU staff remove the individual from the STAR+PLUS HCBS program interest list and close the case record in the CSIL database, using "Could Not Locate" as the denial reason.

PSU staff send [Form H2053-A](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2053-a-starplus-waiver-release-letter), STAR+PLUS Waiver Release Letter, or Form H2053-AS (Spanish), to inform the individual that her or his name has come to the top of the STAR+PLUS HCBS program interest list. Along with Form H2053-A and H2053-AS, the staff send:

* [Form H3675](https://hhs.texas.gov/laws-regulations/forms/3000-3999/form-h3675-application-acknowledgement), Application Acknowledgement, and Form H3675-S (Spanish);
* [Form H2053-B](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2053-b-health-plan-selection), Health Plan Selection, and Form H2053-BS (Spanish);
* [Form H1200](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1200-application-assistance-your-texas-benefits), Application for Assistance – Your Texas Benefits;
* STAR+PLUS information; and
* a postage-paid envelope.

Form H3675 and Form H3675-S are sent to applicants upon release from the STAR+PLUS HCBS program interest list. Actions related to the form depend on whether the member released from the interest list does or does not wish to proceed with the eligibility determination process.

* If the member does want to proceed to the eligibility determination process:
  + Do not return Form H3675 if the individual provides a verbal statement of desire to apply for services.
  + Document in the case record the date the individual’s wishes were relayed to PSU staff.
* If the member does not want to proceed with the eligibility determination process:
  + Return Form H3675 (if the form is not readily available, make a diligent effort to obtain the form from the individual).
  + If Form H3675 is not returned, PSU staff must record the date the individual relayed her or his wishes to not pursue the eligibility determination process in the case record.
  + Document any efforts made to secure return of Form H3675 in the case record.

Within 14 days of release from the interest list, PSU staff contact the applicant regarding selection of an MCO as quickly as possible so the selected MCO can conduct the assessment and develop the initial individual service plan (ISP). Any delay in selecting an MCO will result in a delay in eligibility determination for the STAR+PLUS HCBS program

If the applicant has not selected an MCO within 30 days of contact by PSU staff, an MCO is assigned on a rotational basis from the list of available MCOs in the service area. The applicant is contacted within **three business days** and informed that:

* an MCO has been assigned to the individual; and
* the MCO in which the individual is enrolled can be changed at any time, but will not go into effect until after the member has been in the STAR+PLUS HCBS program for at least one full calendar month.

See [Section 3312](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3312), Enrollment, for steps to be taken after an individual is released from the STAR+PLUS HCBS program interest list.

3311.2 Interest List Slot Allocations

Revision 18-2; Effective September 3, 2018

Members receiving Medicaid services under any of the programs listed in the chart below must receive those services through managed care. This does not impact the STAR+PLUS services member's right to access non-Medicaid services through the Texas Health and Human Services Commission (HHSC). STAR+PLUS Home and Community Based Services (HCBS) program members must receive all services through the STAR+PLUS HCBS program, excluding hospice care. Only Medicaid waivers cases count against regional slot allocations, as the following table illustrates:

| **Texas Integrated Eligibility Redesign System (TIERS) Type of Assistance (TA)** | **Program Description** | **Counts Against Interest List Slot Allocation?** |
| --- | --- | --- |
| TP 03 | Medical assistance only (MAO) Medicaid – Pickle | No |
| TA 03 | Manual Supplemental Security Income (SSI) recipient waivers | No |
| TA 02 | SSI recipient waivers | No |
| TP 13 | SSI Medicaid | No |
| TA 10 | Medicaid waivers | Yes |
| TP 18 | Medicaid for disabled adult children | No |
| TP 21 | Disabled widows/widowers Medicaid | No |
| TA 01 | SSI Denied Child | No |
| TP 22 | Early aged widows/widowers Medicaid | No |
| TP 51 | Rider 51 waivers | No |
| TP 87 | Medicaid Buy-in | No |

3311.3 Earliest Date for Adding a Member Back to the Interest List

Revision 18-2; Effective September 3, 2018

The earliest date an applicant or member may be added back to the Community Services Interest List (CSIL) database for the same program the applicant is denied is the date the applicant is determined to be ineligible for the program (for applicants) or (for STAR+PLUS Home and Community Based Services (HCBS) program members), the first date the applicant or member is no longer eligible for the program denied.

Example 1: The applicant is released from the STAR+PLUS HCBS program CSIL on March 2, 2019. The case manager determines the applicant is not eligible for STAR+PLUS HCBS program on March 28, 2019, and sends notification to the applicant of ineligibility. The first date the denied applicant can be added back to the STAR+PLUS HCBS program interest list is March 28, 2019.

Example 2: A STAR+PLUS HCBS program member is determined not eligible on March 28, 2019, and PSU staff send notification to the STAR+PLUS HCBS program member of termination of benefits. Termination is effective April 30. The first date the denied member can be added back to the STAR+PLUS HCBS program interest list is May 1, 2019.

If the applicant's or STAR+PLUS HCBS program member’s name is added back to the interest list prior to the last date of program eligibility, the CSIL database interface match with the Service Authorization System Online (SASO) will cause the name to be removed from the interest list for that program.

Example 3: A member's STAR+PLUS HCBS program services are denied due to medical necessity (MN) and end on March 30, 2019. The first date the member can be added back to the STAR+PLUS HCBS program interest list is April 1, 2019.

Example 4: A member's STAR+PLUS HCBS program services are denied and will end March 13, 2019. The first date the member can be added back to the STAR+PLUS HCBS program interest list is March 14, 2019. If the member is already on another interest list, the denial date for the STAR+PLUS HCBS program would not impact the member's original date on the other interest list.

3311.4 Updating Community Services Interest List Records

Revision 18-2; Effective September 3, 2018

The Community Services Interest List (CSIL) database must be updated to reflect accurate information. Program Support Unit (PSU) staff must complete data entry in CSIL database for STAR+PLUS Home and Community Based Services (HCBS) program actions within **five business days** of the date:

* PSU staff sign [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, certifying or denying applications, except Money Follows the Person (MFP) certifications; and
* the request for other CSIL database actions (updating information, transferring an individual to another region's interest list or removing a  member from the interest list upon request by the individual).

For MFP certifications, CSIL is updated when the Service Authorization System Online (SASO) data entry is completed to register the initial individual service plan (ISP). Delaying data entry of the disposition status into CSIL database for an applicant certified through MFP provisions prevents removing the individual from the interest list before the actual discharge from the nursing facility (NF) is verified.

PSU staff must ensure CSIL database closures are recorded accurately by using the *Community Services Interest List (CSIL) User's Guide,* available to PSU staff on the intranet.

3312 Enrollment

Revision 18-2; Effective September 3, 2018

The enrollment broker mails enrollment packets to all Medicaid recipients who are candidates for STAR+PLUS. This packet contains information about STAR+PLUS, instructions for completing the enrollment form and information about the available STAR+PLUS managed care organizations (MCOs) from which the recipient can choose. Recipients can return enrollment forms via mail, complete an enrollment form at an enrollment event or presentation, or call the enrollment broker and enroll via telephone.

Recipients have 30 days after receiving an enrollment packet to select an MCO. If a selection is not made within 30 days, the recipient will be assigned to an MCO and a primary care provider (PCP). Failure to choose an MCO could lead to delays in services or default assignment to an MCO. Recipient assignments to an MCO or PCP are automatic, using a default process. Recipients assigned through the default process may still make a choice about their STAR+PLUS MCO and PCP after they have been enrolled at least one month. However, they 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 physician's order or medical necessity (MN) determination is required.

3312.1 Enrollment Procedures Following Release from the Interest List

Revision 18-2; Effective September 3, 2018

Within 14 days of release from the interest list (see [Section 3311.1](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3311.1), Interest List Procedures), Program Support Unit (PSU) staff take the following steps to ensure candidates are successfully enrolled in the STAR+PLUS Home and Community Based Services (HCBS) program.

PSU staff contact the applicant or authorized representative (AR) to:

* give a general description of STAR+PLUS HCBS program services;
* provide a list of managed care organizations (MCOs) and encourage the member to contact one for service information;
* discuss the importance of choosing an MCO so assessments and initial individual service plans (ISPs) can be completed timely in order to avoid a delay in eligibility determination for the STAR+PLUS HCBS program; and
* inform the individual the MCO in which he or she enrolls can be changed at any time after the first month of service.

If the Service Authorization System Online (SASO) and Texas Integrated Eligibility Redesign System (TIERS) inquiry conducted before release from the interest list indicates an individual does not have pre-existing Medicaid coverage, PSU staff send an application for assistance ([Form H1200](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1200-application-assistance-your-texas-benefits), Application for Assistance – Your Texas Benefits) to the individual released from the interest list to begin the Medicaid eligibility determination process. Once the form is returned, PSU staff send the signed and completed application form, identifying the action to be taken, within **two business days** of receipt to Medicaid for the Elderly and People with Disabilities (MEPD) specialists, along with [Form H1746-A](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1746-a-mepd-referral-cover-sheet), MEPD Referral Cover Sheet.

The applicant chooses an MCO and notifies PSU staff verbally or in writing.

Within **two business days** of the MCO selection, PSU staff complete Section A of [Form H3676](https://hhs.texas.gov/laws-regulations/forms/3000-3999/form-h3676-managed-care-pre-enrollment-assessment-authorization), Managed Care Pre-Enrollment Assessment Authorization, and post it on TxMedCentral in the MCO's SPW folder, following the naming convention instructions in [Section 5110](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-5000-sph-automation-and-payment-issues-starplus#5110), TxMedCentral Naming Convention and File Maintenance.

The MCO completes:

* Section B of Form H3676;
* a Medical Necessity and Level of Care (MN/LOC) Assessment; and
* [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-spw-pg-1), Individual Service Plan (Pg. 1).

**Note**: The Uniform Managed Care Contract (UMCC) requires the MCO to initiate contact with the applicant 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 via Form H3676, Part B, to PSU staff.

The MCO posts the STAR+PLUS HCBS program ISP to TxMedCentral in the MCO's ISP folder, following the naming instructions in Section 5110. The MCO posts Form H3676 to TxMedCentral in the SPW folder, following instructions in Section 5110.

If the MCO does not post an ISP within 45 days after PSU staff posted Form H3676, Part A, PSU staff notify by email the Managed Care Compliance & Operations (MCCO) staff assigned to the MCO.

Within **five business days** of receipt of all required STAR+PLUS HCBS program eligibility documentation, PSU staff verify eligibility based on Medicaid eligibility, medical necessity and level of care (MN/LOC), and an ISP cost within the individual's assessed cost limit based on the established Resource Utilization Group value.

The start of care (SOC) date for the STAR+PLUS HCBS program is the first day of the month following receipt of the latter of:

* MN/LOC;
* ISP; and
* Medicaid eligibility.

Example: MN/LOC is received at Texas Medicaid & Healthcare Partnership (TMHP) on May 15, the ISP is posted to TxMedCentral on June 2, and Medicaid eligibility is effective May 1. The SOC date is July 1.

The SOC date is the same as the ISP begin date, and will always be the first day of the month. Because individuals are not eligible for any STAR+PLUS HCBS program benefits between the notification form signature date and the ISP begin date, PSU staff must take care in recording the correct date on the notification to the member

If eligibility is approved, PSU staff complete Form H2065-D, and:

* mail the original to the applicant;
* post the form on TxMedCentral in the MCO's SPW folder, following the instructions in Section 5110;
* fax or mail a copy to the MEPD specialist; and
* notify Enrollment Resolution Services (ERS) by email.

If eligibility is denied, PSU staff complete Form H2065-D and:

* mail the original to the applicant;
* post it on TxMedCentral in the MCO's SPW folder, following the instructions in Section 5110; and
* fax or email a copy to the MEPD specialist.

PSU staff make Service Authorization System Online (SASO) entries following procedures in the SAS Help File within **five business days** of receipt of all required eligibility verification.

After the individual has been determined eligible for the STAR+PLUS HCBS program, ERS updates the member's TIERS record to indicate managed care enrollment.

3313 Termination of CCAD Services Upon STAR+PLUS Home and Community Based Services Program Enrollment

Revision 18-2; Effective September 3, 2018

Code of Federal Regulations (CFR) §431.213 Exceptions from advance notice.

The agency may mail a notice not later than the date of action if —

(a) The agency has factual information confirming the death of a recipient;

(b) The agency receives a clear written statement signed by a recipient that —

(1) He no longer wishes services; or

(2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;

(c) The recipient has been admitted to an institution where he is ineligible under the plan for further services;

(d) The recipient's whereabouts are unknown and the post office returns agency mail directed to her or him indicating no forwarding address (See §431.231 (d) of this subpart for procedure if the recipient's whereabouts become known);

(e) The agency establishes the fact 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.

Program Support Unit (PSU) staff must coordinate the termination of other waiver or Community Care for the Aged and Disabled (CCAD) services with the CCAD case manager so that the individual does not experience a break in services and does not receive concurrent services through another waiver or CCAD service. The STAR+PLUS Home and Community Based Services (HCBS) program member must be encouraged to contact the managed care organization (MCO) to request any services being denied that are not included in the STAR+PLUS HCBS program individual service plan (ISP).

The 10-day adverse action prior notice requirement does not apply to individuals transferring 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

Revision 18-2; Effective September 3, 2018

For individuals just entering the STAR+PLUS Home and Community Based Services (HCBS) program, Program Support Unit (PSU) staff must coordinate the termination of other waiver or Community Care for the Aged and Disabled (CCAD) services with the waiver or CCAD case manager. This ensures the individual does not experience a break in services and does not receive concurrent services through another waiver or CCAD service.

The case manager must send [Form 2065-E](https://hhs.texas.gov/node/17292), Notification of In-Home Family Support Program Benefits, to initiate denial. It is not necessary to provide an adverse action period prior to closing the authorization in the Service Authorization System Online (SASO).

CCAD services are terminated by the CCAD case manager no later than the day prior to STAR+PLUS HCBS program enrollment. This is crucial since no STAR+PLUS HCBS program individual may receive CCAD and STAR+PLUS HCBS program services on the same day. The CCAD case manager must send:

* [Form 2065-A](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-2065-a-notification-community-care-services), Notification of Community Care Services, denying ongoing Texas Health and Human Services Commission (HHSC) services; and
* [Form 2101](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-2101-authorization-community-care-services), Authorization for Community Care Services, to the provider. Include a notation in the comments section that the individual is transferring to the STAR+PLUS HCBS program.

3313.2 Procedure for STAR+PLUS Home and Community Based Services Program Members

Revision 18-2; Effective September 3, 2018

If it is determined that an existing STAR+PLUS Home and Community Based Services (HCBS) program member is receiving any Service Group (SG) 7 Community Care for the Aged and Disabled (CCAD) services, Program Support Unit (PSU) staff must begin denial procedures for the SG 7 service immediately.

If CCAD services are authorized in SASO, the CCAD case manager must immediately send:

* [Form 2065-A](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-2065-a-notification-community-care-services), Notification of Community Care Services, including a notation to the provider in the comments section that the individual is transferring to the STAR+PLUS HCBS program; and
* [Form 2101](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-2101-authorization-community-care-services), Authorization for Community Care Services.

3314 Managed Care Organization Changes

Revision 18-2; Effective September 3, 2018

Members may change managed care organization (MCO) plans as often as monthly by contacting the enrollment broker at 1-800-964-2777. The enrollment broker makes plan changes based on the monthly cutoff periods, which occur around the middle of the month. Depending on which day of the month (before or after the enrollment broker cutoff), the plan change will either occur the first day of the next month or the month after. The change will show up on the 834 daily enrollment file notifying the MCO of the new member. The Program Support Unit (PSU), when notified by the member, state or an MCO that a member has elected to change MCOs, will update the Service Authorization System Online (SASO) to change the previous MCO to the new MCO.

3315 STAR+PLUS Home and Community Based Services Program Individuals Requesting Non-Managed Care Services

Revision 18-2; Effective September 3, 2018

Requirements of the STAR+PLUS Home and Community Based Services (HCBS) program provide all of the services (excluding hospice) needed to enable the member to live safely in the community. Therefore, non-managed care services cannot be authorized for STAR+PLUS HCBS program member. STAR+PLUS HCBS program member requesting additional services must be referred to the managed care organization's service coordinator.

Hospice services may be authorized along with STAR+PLUS services or the STAR+PLUS HCBS program.

3315.1 Requests from Individuals Awaiting Managed Care Enrollment

Revision 18-2; Effective September 3, 2018

Individuals awaiting managed care enrollment may be assessed for interim Community Care for the Aged and Disabled (CCAD) services. Texas Health and Human Services Commission (HHSC) case managers may assess all individuals whose managed care enrollment is pending if it appears CCAD services can be approved and delivered prior to enrollment in managed care.

3315.2 Requests from STAR+PLUS Home and Community Based Services Program Members

Revision 18-2; Effective September 3, 2018

Requirements of the federal 1115 waiver dictate that the STAR+PLUS Home and Community Based Service (HCBS) program provide the services (excluding hospice) needed to enable the member to live safely in the community. Therefore, non-managed care services cannot be authorized for STAR+PLUS HCBS program members. STAR+PLUS HCBS program members requesting additional services must be referred to the managed care organization's (MCO’s) service coordinator.

Hospice services may be authorized along with STAR+PLUS services or the STAR+PLUS HCBS program.

3315.3 Requests from STAR+PLUS Services Members

Revision 18-2; Effective September 3, 2018

When a STAR+PLUS services managed care member requests non-Medicaid services, Texas Health and Human Services Commission (HHSC) staff must first determine if there is a slot available for the requested service. If not, the individual's name is added to the appropriate interest list by entering the information in the Community Services Interest List (CSIL) system. Members are released from the interest list on a first-come, first-served basis; eligibility determinations are conducted as slots for services become available.

When a slot is available, or before release from the interest list, HHSC staff consult the Texas Integrated Eligibility Redesign System (TIERS) to determine if the individual is a STAR+PLUS member (see [Section 5130](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-5000-sph-automation-and-payment-issues-starplus#5130), Managed Care Data in TIERS). If it is determined that the individual is a STAR+PLUS member, intake staff must contact Program Support Unit (PSU) staff before assignment to a case manager to determine if the managed care organization (MCO) is already delivering the managed care version of the requested service.

Within **two business days** of contact by intake staff, PSU staff:

* contact the appropriate MCO by posting [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-case-information), Managed Care Programs Communication, to TxMedCentral in the MCO XXXSPW folder using the appropriate naming convention. Form H2067-MC must contain:
  + the individual's name;
  + Medicaid identification (ID) number; and
  + a request to determine if service is already being delivered; and
* follow up by phone every **five business days** until a response is received from the MCO.

Within **five business days** of receiving posted Form H2067-MC, the MCO must respond to PSU staff by posting Form H2067-MC to the XXXSPW folder in TxMedCentral using the appropriate naming convention.

Within **two business days** of receipt of the MCO's response, PSU staff must notify the referring HHSC staff by email or with Form H2067-MC.

If PSU staff determine the requested service is not being delivered 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 PSU staff's response must be included in materials forwarded to the case manager at the time of case assignment. How the case manager proceeds with the eligibility determination process depends on the PSU's documented response.

If PSU staff determine the requested service is already being delivered by the MCO, PSU staff inform the member of the MCO's response. The member is urged to consult the MCO if he or she disagrees or feels the services are not sufficient to meet her or his needs.

See [Section 3310](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3310), Intake and Enrollment, for additional information on intake and referral procedures.

3316 Requests for STAR+PLUS Home and Community Services Program from Participants in 1915(c) Medicaid Waivers

Revision 18-2; Effective September 3, 2018

Participants in 1915(c) Medicaid waivers may 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 another full Medicaid program; or
* are medical assistance only (MAO).

When a 1915(c) 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) staff.

PSU staff are responsible for completing the following activities within 14 days of the initial request for a STAR+PLUS HCBS program assessment. All attempted contacts with the member or encountered delays must be documented. PSU staff:

* 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 STAR+PLUS HCBS program services; and
* send a copy of the regional STAR+PLUS managed care organization (MCO) provider directories and comparison chart to the 1915(c) Waiver recipient.

Within **two business days** of notification of the MCO selection by the STAR+PLUS HCBS program applicant, PSU staff complete Section A of [Form H3676](https://hhs.texas.gov/laws-regulations/forms/3000-3999/form-h3676-managed-care-pre-enrollment-assessment-authorization), Managed Care Pre-Enrollment Assessment Authorization, and posts it in the XXXSPW folder on TxMedCentral, using the appropriate naming convention.

The MCO completes:

* [Form H2060](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-needs-assessment-questionnaire-taskhour-guide), Needs Assessment Questionnaire and Task/Hour Guide;
* [Form H2060-A](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-a-addendum-form-h2060), Addendum to Form H2060;
* [Form H2060-B](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-b-needs-assessment-addendum), Needs Assessment Addendum, as applicable;
* medical necessity and level of care (MC/LOC);
* Section B of Form H3676; and
* [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-spw-pg-1), Individual Service Plan (Pg. 1), and [Form H1700-2](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-2-individual-service-plan-spw-pg-2), Individual Service Plan (Pg. 2), and attachments.

The MCO posts both Form H1701-1 and Form H3676 in the XXXSPW folder on TxMedCentral using the appropriate naming convention. If the packet from the MCO is not received within 45 days after the assessment is authorized, PSU staff email Managed Care Compliance & Operations (MCCO) as notification the time frame for completing the individual service plan (ISP) was not met.

Within **two business days** of receipt of all required STAR+PLUS HCBS program eligibility documentation, PSU staff determine STAR+PLUS HCBS program eligibility based upon medical necessity, and an ISP cost within the Resource Utilization Group cost limit.

If eligibility for the STAR+PLUS HCBS program is denied or the applicant decides not to accept the STAR+PLUS HCBS program, PSU staff complete [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, and:

* mail the original to the 1915(c) Waiver individual, with the explanation that this finding does not affect eligibility for the service the individual is currently receiving; and
* notify the MCO by posting a copy to TxMedCentral.

If eligibility is approved and the individual chooses to accept STAR+PLUS HCBS program services, the individual is enrolled in the STAR+PLUS HCBS program the first day of the next month.

Within two days of determining the start of care date for the STAR+PLUS HCBS program, PSU staff complete Form H2065-D and:

* mail the original to the 1915(c) Waiver recipient;
* notify the MCO by posting a copy to TxMedCentral; and
* notify Enrollment Resolution Services (ERS) by email.

PSU staff must coordinate with staff and providers, as appropriate, to ensure the current 1915(c) Waiver services end the day before enrollment in the STAR+PLUS HCBS program.

3320 Coordination with Medicaid for the Elderly and People with Disabilities

Revision 18-2; Effective September 3, 2018

3321 General Eligibility Issues

Revision 18-2; Effective September 3, 2018

At the initial contact, Program Support Unit (PSU) staff must inform the medical assistance only (MAO) applicant or member and/or authorized representative (AR) that Medicaid for the Elderly and People with Disabilities (MEPD) specialists will complete a financial eligibility (Medicaid) determination. PSU staff should encourage the applicant or member and/or AR to cooperate with the MEPD specialist and to provide all verifications necessary in a timely manner.

Any information, including information on third-party insurance, obtained by PSU staff must be shared with the MEPD specialist to prevent the applicant or member from having to provide the information twice.

PSU staff must inform MEPD specialists of the request for the STAR+PLUS Home and Community Based Services (HCBS) program by sending a completed [Form H1200](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1200-application-assistance-your-texas-benefits), Application for Assistance – Your Texas Benefits, within **two business days** of receipt, according to regional procedures. Form H1200 is not required for members receiving Supplemental Security Income (SSI).

3321.1 Disability Determinations

Revision 18-2; Effective September 3, 2018

The following information is provided for informational purposes only regarding the disability determination process. Program Support Unit (PSU) staff have absolutely no role in this process.

If a STAR+PLUS HCBS program applicant's or member's application for Supplemental Security Income (SSI) disability has been pending for over 90 days, the Health and Human Services Commission (HHSC) Disability Determination Unit (DDU) staff may determine disability, pending the Social Security Administration (SSA) determination. PSU staff will not be notified of the individual's Medicaid for the Elderly and People with Disabilities (MEPD) eligibility status until disability is determined. In order for DDU staff to make a disability determination, the MEPD specialist must obtain the following:

* [Form H3034](https://hhs.texas.gov/laws-regulations/forms/3000-3999/form-h3034-disability-determination-socio-economic-report), Disability Determination Socio-Economic Report;
* [Form H3035](https://hhs.texas.gov/laws-regulations/forms/3000-3999/form-h3035-medical-information-releasedisability-determination), Medical Information Release/Disability Determination; and
* a copy of the Medical Necessity and Level of Care (MN/LOC) Assessment.

3322 Actions Pending Past the Medicaid for the Elderly and People with Disabilities Due Date

Revision 18-2; Effective September 3, 2018

Because Program Support Unit (PSU) staff depend on Medicaid for the Elderly and People with Disabilities (MEPD) staff to determine eligibility for medical assistance only (MAO) applicants, there are times when PSU staff must check with MEPD staff regarding the status of an application or program change.

Before contacting the MEPD specialist, PSU staff must ensure the following:

* Make sure the MEPD time frame has expired. MEPD specialists have 45 days to complete applications for individuals over age 65. For individuals under age 65 whose disability has not yet been determined by the Social Security Administration (SSA), MEPD specialists have 90 days.
* Contact the administrative assistant for the appropriate Management Team leader. Do not communicate with anyone other than the administrative assistant.

3330 STAR+PLUS Members Requesting an Upgrade to the STAR+PLUS Home and Community Based Services Program

Revision 18-2; Effective September 3, 2018

Medicaid members enrolled in STAR+PLUS qualify for Medicaid eligibility through various program types. Some members who request the STAR+PLUS Home and Community Based Services (HCBS) program may be Medicaid eligible 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(er) (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 transfer of assets and substantial home equity reviews required to establish financial eligibility for the STAR+PLUS HCBS program. Therefore, these Medicaid types are not eligible for an upgrade and enrollment in the STAR+PLUS HCBS program until Medicaid for the Elderly and People with Disabilities (MEPD) specialists test for the additional criteria.

Managed care organizations (MCOs) must notify Program Support Unit (PSU) staff by posting [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-managed-care-programs-communication), Managed Care Programs Communication, to TxMedCentral within **three business days** of an upgrade request for a member who has one of these Medicaid program types. PSU staff must contact the member within three business days of the posting date of Form H2067-MC to advise the member [Form H1200](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1200-application-assistance-your-texas-benefits), Application for Assistance - Your Texas Benefits, must be completed and returned to PSU staff.

Once the member returns Form H1200, PSU staff send the signed and completed application form within **two business days** of receipt to the MEPD specialist, along with [Form H1746-A](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1746-a-mepd-referral-cover-sheet), MEPD Referral Cover Sheet, identifying the action to be taken.

The MCO service coordinator must, within 45 days of a STAR+PLUS member's request for the STAR+PLUS HCBS program:

* complete an assessment in order to prepare 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 request medical necessity (MN); and
* post [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-spw-pg-1), Individual Service Plan (Pg. 1) in TxMedCentral.

Within **five business days** of receipt of Form H1700-1 from the MCO, PSU staff review the form to determine if the member meets eligibility criteria for the STAR+PLUS HCBS program.

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

PSU staff must apply *STAR+PLUS Handbook* policy regarding upgrades to determine if the member meets the eligibility criteria for the STAR+PLUS HCBS program. This will include not only review of the functional criteria evaluated by the MCO, but also a determination that the member's Medicaid type is eligible for 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 staff:

* follow actions in [Section 3632](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3632), Program Support Unit (PSU)-Initiated Denials/Terminations, to deny the request;
* send [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, within three business days to the member; and
* post Form H2065-D to TxMedCentral to the MCO's SPWXXX folder.

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

* completing Form H2065-D and send it to the member and (if applicable) the MEPD specialist;
* posting Form H2065-D in TxMedCentral to the MCO's SPWXXX folder; and
* completing Service Authorization System (SAS) entries to authorize eligibility for the STAR+PLUS HCBS program.

3400 Transferring Into STAR+PLUS

Revision 18-2; Effective September 3, 2018

Mandatory STAR+PLUS program members may continue to receive their current non-Medicaid services from the Texas Health and Human Services Commission (HHSC) until the managed care organization (MCO) is able to authorize Medicaid services. For example, a member would be able to continue to receive Family Care until the MCO authorizes personal attendant services. STAR+PLUS members are also entitled to be placed on an interest list for non-Medicaid services following policy specified in the *Case Manager Community Care for Aged and Disabled (CM-CCAD) Handbook*, [Section 2230](https://hhs.texas.gov/laws-regulations/handbooks/case-manager-community-care-aged-and-disabled-handbook/cm-ccad-section-2000-case-management#2230), Interest List Procedures.

Any application for new long-term services and supports (LTSS) from HHSC requires the mandatory member to be sent to her or his MCO first. This must be coordinated through Program Support Unit (PSU) staff. See [Section 3125](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3125), STAR+PLUS Home and Community Based Services Program Members Requesting Non-Managed Care Services.

Some STAR+PLUS Home and Community Based Services (HCBS) program applicants or members transferring in and out of STAR+PLUS will have an individual service plan (ISP) that is over the cost limit and is approved for general revenue (GR) funds. For these applicants or members, the losing area must inform the gaining area of the GR status. The gaining area must follow the GR process.

3410 Transfer Scenarios

Revision 18-2; Effective September 3, 2018

3411 STAR+PLUS Home and Community Based Services Program Member Transferring to Another Service Area with Prior Knowledge

Revision 18-2; Effective September 3, 2018

When Program Support Unit (PSU) staff are notified of a transfer from one STAR+PLUS service area to another STAR+PLUS area, within **two business days**, the losing PSU staff:

* notify the gaining PSU staff a member is transferring to its service area and provides the member's:
  + name;
  + Social Security number;
  + Medicaid identification (ID) number;
  + current and future contact information; and
  + date of the move or anticipated move;
* send [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-spw-pg-1), Individual Service Plan (Pg. 1), to the gaining PSU staff;
* notify the Medicaid for the Elderly and People with Disabilities (MEPD) specialist using [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-starplus-communication), Managed Care Programs Communication, on medical assistance only (MAO) individuals;
* remind Supplemental Security Income (SSI) members to contact the Social Security Administration (SSA) to change the address; and
* post Form H2067-MC to the managed care organization (MCO) XXXSPW folder in TxMedCentral using the appropriate naming convention, and requests Form H1700-1 and all forms listed below from the losing MCO:
  + [Form H1700-2](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-2-individual-service-plan-spw-pg-2), Individual Service Plan (Pg. 2);
  + Form H1700-3, Nursing Service Plan;
  + [Form H1700-A](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-a-rationale-hcbs-starplus-waiver-itemsservices), Rationale for STAR+PLUS HCBS Program Items/Services;
  + [Form H1700-A1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-a1-certification-completiondelivery-hcbs-starplus-waiver-itemsservices), Certification of Completion/Delivery of STAR+PLUS HCBS Program Items/Services;
  + [Form H1700-B](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-b-non-hcbs-starplus-waiver-services), Non-STAR+PLUS HCBS Program Services;
  + [Form 8604](https://hhs.texas.gov/laws-regulations/forms/8000-8999/form-8604-transition-assistance-services-tas-assessment-and), Transition Assistance Services (TAS) Assessment and Authorization;
  + the Medical Necessity and Level of Care (MN/LOC) Assessment;
  + [Form H2060](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-needs-assessment-questionnaire-taskhour-guide), Needs Assessment Questionnaire and Task/Hour Guide;
  + [Form H2060-A](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-a-addendum-form-h2060), Addendum to Form H2060; and
  + [Form H2060-B](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-b-needs-assessment-addendum), Needs Assessment Addendum, as applicable.

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

* medical necessity (MN);
* Resource Utilization Group (RUG); and
* financial eligibility determination by MEPD, if applicable.

The gaining PSU staff coordinate all appropriate activities between the losing PSU staff, MCOs, member, Enrollment Resolution Services (ERS) and other key parties to help ensure a successful transition. For PSU staff, this includes tracking each step of the process through the start of the new STAR+PLUS Home and Community Based Services (HCBS) program in the gaining area.

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

* send an email to ERS notifying ERS the member has moved;
* manually close all Service Authorization System Online (SASO) records for the losing MCO effective the end of the month the member moves;
* update SASO with the gaining MCO's information;
* send [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, to the member and include the begin and end dates in the Comments section; and
* post a copy of Form H2065-D to the appropriate MCO's XXXSPW folder in TxMedCentral, using the appropriate naming convention.

Within **three business days** of notification of the move, ERS disenrolls the member effective the end of the month in which the member moved and re-enrolls the member to the gaining MCO.

3412 STAR+PLUS Home and Community Based Services Program Member Transferring to Another Service Area Without Prior Knowledge

Revision 18-2; Effective September 3, 2018

When Program Support Unit (PSU) staff are notified a transfer from one STAR+PLUS service area to another STAR+PLUS area has already occurred, within **one business day** the losing PSU staff:

* notify the gaining PSU staff a member has transferred to its service area and provides the member's:
  + name;
  + Social Security number;
  + Medicaid identification (ID) number;
  + current and future contact information; and
  + date of the move or anticipated move;
* post [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-starplus-communication), Managed Care Programs Communication, to the managed care organization (MCO) XXXSPW folder in TxMedCentral, using the appropriate naming convention, and requests [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-spw-pg-1), Individual Service Plan (Pg. 1), and all the forms listed below from the losing MCO:
  + [Form H1700-2](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-2-individual-service-plan-spw-pg-2), Individual Service Plan (Pg. 2);
  + Form H1700-3, Nursing Service Plan;
  + [Form H1700-A](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-a-rationale-hcbs-starplus-waiver-itemsservices), Rationale for STAR+PLUS HCBS Program Items/Services;
  + [Form H1700-A1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-a1-certification-completiondelivery-hcbs-starplus-waiver-itemsservices), Certification of Completion/Delivery of STAR+PLUS HCBS Program Items/Services;
  + [Form H1700-B](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-b-non-starplus-hcbs-program-services), Non-STAR+PLUS HCBS Program Services;
  + [Form 8604](https://hhs.texas.gov/laws-regulations/forms/8000-8999/form-8604-transition-assistance-services-tas-assessment-and), Transition Assistance Services (TAS) Assessment and Authorization;
  + the medical necessity/level of care (MN/LOC);
  + [Form H2060](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-needs-assessment-questionnaire-taskhour-guide), Needs Assessment Questionnaire and Task/Hour Guide; and
  + [Form H2060-A](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-a-addendum-form-h2060), Addendum to Form H2060; and
  + [Form H2060-B](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-b-needs-assessment-addendum), Needs Assessment Addendum, as applicable.
* notify the Medicaid for the Elderly and People with Disabilities (MEPD) specialist using [Form H1746-A](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1746-a-mepd-referral-cover-sheet), MEPD Referral Cover Sheet, for medical assistance only (MAO) individuals; and
* remind Supplemental Security Income (SSI) members to contact the Social Security Administration (SSA) to change the address.

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

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

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

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

* MN/LOC;
* Resource Utilization Group (RUG); and
* financial eligibility determination by the MEPD specialist, if applicable.

The gaining PSU staff coordinate all appropriate activities between the losing PSU staff, MCOs, the member, Enrollment Resolution Services (ERS) and other key parties to help ensure a successful transition. For PSU staff, this includes tracking each step of the process through the start of the new STAR+PLUS Home and Community Based Services (HCBS) program in the gaining area.

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

* send an email to ERS notifying ERS the member has moved;
* manually close all service authorization records effective the end of the month the member moves;
* update the Service Authorization System Online (SASO) with the gaining MCO's information;
* send [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, to the member (with the begin and end date in the Comments section); and
* post a copy of Form H2065-D to the appropriate XXXSPW folder in TxMedCentral, using the appropriate naming convention.

Within **two business days** of notification of the move, ERS considers coordination of claims to limit provider impact.

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

Revision 18-2; Effective September 3, 2018

Once the initial enrollment period of one month is passed, a member is eligible to change managed care organization (MCO) plans. When a member chooses to change from one MCO to another MCO in the same area, the member or authorized representative (AR) must contact the state-contracted enrollment broker via phone call to 1-800-964-2777, or via written correspondence.

The enrollment broker will ask if the member is in a hospital or residing in a nursing facility (NF). If so, the member cannot change plans until the member has been discharged. The member can change MCOs as many times as the member wants, but not more than once per month.

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

Examples:

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

For more details, see the [*Uniform Managed Care Manual*](https://hhs.texas.gov/services/health/provider-information/contracts-manuals/texas-medicaid-chip-uniform-managed-care-manual), Chapter 3.4, Attachment C to the Medicaid Managed Care Member Handbook Required Critical Elements.

Monthly Plan Changes Report

Texas Health and Human Services Commission (HHSC) Enrollment Resolution Services (ERS) prepares and sends the Monthly Plan Changes report to Program Support Unit (PSU) staff and the gaining MCOs. PSU staff receive a full list; the MCO receives a member-specific report. The report gives a list of STAR+PLUS Home and Community Based Services (HCBS) program members who have changed MCOs from the previous month. PSU staff must correct the contract number in the Service Authorization System Online (SASO) to reflect all MCO changes. See [Appendix I-E](https://hhs.texas.gov/laws-regulations/handbooks/appendices/appendix-i-e-starplus-monthly-plan-changes), Monthly Plan Changes.

Within **five business days** of receiving the list, the gaining MCO must request [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-pg-1), Individual Service Plan (Pg. 1), and Medical Necessity and Level of Care (MN/LOC) Assessment from the losing MCO. Within **five business days** of receiving the request, the losing MCO must provide the requested documents to the gaining MCO.

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

3420 Individuals Transitioning to an Adult Program

Revision 18-2; Effective September 3, 2018

STAR Kids and STAR Health eligibility will terminate the last day of the month in which the member's 21st birthday occurs and the member must receive services through programs serving adults. The following services end at the end of the month following the member’s 21st birthday.

* Medically Dependent Children Program (MDCP) operated by STAR Kids or 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.

In addition to the programs and services above, individuals for Community First Choice (CFC) services and personal care services (PCS) must transition to an adult program.

Members who receive MDCP, PDN/PPECC, CFC or PCS and transitioning to adult programs may apply for services through STAR+PLUS or the STAR+PLUS Home and Community Based Services (HCBS) program to continue to receive community services and avoid institutionalization beginning the 1st of the month following their 21st birthday.

3421 Procedures for Children Transitioning from STAR Kids/STAR Health Receiving Medically Dependent Children Program or Texas Health Steps Comprehensive Care Program/Private Duty Nursing or Prescribed Pediatric Extended Care Centers

Revision 18-2; Effective 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 Prior to the Member's 21st Birthday

Revision 18-2; Effective September 3, 2018

Twelve months prior to 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 following process begins.

Each quarter, the Texas Health and Human Services Commission (HHSC) Utilization Review (UR) provides a copy of the CCP Transition Report, which lists members enrolled in STAR Kids/STAR Health and receiving MDCP, CCP/PDN or PPECC services, who may transition to STAR+PLUS or the STAR+PLUS Home and Community Based Services (HCBS) program in the next 18 months to the:

* Interest List Management (ILM) Unit; and
* Intellectual or Developmental Disabilities (IDD) Waiver/Community Services/Hospice UR Unit contact.

The STAR Kids and STAR Health managed care organizations (MCOs) identify all members turning age 21 within the next 12 months and schedule a face-to-face visit with the member and the member's support person including her or his authorized representative (AR), if applicable, to initiate the transition process.

During the face-to-face visit with the member and her or his support person, the MCO must present an overview of STAR+PLUS, including the STAR+PLUS HCBS program, and the changes that will take place when the member transitions to STAR+PLUS. Specific information that must be provided during the face-to-face visit can be found in the *STAR Kids Handbook*, or for STAR Health, in the *Uniform Managed Care Manual*.

The STAR Kids MCO:

* makes a referral to Program Support Unit (PSU) staff via email using [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-managed-care-programs-communication), Managed Care Programs Communication, and includes, "PDN/PPECC and/or MDCP Transition” in the subject line;
* monitors transition activities with the member or the  support person, including her or his AR, every 90 days during the year before the member turns age 21; and
* notifies UR via email indicating this may be a high needs member, if the member appears to meet the criteria in  [Appendix XIV](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/appendices/appendix-xiv-determination-high-needs-status-starplus-hcbs-program), Determination of High Needs Status for the STAR+PLUS HCBS Program.

The STAR Health MCO:

* notifies UR via email if the member appears to meet the high needs criteria below:
  + the member is on ventilator care; and/or
  + the member has high skilled nursing needs, such as tracheostomy care, wound care, suctioning or feeding tubes.

The UR Transition/High Needs coordinator must:

* monitor the CCP Transition Report and identify all STAR Health members turning age 21 in 12 months and not enrolled in one of the following IDD 1915(c) waivers:
  + Community Living Assistance and Support Services (CLASS);
  + Deaf Blind with Multiple Disabilities (DBMD);
  + Home and Community-based Services (HCS); and
  + Texas Home Living (TxHmL).
* coordinate with UR staff for the IDD waivers and PSU staff if it is determined the member has high needs and/or needs to be assessed for the STAR+PLUS HCBS program.

ILM Unit staff:

* monitor the HHSC Managed Care Program Support mailbox for referrals submitted with subject line "PDN/PDN and/or MDCP Transition”;
* perform a search prior to assigning the referral to see if a Health and Human Services (HHS) Enterprise Administrative Report and Tracking System (HEART) case has been created by PSU staff from monitoring the CCP Transition Report; and
* if a HEART case is found, upload the MCO’s referral and advise PSU staff by email; or
* if a HEART case is not found, create a HEART case, upload the referral and assign to PSU staff for further action.

PSU staff:

* monitor the CCP Transition Report and identify all members receiving MDCP, PDN or PPECC services turning age 21 in 12 months and not enrolled in one of the following IDD 1915(c) waivers:
  + CLASS;
  + DBMD;
  + HCS; and
  + TxHmL;
* create a case in HEART noting:
  + if the MCO determines the member is high needs;
  + the program type (MDCP, or PDN/PPECC) the member is transitioning from; and
  + the due date for the nine-month contact.

**Note**: PSU staff must **not** post [Form H3676](https://hhs.texas.gov/laws-regulations/forms/3000-3999/form-h3676-managed-care-pre-enrollment-assessment-authorization), Managed Care Pre-Enrollment Assessment Authorization, to TxMedCentral in the XXXSPW folder earlier than five months prior to the member’s 21st birthday.

The following chart outlines the responsibilities for monitoring the CCP Transition Report and contacting members transitioning from STAR Kids/STAR Health who receive MDCP waiver or PDN/PPECC 12 months prior to the member’s 21st birthday.

| **Twelve Month Transition Chart** | | | |
| --- | --- | --- | --- |
| **Under Age 21 MDCP** | **Under Age 21 Other Services Received** | **Monitors CCP Report** | **12-Month Contact** |
| MDCP | CCP/PDN or PPECC | PSU Staff | MCO |
| MDCP | None | PSU Staff | MCO |
| Not Applicable | CCP/PDN | PSU Staff | MCO |
| Not Applicable | CCP/PPECC | PSU Staff | MCO |

3421.2 Nine Months Prior to the Member's 21st Birthday

Revision 18-2; Effective September 3, 2018

Nine months prior to the 21st birthday of a 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) service, the following process begins.

The STAR Kids and Star Health managed care organization (MCO):

* monitors transition activities with the member and the member’s available supports, including her or his authorized representative (AR), every 90 days during the year before the member turns age 21; and
* notifies Program Support Unit (PSU) staff of any issues or concerns by using [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-managed-care-programs-communication), Managed Care Programs Communication, and posts to TxMedCentral.

PSU staff:

* monitor the CCP Transition Report and identify all members transitioning from STAR Kids and receiving MDCP, PDN, or PPECC turning age 21 in nine months and not enrolled in one of the following intellectual and developmental disability (IDD)1915(c) waivers:
  + Community Living Assistance and Support Services (CLASS);
  + Deaf Blind with Multiple Disabilities (DBMD);
  + Home and Community-based Services (HCS); and
  + Texas Home Living (TxHmL);
* send the STAR Kids member [Form 2114](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-2114-nine-month-transition-letter), Nine-Month Transition Letter, along with a STAR+PLUS enrollment packet (including the STAR+PLUS MCO list and comparison chart). 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’s support person or AR, within 30 days to discuss the transition process and review the enrollment packet; and
* update the case in the Health and Human Services (HHS) Enterprise Administrative Report and Tracking System (HEART) by:
  + documenting the date the Initial Transition letter was sent out;
  + uploading the Initial Transition letter to HEART;
  + documenting the due date for the telephonic contact 30 days from the date the STAR+PLUS Home and Community Based Services (HCBS) program enrollment packet is mailed; and
  + uploading Form H2067-MC if the MCO documented any issues or concerns.

**Note**: PSU staff must **not** post [Form H3676](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/node/18138/), Managed Care Pre-Enrollment Assessment Authorization, to TxMedCentral in the XXXSPW folder earlier than five months prior to the member's 21st birthday.

Within 30 days of the enrollment packet mailing, PSU staff schedule and complete a telephonic contact with the member or the member’s available supports, including her or his AR, to explain the following:

* STAR Kids eligibility, MDCP or PDN/PPECC services will terminate on the last day of the month in which the member’s 21st birthday occurs.
* The STAR+PLUS HCBS program is an option available to eligible members at age 21. PSU staff also present an overview of the array of services available within the STAR+PLUS HCBS program.
* The STAR+PLUS program enrollment packet sent to the member is reviewed. The packet contains a list of the STAR+PLUS MCOs in the service area and a comparison chart to assist the member in making a selection. The member will choose a STAR+PLUS MCO in her or his service area that will perform the assessment for services and oversee the delivery of services.
* The importance of choosing an MCO six months before the 21st birthday in order to avoid having a gap in services.
* The member can change MCOs any time after the first month of enrollment.
* The STAR+PLUS HCBS program has a cost limit based on a medical assessment, the Medical Necessity/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 will meet the member's needs and ensure health and safety.
* If an ISP cannot be developed within the cost limit that ensures member’s health and safety in the community, the STAR+PLUS HCBS program will be denied.
* The ISP considers all resources available to meet the member's needs, including community supports, other programs, and what the member's informal support system can provide to meet the member's needs.
* The STAR+PLUS HCBS program assessment process will begin six months before the member's 21st birthday. PSU staff will contact the member to begin the application process and find out which MCO has been selected. If an MCO has not been selected, then 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 begin the assessment for services and assist the member, support person, or AR in identifying and developing additional resources and community supports to help meet the member's needs.
* The MCO service coordinator will assist the member in determining the services needed within this service array to meet her or his needs and ensure health and safety. **Example**: If other needs are met, but the member primarily requires nursing, then a plan can be developed with the maximum number of nursing hours within the cost limit while the member's other needs are met through other resources.
* Reassure the member, support person or AR that every effort will be made to help them make a successful transition to the STAR+PLUS HCBS program.
* The member may potentially receive an enrollment packet from MAXIMUS and the importance of selecting the same MCO.

PSU staff will update the case in HEART by noting the due date for the six-month contact.

The following chart outlines the responsibilities for monitoring the CCP Transition Report and contacting members transitioning from STAR Kids or STAR Health and receiving MDCP Waiver or PDN/PPECC nine months prior to the member’s 21st birthday:

|  |  |  |  |
| --- | --- | --- | --- |
| Nine Month Transition Chart | | | |
| **Under Age 21 MDCP** | **Under Age 21 Other Services Received** | **Monitors CCP Transition Report:** | **Nine-Month Contact:** |
| MDCP | CCP/PDN or PPECC | PSU Staff | PSU Staff |
| MDCP | None | PSU Staff | PSU Staff |
| None | CCP/PDN | PSU Staff | PSU Staff |
| None | CCP/ PPECC | PSU Staff | PSU Staff |

3421.3 Six Months Prior to the Member's 21st Birthday

Revision 18-2; Effective September 3, 2018

Six months prior to the 21st birthday of a member receiving the Medically Dependent Children Program (MDCP) or Texas Health Steps Comprehensive Care Program (CCP)/Private Duty Nursing (PDN) or Prescribed Pediatric Extended Care (PPECC) services, the following process begins.

Utilization Review (UR) must:

* monitor the CCP Transition Report and identify all members turning age 21 in six months receiving CCP/PDN through Fee-For-Service or STAR Health and not enrolled in one of the following Intellectual and Developmental Disability (IDD) 1915(c) waivers:
  + Community Living Assistance and Support Services (CLASS);
  + Deaf Blind with Multiple Disabilities (DBMD);
  + Home and Community-based Services (HCS); and
  + Texas Home Living (TxHmL).
* coordinate with Program Support Unit (PSU) staff  if it is determined the member is high needs and/or will need to be assessed for the STAR+PLUS Home and Community Based Services (HCBS) program.

The IDD Waiver/Community Services/Hospice UR:

* monitors the CCP Transition Report for members enrolled in one of the following 1915(c) waivers for individuals with intellectual or developmental disabilities (IDD) and who are turning age 21 in the next six months:
  + CLASS;
  + DBMD;
  + HCS; or
  + TxHmL; and
* makes a STAR+PLUS HCBS program referral to PSU staff via email using [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-managed-care-programs-communication), Managed Care Programs Communication, for members requesting a STAR+PLUS HCBS program assessment, or whose proposed waiver plan exceeds the member cost limit for the 1915(c) IDD waiver listed above.

PSU staff:

* monitor the CCP Transition Report and identify all members referenced in Section 3421 turning age 21 in six months and not enrolled in one of the 1915(c) IDD waivers listed above;
* must not reach out to members in CLASS, DBMD, HCS or TxHmL, unless the IDD Waiver UR unit submits a referral, as documented above;
* send [Form H2116](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2116-age-out-mdcp-pdn-contact-letter), Age-Out MDCP and PDN Contact Letter, to the member;
* contact the member or authorized representative (AR) by telephone to:
  + review the STAR+PLUS enrollment packet discussed at the 12-month or the nine-month contact;
  + inform the member or AR of a 30-day timeframe to choose a managed care organization (MCO) and a primary care physician;
  + explain if the member or AR does not timely choose an MCO, the state will assign an MCO for the member; and
  + explain that the member can change MCOs any time after the first month of enrollment.
* notify UR via email regarding all possible high needs situations; and
* update the case in the Health and Human Services (HHS) Enterprise Administrative Report and Tracking System (HEART) documenting the:
  + contact or contact attempt date;
  + MCO selection; and
  + due date for the five-month contact.

**Note**: PSU staff must **not** post [Form H3676](https://hhs.texas.gov/node/18138/), Managed Care Pre-Enrollment Assessment Authorization, to TxMedCentral in the XXXSPW folder earlier than five months prior to the member's 21st birthday.

The following chart outlines the responsibilities for agency referrals and PSU action for members enrolled in STAR Kids or STAR Health and receiving MDCP or PDN/PPECC transitioning six months prior to the member’s 21st birthday.

|  |  |  |
| --- | --- | --- |
| Six Month Transition Chart | | |
| **Under Age 21 Current** | **Under Age 21 Other Services Received** | **PSU Action** |
| MDCP | CCP/PDN or PPECC | Monitors the CCP report and contacts the member. |
| MDCP | Not Applicable | Monitors the CCP report and contacts the member. |
| Not Applicable | CCP/PDN | Monitors the CCP report and contacts the member. |
| Not Applicable | CCP/PPECC | Monitors the CCP report and contacts the member. |
| CLASS, DBMD, HCS and TxHmL | Not Applicable, CCP/PDN/ PPECC | Contacts the member when the referral is received. |

3421.4 Five Months Prior to the Member's 21st Birthday

Revision 18-2; Effective September 3, 2018

Five months prior to the 21st birthday of a member receiving Medically Dependent Children Program (MDCP) or Texas Health Steps Comprehensive Care Program (CCP)/Private Duty Nursing (PDN), or Prescribed Pediatric Extended Care Centers (PPECC) services, and within 30 days of the previous contact, Program Support Unit (PSU) staff contact the individual or family by telephone.

If the member or authorized representative (AR) receiving MDCP or CCP/PDN or PPECC has made a managed care organization (MCO) and primary care provider (PCP) choice:

* the member or AR receiving MDCP or CCP/PDN or PPECC informs PSU staff of the MCO choice; and
* PSU staff inform the:
  + member that he or she must remain with this MCO through the first month of STAR+PLUS enrollment to ensure a smooth transition and service continuity;
  + MCO of the member's choice by posting [Form H3676](https://hhs.texas.gov/laws-regulations/forms/3000-3999/form-h3676-managed-care-pre-enrollment-assessment-authorization), Managed Care Pre-Enrollment Assessment Authorization, to TxMedCentral in the XXXSPW folder, using the appropriate naming convention; and
  + MCO of a possible high needs member, by noting this in the comments field of Form H3676, Section A, and a request to expedite the assessment and individual service plan (ISP) development process.

If the member or AR receiving MDCP or CCP/PDN or PPECC has not made an MCO and PCP choice:

* PSU staff inform the member or AR that if an MCO is not selected within seven days from the PSU contact, one will be assigned; and
* if the selection is not made within seven days from the PSU contact, PSU staff:
  + select an MCO for the member;
  + inform the member that:
    - the state has selected an MCO; and
    - he or she must remain with this MCO through the first month of STAR+PLUS enrollment to ensure a smooth transition and service continuity; and
  + inform the MCO of the choice by posting Form H3676 to TxMedCentral in the XXXSPW folder, using the appropriate naming convention.

**Note**: Within 14 days of the PSU Form H3676 posting date, the MCO must schedule the initial home visit with the MDCP or CCP/PDN member or AR.

3421.5 Within 45 Days of Receiving Notification of a Form H3676 Referral

Revision 18-2; Effective September 3, 2018

Within 45 days of receiving email notification of [Form H3676](https://hhs.texas.gov/laws-regulations/forms/3000-3999/form-h3676-managed-care-pre-enrollment-assessment-authorization), Managed Care Pre-Enrollment Assessment Authorization, Section A, the managed care organization (MCO):

* completes either [Form H2060](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-needs-assessment-questionnaire-taskhour-guide), Needs Assessment Questionnaire and Task/Hour Guide, or [Form H6516](https://hhs.texas.gov/laws-regulations/forms/6000-6999/form-h6516-community-first-choice-assessment), 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 initial MN/LOC may not be submitted earlier than 120 days prior to the member's 21st birthday, unless the member is designated as having high needs status, as described in [Appendix XIV](https://hhs.texas.gov/laws-regulations/handbooks/appendices/appendix-xiv-sph-determination-high-needs-status-hcbs-starplus-waiver-spw), Determination of High Needs Status for the STAR+PLUS HCBS Program, in which case the MN/LOC may be submitted up to 180 days prior to the member’s 21st birthday);
* makes a referral to a Local Intellectual and Developmental Disability Authority (LIDDA), for members who may have an intellectual disability or developmental disability, so the LIDDA can complete the necessary assessments used to determine whether the member meets the intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID) level of care necessary to qualify for Community First Choice (CFC);
* completes [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-spw-pg-1), Individual Service Plan (Pg. 1), and [Form H1700-2](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-2-individual-service-plan-spw-pg-2), Individual Service Plan (Pg. 2), according to STAR+PLUS HCBS program eligibility referenced in Section 3421.6 that follows;
* posts Form H1700-1 and Form H1700-2 to TxMedCentral in the MCO's XXXISP folder, using the appropriate naming convention. An approved MN/LOC must be received before posting Form H1700-1, if the member has a need for the STAR+PLUS HCBS program;
* completes Section B of Form H3676; and  
  posts Form H3676 to TxMedCentral in the MCO XXXSPW folder, using the appropriate naming convention.

3421.6 Confirm STAR+PLUS Home and Community Based Services Program Eligibility

Revision 18-2; Effective September 3, 2018

Program Support Unit (PSU) staff confirm eligibility within **five business days** of receipt of all required eligibility documentation from the managed care organization (MCO) and Texas Medicaid & Healthcare Partnership (TMHP), based on:

* an approved medical necessity and level of care (MN/LOC);
* at least one STAR+PLUS Home and Community Based Services (HCBS) program service is listed on 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 3421.7](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3421.7), ISP Cost Exceeds 202 Percent of the RUG Cost Limit.

PSU staff must request STAR+PLUS HCBS program enrollment from Enrollment Resolution Services (ERS) no later than 60 days prior to the individual's 21st birthdate so MAXIMUS does not send a STAR+PLUS HCBS program enrollment packet to the individual.

If STAR+PLUS HCBS program eligibility is approved, within **two business days**, PSU staff:

* establish the start-of-care date, which is the first of the month following the member’s 21st birthday;  
  For example, the 21st birthday of the member receiving 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, 2017:
  + STAR+PLUS HCBS program registration is effective April 1, 2017;
  + ISP is entered for the STAR+PLUS HCBS program ISP period; and
  + STAR+PLUS HCBS program registration is April 1, 2017, to March 31, 2018;
* complete [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, and
  + send the original to the member;
  + upload Form H2065-D to the HHS Enterprise Administrative Report and Tracking System (HEART);
  + post Form H2065-D to TxMedCentral in the MCO's XXXSPW folder, using the appropriate naming convention; and
  + send an email, with Form H2065-D attached, to ERS, which includes the Medicaid number and primary care provider (PCP), for individuals who are Medicaid only and do not have Medicare; and
* coordinate with the Intellectual and Developmental Disability (IDD) Waiver/Community Services/Hospice Utilization Review on the termination date, if the individual is enrolled in one of the following IDD 1915(c) waivers:
  + Community Living Assistance and Support Services (CLASS);
  + Deaf Blind with Multiple Disabilities (DBMD);
  + Home and Community-based Services (HCS); and
  + Texas Home Living (TxHmL) Program; and
* coordinate ERS.

Within **five business days** of receipt of Form H2065-D from PSU staff, ERS:

* forces enrollment of the member into STAR+PLUS in the Texas Integrated Eligibility Redesign System (TIERS); and
* establishes STAR+PLUS enrollment effective 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, enrollment is effective the same day and month following the 21st birthday of the member receiving MDCP or CCP/PDN or PPECC.

Examples:

* The 21st birthday of the member receiving MDCP or CCP/PDN or PPECC is March 3, 2017. STAR+PLUS enrollment is effective April 1, 2017.
* The 21st birthday of the member receiving MDCP or CCP/PDN or PPECC is April 1, 2017. STAR+PLUS enrollment is effective May 1, 2017.

If STAR+PLUS HCBS program eligibility is denied, HHSC PSU staff:

* complete [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services);
* mail the original Form H2065-D to the member;
* upload Form H2065-D to HEART;
* post Form H2065-D on TxMedCentral in the MCO's XXXSPW folder, using the appropriate naming convention; and
* email a copy of Form H2065-D to the IDD UR contact for members enrolled in one of the following 1915(c) IDD waivers:
  + CLASS;
  + DBMD;
  + HCS; or
  + TxHmL.

3421.7 Individual Service Plan Cost Exceeds 202 Percent of the Resource Utilization Group Cost Limit

Revision 18-2; Effective September 3, 2018

If the individual service plan (ISP) cost exceeds 202 percent of the Resource Utilization Group (RUG) cost limit, the managed care organization (MCO) submits the documents below 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](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-pg-1), Individual Service Plan (Pg.1);
* Form H1700-3, Nursing Service Plan;
* [Form H1700-A](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-a-rationale-hcbs-starplus-waiver-itemsservices), Rationale for STAR+PLUS HCBS Program Items/Services;
* [Form H1700-B](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-b-non-starplus-hcbs-program-services), Non-STAR+PLUS HCBS Program Services;
* [Form H2060](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-needs-assessment-questionnaire-taskhour-guide), Needs Assessment Questionnaire and Task/Hour Guide;
* [Form H6516](https://hhs.texas.gov/laws-regulations/forms/6000-6999/form-h6516-community-first-choice-assessment), Community First Choice Assessment, if applicable;
* [Form H2060-A](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-a-addendum-form-h2060), Addendum to Form H2060, if applicable;
* [Form H2060-B](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-b-needs-assessment-addendum), Needs Assessment Addendum; and
* Two weeks of nursing notes, including Medication Administration Records.

UR may request a clinical review of the case to consider the use of state of Texas General Revenue funds to cover costs exceeding the 202 percent cost limit.

**Note**: MCOs must not discuss with applicants or members, or request the use of, state of Texas General Revenue funds for services above the cost limit.

3422 Transition Policy for Non-Waiver Members Receiving Personal Care Services or Community First Choice Only

Revision 17-5; Effective September 1, 2017

STAR Kids and STAR Health eligibility will terminate the last day of the month in which the member's 21st birthday occurs and will need to receive services through programs serving adults. Members must transition their Personal Care Services (PCS) and Community First Choice (CFC) services to an adult program.

Depending on eligibility requirements, some members may continue to receive PCS or CFC through STAR Health until age 22.

MAXIMUS will reach out to the member 30 days prior to the member’s 21st birthday and provide the member with STAR+PLUS enrollment packets (containing the STAR+PLUS managed care organization (MCO) list). Fifteen days is allowed for the member to make an MCO selection. If the member has not made a selection after 15 days, MAXIMUS will select an MCO for the member, as outlined in 1 Texas Administrative Code [§353.403(3) (link is external)](https://texreg.sos.state.tx.us/public/readtac%24ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=1&pt=15&ch=353&rl=403), Enrollment and Disenrollment.

3423 Intrapulmonary Percussive Ventilator

Revision 17-2; Effective March 17, 2017

Members who were approved for and are using an intrapulmonary percussive ventilator (IPV) are permitted to continue using the IPV if it is deemed to have a beneficial impact on the health of the member. The member must not be subjected to abrupt removal of the equipment. The member continues 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 HHSC's Office of the Medical Director.

3500 Money Follows the Person

Revision 18-2; Effective September 3, 2018

See [Section 3311.1](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/sph-section-3000-waiver-eligibility-services#3311.1), Interest List Procedures, for information regarding use of the Community Services Interest List as a tracking system for Money Follows the Person (MFP) applications from individuals who are not yet members of a managed care organization (MCO).

3510 Money Follows the Person and Managed Care

Revision 18-2; Effective September 3, 2018

The Money Follows the Person (MFP) procedure allows Medicaid-eligible nursing facility (NF) residents to receive services in the community by transitioning to long-term services and supports (LTSS). For residents who need the STAR+PLUS 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 medical necessity and level of care (MN/LOC), and Program Support Units (PSUs) can accept an NF’s MN/LOC for MFP applicants as long as the MN/LOCs are approved and have not yet expired. The NF’s MN/LOC may not be used for upgrades. For more information about upgrades, see [Section 3330](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/sph-section-3000-waiver-eligibility-services#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 be approved for the STAR+PLUS HCBS program prior to leaving the NF. Individuals must reside in the NF until a final determination is made indicating approval of the STAR+PLUS HCBS program. Individuals leaving before receiving an approval notification form are denied using Denial Code 39 (Other).

Once the assessment process has been completed and the resident is determined eligible for the STAR+PLUS HCBS program, the MCO must be prepared to initiate the individual service plan (ISP) upon notification of eligibility. Individuals are enrolled in managed care on the first day of the month in which discharge from the NF is planned. This flexible enrollment process only applies to MFP.

See [Section 3310](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/sph-section-3000-waiver-eligibility-services#3310), Intake and Enrollment, for more information about MFP.

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

Revision 18-2; Effective September 3, 2018

A referral is made through the Texas Health and Human Services Commission (HHSC) Access and Eligibility when a nursing facility (NF) resident wishes to receive services in the community through the STAR+PLUS Home and Community Based Services (HCBS) program. Intake staff must refer all Money Follows the Person (MFP) requests to Program Support Unit (PSU) staff. Referrals can be made by anyone, including family members, NF staff, relocation specialists and HHSC case managers.

3512 Money Follows the Person Applications Pending Due to Delay in Nursing Facility Discharge

Revision 18-2; Effective September 3, 2018

In keeping with the Promoting Independence Initiative, the Program Support Unit (PSU) and managed care organizations are obligated to assist the nursing facility (NF) applicant or member who wants to return to the community by providing information and referrals to possible resources in the community. However, in situations where specific eligibility criteria will not be met in the foreseeable future, PSU staff have the option to deny the request for services. Time frames are set as a guideline for denying requests pending service arrangements.

A four month timeframe is the guideline used in determining pending or denying requests for services. The assessment process does not stop during this period; however, eligibility cannot be established until the member is ready to discharge from the NF.

Examples:

* A STAR+PLUS Home and Community Based Services (HCBS) program applicant has a definite date of discharge within four months from the date services were requested. Allow the referral 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 her or him to leave the NF within four months from the date services were requested. Allow the application to remain open.

If the applicant has an estimated date of discharge that may or may not go beyond the four month period, PSU staff should keep the request for services open. See Section 3513 below for information about applications pending more than four months.

3513 Applications Pending More than Four Calendar Months Due to Delay in Nursing Facility Discharge

Revision 18-2; Effective September 3, 2018

Program Support Unit (PSU) and managed care organization (MCO) staff must use their judgment and work with applicants who have arrangements pending, but are not finalized. If the applicant has an estimated date of discharge that goes beyond the four month period, PSU staff should keep the request for services open.

Applicants who have not made any 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 denied. Deny the request for services by sending [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, within **two business days** after the end of the four month pending period.

If an assisted living (AL) applicant meets eligibility criteria but is on an interest list for a contracted STAR+PLUS HCBS program AL facility (ALF), PSU staff verify through the MCO that the applicant is on the list and may leave the service request pending until the slot opens.

3514 STAR+PLUS Members Residing in a Facility

Revision 18-2; Effective September 3, 2018

When a managed care organization (MCO) receives a request from, or becomes aware of, a STAR+PLUS member who is requesting to transition to the community, the MCO service coordinator must contact the applicant or member within **five business days** and must meet with the member within **14 business days** to explain the process of transitioning to the community.

* Within **three business days** after meeting with the member, the MCO service coordinator must make a referral for relocation assistance by completing [Form 1579](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1579-referral-relocation-services), Referral for Relocation Service, if applicable.
* Inform Program Support Unit (PSU) staff of the request to transition to the community by posting [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-managed-care-programs-communication), Managed Care Programs Communication, to TxMedCentral using the appropriate naming convention for Money Follows the Person (MFP).

Within **two business days** after the MCO has posted Form H2067-MC, PSU staff must:

* create a case in the Texas Health and Human Services (HHS) Enterprise Administrative Report and Tracking System (HEART);
* check the Texas Integrated Eligibility Redesign System (TIERS) for the Medicaid type program;
* check the Community Services Interest List (CSIL) to see if the member is on a Texas Health and Human Services Commission (HHSC) 1915(c) interest list; or
* determine, according to the procedures below, if the member has either an open enrollment or services have been temporarily suspended in an HHSC 1915(c) waiver:
  + For either the Texas Home Living (TxHmL) or Home and Community-based Services Waivers (HCS), check the Client Assignment and Registration (CARE) System, Screen 397 series, Client ID Information Screens, to verify whether a member is enrolled in one of these programs. The screen specific to "waiver consumer assignment history" identifies enrollment, when applicable.
  + For the Community Living Assistance and Support Services (CLASS) (Service Group 2) and Deaf Blind with Multiple Disabilities (DBMD) (Service Group 16) Waiver programs, check 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 no termination code, this indicates the waiver has been temporarily suspended; and
* inform the MCO if the member is on an HHSC 1915(c) interest list, in an HHSC 1915(c) waiver notated as open enrollment or services temporarily suspended, or neither, by posting Form H2067-MC to TxMedCentral. Program Support Unit (PSU) staff also indicate whether the member is potentially eligible to participate in the MFPD by indicating the MFPD qualifying begin and end dates, if applicable, on Form H2067-MC.

Within 45 days after becoming aware of a member requesting to transition to the community, the MCO service coordinator must have completed the assessment for the applicant or member for the appropriate services and community settings. The MCO completes the following activities:

* The MCO completes the Medical Necessity and Level of Care (MN/LOC) Assessment if there is no valid Minimum Data Set (MDS) or has the option to complete its own MN/LOC assessment in lieu of using the nursing facility's (NF’s) MDS.
  + The MCO should ask the NF for a courtesy copy of the MN/LOC Assessment completed by the NF. If the NF refuses, it is not mandatory for the MCO to have a copy.
  + A denied MN/LOC decision resulting from the assessment the MCO submits is not used to deny a STAR+PLUS Home and Community Based Services (HCBS) program applicant who has a valid NF MDS. The NF MDS and Resource Utilization Group (RUG) are used for STAR+PLUS HCBS program eligibility determinations.
  + An MN record must be located in the SASO so the individual service plan (ISP) registration does not suspend. The SASO MN record must match the ISP effective end date and must have an active MN period covering the entire ISP period. The MN/LOC end date must be adjusted to match the ISP end date, if necessary.
* If a Supplemental Security Income (SSI) or SSI-related member will only be receiving state plan long-term services and supports (LTSS) (e.g., personal assistance services (PAS) or Day Activity and Health Services (DAHS)), the MCO must inform PSU staff by posting Form H2067-MC to TxMedCentral
* If the member meets functional criteria for the STAR+PLUS HCBS program, the MCO follows policy in Section 3514.1, Transition to Community with STAR+PLUS Home and Community Based Services Program.

**Note:** PSU staff close the case in HEART if the member will only receive state plan services**.**

3514.1 Transition to Community with STAR+PLUS Home and Community Based Services Program

Revision 18-2; Effective September 3, 2018

During the initial 45-day time frame for the assessment, if the member is temporarily suspended from a Texas Health and Human Services Commission (HHSC) 1915(c) waiver, the managed care organization (MCO) service coordinator explains the STAR+PLUS Home and Community Based Services (HCBS) program to the member so he or she can choose between the STAR+PLUS HCBS program or remain in her or his previous HHSC 1915(c) waiver.

* If the member chooses the STAR+PLUS HCBS program, the MCO service coordinator:
  + reviews the current [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-pg-1), Individual Service Plan (Pg. 1), or develops a new individual service plan (ISP) if one previously did not exist or if the ISP has expired;
  + coordinates Transition Assistance Services (TAS) as part of the STAR+PLUS HCBS program, if needed;
  + notifies HHSC the member has selected the STAR+PLUS HCBS program; and
  + notifies Program Support Unit (PSU) staff of the selection by posting [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-managed-care-programs-communication), 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) waiver, the MCO service coordinator notifies PSU staff of the selection by posting Form H2067-MC to TxMedCentral using the MFP naming convention.

Within **two business days** of receipt of Form H2067-MC from the MCO notifying them of the member’s selection, PSU staff complete the following activities:

* If the member chooses the STAR+PLUS HCBS program, PSU staff:
  + upload Form H2067-MC to the Texas Health and Human Services (HHS) Enterprise Administrative Report and Tracking System (HEART);
  + add the member to the STAR+PLUS interest list, if applicable; and
  + immediately release the member from the list.
* If the member chooses to return to the HHSC 1915(c) waiver for services, PSU staff:
  + upload Form H2067-MC to HEART; and
  + close the case in HEART.

For Medicare/Medicaid dually eligible individuals who became members during the nursing facility (NF) stay but have chosen to return to the HHSC 1915(c) waiver, PSU staff notify Enrollment Resolution Services (ERS) to request disenrollment at the time of discharge.

When the member chooses the STAR+PLUS HCBS program, the MCO coordinates with HHSC relocation contractors and Local Intellectual and Developmental Disability Authority (LIDDA) service coordinators, as needed, to ensure everything required for community living is in place at the time of discharge from the NF. Supplemental Transition Support (STS) services must be coordinated between the relocation specialist and the MCO service coordinator when the relocation specialist determines the member may benefit from STS services. See Appendix XXX, Relocation Function, for responsibilities of relocation specialists and MCOs. The MCO is not responsible for obtaining independent housing for the member, but is responsible for identifying adult foster care (AFC) or assisted living (AL) alternatives available in the network.

For all members transitioning into the STAR+PLUS HCBS program, the MCO posts the following information to TxMedCentral:

* Form H1700-1, if the ISP has expired or one did not previously exist; and
* Form H2067-MC notifying PSU staff if the NF discharge date is known.

PSU staff send an email to Managed Care Compliance & Operations if the MCO does not post the above information within 45 days after the member's request to return to the community. PSU staff continue to monitor for receipt of the above information when required. Within **five business days** after receipt of all required documentation, PSU staff:

* confirm STAR+PLUS HCBS program eligibility based upon:
  + Medicaid eligibility for STAR+PLUS;
  + an approved medical necessity; and
  + an ISP with:
    - at least one STAR+PLUS HCBS program; and
    - a cost within the individual's cost limit;
* send an initial [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, to the member as notification he or she has met the eligibility qualifications to participate in the STAR+PLUS HCBS program; and
* post a copy of Form H2065-D to TxMedCentral within **two business days** to inform the MCO PSU staff sent the notice of initial eligibility determination to the member.

Once STAR+PLUS HCBS program eligibility is approved, the MCO, relocation specialist, NF, NF resident and PSU staff collaborate to identify a proposed discharge date. The MCO is the responsible party for notifying PSU staff of the discharge date by posting Form H2067-MC to TxMedCentral. Should any other entity contact PSU staff with a discharge date, PSU staff must notify the MCO within **two business days** by posting Form H2067-MC to TxMedCentral to determine if the date is acceptable. The MCO must respond with the correct scheduled discharge date by posting Form H2067-MC to TxMedCentral within **two business days** of PSU staff's Form H2067-MC posting date.

Within **two business days** of the individual's discharge from the NF, the MCO posts Form H2067-MC to TxMedCentral to communicate the discharge to PSU staff. Within **one business day**, PSU staff complete a second Form H2065-D containing the service effective date and:

* mail the original to the member;
* post a copy to TxMedCentral in the MCO's XXXSPW folder using the appropriate naming convention; and
* for medical assistance only (MAO) members, fax or email a copy of Form H2065-D, as well as [Form H1746-A](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1746-a-mepd-referral-cover-sheet), MEPD Referral Cover Sheet, to the Medicaid for the Elderly and People with Disabilities (MEPD) specialist to facilitate the Medicaid program transfer.

Within **one business day** of mailing the final Form H2065-D to the member, PSU staff create Service Authorization System Online (SASO) entries documented in [Section 9400](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-9000-sph-service-authorization-system-help-file#9400), Money Follows the Person (MFP) Authorization for a STAR+PLUS HCBS Program Applicant, with the exception of creating a one day STAR+PLUS service authorization for the first day of the month in which an MFP individual is discharged from an NF. It is not necessary to complete a one-day service authorization record for members who discharge mid-month and begin receiving the STAR+PLUS HCBS program.

If the NF records in SASO do not reflect the NF end date within **three business days** of the individual's discharge date, PSU staff will contact the HHSC Provider Claims 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 to do so.

If STAR+PLUS HCBS program eligibility is denied, PSU staff complete Form H2065-D and:

* mail the original to the member; and
* post it to TxMedCentral in the MCO's XXXSPW folder using the appropriate naming convention.

If a Medicaid eligibility NF MAO member chooses to leave the NF and return to the community before being determined eligible for the STAR+PLUS HCBS program, PSU staff perform the following steps additional to those referenced above:

* fax or email a copy of Form H2065-D to MEPD specialist;
* email a copy to ERS requesting disenrollment from STAR+PLUS; and
* upload Form H2065-D to HEART.

3515 Non-STAR+PLUS Members Residing in a Nursing Facility

Revision 18-2; Effective September 3, 2018

For requests to transition to the community for a non-STAR+PLUS member, the Texas Health and Human Services Commission (HHSC) Access and Eligibility staff make a referral to Program Support Unit (PSU) staff. Within **two business days** of the referral from HHSC, PSU staff:

* determine whether the individual has either an open enrollment or services have been temporarily suspended in an HHSC 1915(c) waiver according to the following:
  + For either the Texas Home Living (TxHmL) or Home and Community-based Services (HCS) waivers, check the Client Assignment and Registration (CARE) System, Screen 397 series, Client ID Information Screens, to verify if the individual is enrolled in one of these programs. The screen specific to "waiver consumer assignment history" identifies enrollment, when applicable.
  + For the Community Living Assistance and Support Services (CLASS) (Service Group 2) and Deaf Blind with Multiple Disabilities (DBMD) (Service Group 16) waiver programs, check 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 no termination code, this indicates 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) waivers;
* open a case in the Texas Health and Human Services (HHS) Enterprise Administrative Report and Tracking System (HEART); and
* document the member's STAR+PLUS HCBS program choice in HEART.

Within **two business days** of receipt of the notification of the nursing facility (NF) resident's STAR+PLUS HCBS program selection, PSU staff immediately close the case in HEART if the individual has selected an HHSC 1915(c) waiver program and email the LIDDA indicating PSU staff are closing the case. The LIDDA is responsible for processing the case if the individual chooses the TxHmL or HCS waiver. If the individual selects the CLASS or the DBMD waiver, the LIDDA makes a referral to HHSC for processing. If the individual selects to apply for the STAR+PLUS HCBS program, PSU staff determine the individual's Medicaid status to evaluate for proper coordination with the Medicaid for the Elderly and People with Disabilities (MEPD) specialist.

When the individual has elected to apply for the STAR+PLUS HCBS program, PSU staff must complete the following activities within **two business days** of notification of the selection:

* Check the Texas Integrated Eligibility Redesign System (TIERS) to verify if either [Form H1200](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1200-application-assistance-your-texas-benefits), Application for Assistance – Your Texas Benefits, has already been submitted for the NF stay, or the individual already has full Medicaid eligibility for a type program applicable to the STAR+PLUS HCBS program.
* Contact or attempt to contact the NF resident or authorized representative (AR) by phone to explain the Medicaid application process, when applicable, the selection of a managed care organization (MCO) and the importance of promptly returning the forms that PSU staff mail to the individual.
* Inform the NF resident during the phone contact that he or she may change the MCO in which he or she is enrolled at any time after one full month of the STAR+PLUS HCBS program provision.
* Send Form H1200, when applicable, and the appropriate STAR+PLUS MCO enrollment packet to the NF resident or responsible party.
* 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 and immediately release the individual from the STAR+PLUS HCBS program interest list.
* Refer the individual for relocation assistance by completing [Form 1579](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1579-referral-relocation-services), Referral for Relocation Services.
* Notify HHSC the individual is applying for the STAR+PLUS HCBS program.

PSU staff are responsible for completing the following activities 14 days following the STAR+PLUS HCBS program selection. PSU staff must document in HEART all attempted contacts with the NF resident and any encountered delays. PSU staff:

* contact the NF resident if PSU staff have not received Form H1200; and
* discuss with the NF resident the importance of choosing an MCO if the individual did not select one during the initial contact, explaining the MCO conducts the assessment and develop the initial individual service plan (ISP) to facilitate an eligibility determination for the STAR+PLUS HCBS program.

If, during the 14-day follow-up contact, the NF resident states that he or she, the AR or the NF has already submitted a completed Form H1200, PSU staff check the Texas Integrated Eligibility Redesign System (TIERS) to verify Form H1200 has been submitted. If the NF resident communicates Form H1200 has not been submitted, or if TIERS does not have a record Form H1200 has been submitted, PSU staff notify the NF resident to immediately return Form H1200 to PSU staff because the application for the STAR+PLUS HCBS program will be denied for failure to return Form H1200 has been submitted. If the NF resident communicates Form H1200 has not been submitted, or if TIERS does not have a record Form H1200 has been submitted, the PSU notifies the NF resident to immediately return Form H1200 to PSU staff because the application for SPW services will be denied for failure to return the Form H1200 within 45 days from the date 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](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1746-a-mepd-referral-cover-sheet), MEPD Referral Cover Sheet, to include submission of the returned Medicaid application.

If Form H1200 is not received within 45 days from the date PSU staff sent Form H1200 to the NF resident, PSU staff deny the application for the STAR+PLUS HCBS program by:

* documenting in HEART Form H1200 was not received within 45 days;
* sending the NF resident [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care  Program Services; and
* posting Form H2065-D to TxMedCentral using the appropriate naming convention.

Within **two business** **days** from when the NF resident notifies PSU of the MCO selection orally or in writing, or from when the member is defaulted to an MCO, PSU staff must:

* check SASO to determine if the applicant has a current medical necessity (MN);
* complete Section A of [Form H3676](https://hhs.texas.gov/laws-regulations/forms/3000-3999/form-h3676-managed-care-pre-enrollment-assessment-authorization), Managed Care Pre-Enrollment Assessment Authorization, indicating whether the applicant has a current MN by entering the Resource Utilization Group (RUG) and expiration date in Item 6;
* post Form H3676 to the MCO's XXXSPW folder on TxMedCentral using the appropriate naming convention;
* post [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-managed-care-programs-communication), Managed Care Programs Communication, to TxMedCentral, notating whether or not the applicant is on an HHSC 1915(c) interest list; and
* ensure the appropriate items on Form H3676 are completed and faxed to the relocation specialist, if the NF resident requires assistance transitioning to the community because of lack of supports, 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 from receipt of Form H3676, the MCO service coordinator assesses the applicant for the appropriate services and community settings. The MCO completes the following activities

* The MCO completes the Medical Necessity and Level of Care (MN/LOC) Assessment if there is no valid Minimum Data Set (MDS) or has the option to complete its own MN/LOC assessment in lieu 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 denied MN/LOC decision resulting from the assessment the MCO submits is not used to deny a STAR+PLUS HCBS program applicant who has a valid NF MDS. The NF MDS and RUG are used for STAR+PLUS HCBS program eligibility determinations.
  + An MN record must be located in SAS so the ISP registration does not suspend. The SASO MN record must match the ISP effective end date and must have an active MN period covering the entire ISP period. The MN/LOC end date must be adjusted to match the ISP end date, if necessary.
* If the applicant requires services through the STAR+PLUS HCBS program, the MCO completes Section B of Form H3676 and develops the ISP using [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-pg-1), Individual Service Plan (Pg. 1).
* If a referral for relocation services is not indicated in section A of Form H3676 and the applicant needs these services, the MCO updates Form H3676, Section B, and sends Form 1579 to the relocation specialist.
* If the applicant is not eligible for the STAR+PLUS HCBS program, the MCO must inform PSU staff by posting Form H2067-MC to TxMedCentral.

When the MCO has determined the applicant meets the functional eligibility requirements for the STAR+PLUS HCBS program, the MCO coordinates with the relocation specialists to ensure everything needed for community living is in place at the time of discharge from the NF. The MCO must coordinate Transition Assistance Services (TAS) when needed by the applicant 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 assisted living (AL) alternatives available in the network. When the applicant needs Supplemental Transition Support (STS) services, relocation specialists must coordinate these through the MCO service coordinator.

As needed, PSU staff collaborate with involved parties throughout the STAR+PLUS HCBS program eligibility determination process to assist with problem resolution and to document any delays. PSU staff track all actions and communications in HEART until all STAR+PLUS HCBS program enrollment activities are complete.

The MCO posts the following information to TxMedCentral:

* Form H1700-1;
* Form H3676 with Section B completed; and
* Form H2067-MC, notifying PSU staff of the NF proposed discharge date.

PSU staff send an email to Managed Care Compliance & Operations if the MCO does not post the above information within 45 days after the NF resident's request to return to the community. PSU staff continue to monitor for receipt of the above-referenced forms. Within **two business days** of receipt of this information, PSU staff complete and send [Form H1746-A](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1746-a-mepd-referral-cover-sheet), MEPD Referral Cover Sheet, to notify the MEPD specialist of the approved ISP and MN/LOC so the MEPD specialist can complete the Medicaid eligibility determination.

Upon completion of the evaluation for financial eligibility, the MEPD specialist notifies PSU staff of the determination by sending an email to the appropriate mailbox designated for the MEPD specialist to submit communications to PSU staff.

Within **five business days** after receipt of 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 STAR+PLUS HCBS program eligibility based upon:
  + Medicaid eligibility for STAR+PLUS;
  + an approved MN;
  + an ISP with:
    - at least one STAR+PLUS HCBS program;
    - a cost within the individual's cost limit; and
* send the initial Form H2065-D to the member and post a copy to TxMedCentral to inform the MCO PSU staff notified the individual of this determination.

The MCO collaborates with the relocation specialist, NF, NF resident and PSU staff to identify a proposed discharge date. Once the discharge date has been determined, the MCO must notify PSU staff of the discharge date within **two business days** by posting Form H2067-MC to TxMedCentral. Should any other entity contact PSU staff with a discharge date, PSU staff must notify the MCO within **two business days** by posting Form H2067-MC to TxMedCentral to determine if the date is acceptable. The MCO resolves this discrepancy and must confirm the scheduled discharge date by posting Form H2067-MC to TxMedCentral within **two business days** of PSU’s Form H2067-MC posting date.

Within **two business days** of the individual's discharge from the NF, the MCO posts Form H2067-MC to TxMedCentral to communicate the discharge to PSU staff. Within **one business day**, PSU staff complete the final Form H2065-D containing the service effective date and:

* mail the original to the individual;
* post it on TxMedCentral in the MCO's XXXSPW folder using the appropriate naming convention;
* fax or email a copy, as well as Form H1746-A, to the assigned MEPD specialist for generation of a pending task in TIERS.

Within **one business day** of sending the final Form H2065-D, PSU staff:

* verify that NF records in the SASO reflect the NF end date;
* contact HHSC 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 reflecting the discharge has not processed;
* update the CSIL, in accordance with [Section 3311.4](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/sph-section-3000-waiver-eligibility-services#3311.4), Updating Community Services Interest List (CSIL) Records, ensuring accurate selection of the CSIL closure code(s); and
* email Enrollment Resolution Services (ERS) requesting enrollment effective the first of the month in which the individual is discharged, as required by [Section 3510](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/sph-section-3000-waiver-eligibility-services#3510), Money Follows the Person and Managed Care.

If STAR+PLUS HCBS program eligibility is denied, PSU staff complete Form H2065-D, and:

* mail the original to the applicant;
* post Form H2065-D on TxMedCentral in the MCO's XXXSPW folder using the appropriate naming convention;
* upload Form H2065-D to HEART; and
* close the case in HEART.

If the applicant chooses to leave the NF before being determined eligible for the STAR+PLUS HCBS program, PSU staff fax or email a copy of Form H2065-D to the MEPD specialist. Upon completion of all STAR+PLUS HCBS program actions, PSU staff close the case in HEART

3520 Money Follows the Person Demonstration

Revision 18-2; Effective September 3, 2018

3521 Money Follows the Person Demonstration Entitlement Period Tracking

Revision 18-2; Effective September 3, 2018

Individuals who choose to enroll in and meet the eligibility requirements for Money Follows the Person Demonstration (MFPD) must be designated in the Service Authorization System Online (SASO) using the following procedures:

* Enrollment Record — Enrolled From Field: Choose "12-Rider 37/28 (FAC to COMM)."
* Service Authorizations:
  + Force Box — Check the Force box for each service authorization.
  + Fund Type — Choose "19MFP-Money Follows the Person." This code applies only to MFPD recipients.
  + Force Comment — Enter "MFP Demonstration Member" and select "Force."

Fund Type "19MFP-Money Follows the Person" must be selected for the first individual service plan (ISP) period of participation in MFPD. This fund type is removed after the MFPD period is over or if the member withdraws from MFPD. If a member enters a nursing facility (NF) and then re-enters the community setting before the MFPD ISP period is over, the MFPD entitlement period resumes until the end of the ISP or the month of a new ISP period if the 365-day period extends beyond the current ISP period.

The Program Support Unit (PSU) must maintain a list of MFPD participants. This list must contain the participant's:

* name;
* Medicaid identification (ID) number; and
* ISP start date.

The member may withdraw from MFPD at any time by completing [Form 3632](https://hhs.texas.gov/laws-regulations/forms/3000-3999/form-3632-withdrawal-confirmation" \o "Form 3632, Withdrawal Confirmation), Withdrawal Confirmation, and sending it to PSU staff. Although MFPD eligibility may end, the member continues to receive the STAR+PLUS HCBS program if all eligibility criteria are met.

Time spent in an institutional setting does not count toward the 365-day period; therefore, tracking is required to ensure MFPD members receive the full 365-day entitlement period. The entitlement period begins the date the member who agrees to participate in the demonstration is enrolled in the STAR+PLUS HCBS program.

In order to assure that the member has been put in the SASO as an MFPD applicant, Program Support Unit (PSU) staff must notify the managed care organization (MCO) via [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-managed-care-programs-communication), Managed Care Programs Communication, in the MCO's XXXSPW folder using the most appropriate naming convention, that Fund Code 19MFP has been entered.

Example: The applicant chooses to participate in MFPD and is enrolled in the STAR+PLUS HCBS program effective June 1. If there are no institutional stays during the initial individual service plan (ISP) period, the MFPD period ends on May 31. If the MFPD member is institutionalized for 10 days in April, the MFPD period is extended to June 10, following the ISP end date of May. If the MFPD member is authorized for a new MFPD service during the initial ISP period, the 365-day period would still end on May 31, if there were no institutional stays.

Tracking is required to ensure MFPD members receive the full 365-day entitlement period unless the member withdraws from MFPD. The MCO is responsible for tracking the MFPD entitlement period because PSU staff have no way of knowing when STAR+PLUS HCBS program members are admitted and released from NFs. Once the 365-day period has passed, the MCO is responsible for posting Form H2067-MC, to TxMedCentral to inform PSU staff of the date the member's entitlement period ended. Once received, this information must be forwarded to the regional MFPD reporting coordinator within **two business days**.

It is essential that complete and accurate records are maintained because MFPD tracking is subject to audit by the Centers for Medicare and Medicaid Services. Staff must follow policy in [Section 6412](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-6000-sph-specific-starplus-waiver-services#6412), Maintenance Requirements for Member Information and Forms, which requires a daily backup of TxMedCentral files to compact disk.







3530 High/Complex Needs Members

Revision 18-2; Effective September 3, 2018

3531 Designation of High Needs Members

Revision 18-2; Effective September 3, 2018

The [Uniform Managed Care Contract](https://hhs.texas.gov/sites/default/files/basic_page/uniformmanagedcarecontract.pdf) (UMCC), Attachments A and B-1, Section 8.1.12, specifies the managed care organization (MCO) must develop and maintain a system and procedures for identifying members with special health care needs (MSHCN), including people with disabilities or chronic or complex medical and behavioral health conditions and children with special health care needs (CSHCN).

The MCO must contact members pre-screened by the Texas Health and Human Services Commission (HHSC) Administrative Services contractor as MSHCN to determine whether they meet the MCO's MSHCN assessment criteria, and to determine whether the member requires special services. The MCO must provide information to the HHSC Administrative Services contractor identifying members who the MCO has assessed to be MSHCN, including any members pre-screened by the HHSC Administrative Services contractor and confirmed by the MCO as a MSHCN. The information must be provided in a format and on a time line to be specified 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 information concerning the results of the MCO's identification and assessment of that member's needs to prevent duplication of those activities.

CSHCN means a child (or children) who:

* ranges in age from birth up to age 19;
* has a serious ongoing illness, a complex chronic condition or a disability that has lasted or is anticipated to last at least 12 continuous months or more;
* has an illness, condition or disability that results (or without treatment would be expected to result) in limitation of function, activities or social roles in comparison with accepted pediatric age-related milestones in the general areas of physical, cognitive, emotional, and/or social growth and/or development;
* requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel; and
* has a need for health and/or health-related services at a level significantly above the usual for the child's age.

MSHCN includes a CSHCN and any adult member who:

* has a serious ongoing illness, a chronic or complex condition, or a disability that has lasted or is anticipated to last for a significant period of time; and
* requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel.

3532 Determination of High Needs Status for Ongoing Members

Revision 18-2; Effective September 3, 2018

If during the individual service plan (ISP) period the managed care organization (MCO) determines the member's subsequent ISP may have the potential to exceed the cost limit, that member is considered to have high needs status. Once designated as having a high needs status, the MCO must initiate in the ninth month of the ISP period plans to bring the ISP at/or under the cost limit.

If it appears the subsequent ISP will exceed the cost limit and efforts to explore other alternatives to protect health and safety are not successful, the MCO initiates a request for a staffing with the Texas Health and Human Services Commission (HHSC) to determine whether a request for the use of General Revenue funds is appropriate.

3600 Ongoing Service Coordination

Revision 18-2; Effective September 3, 2018

Based on the needs of the STAR+PLUS Home and Community Based Services (HCBS) program member, the managed care organization's (MCO's) ongoing service coordination responsibilities could include:

* revising the individual service plan (ISP) as necessary to meet the needs of the member, responding to service plan change requests and responding to requests for additional services such as adaptive aids, emergency response services, respite or requests for service suspension;
* coordinating and consulting with MCO-contracted providers regarding delivery of services;
* reminding the member to complete and return Medicaid renewal eligibility documents sent by the Texas Health and Human Services Commission's (HHSC’s) Medicaid for the Elderly and People with Disabilities (MEPD);
* monitoring services delivered to members, evaluating the adequacy and appropriateness of the STAR+PLUS HCBS program and non-STAR+PLUS HCBS program, and documenting monitoring activities;
* assisting the member in accessing and using community, Medicare, family and other third-party resources (TPR);
* assisting with crisis intervention; and
* responding to situations of potential denial of an active member whose ISP costs exceed the individual's assessed cost limit, including requesting a re-evaluation of need, meeting with the interdisciplinary team and administrative staff, and coordinating other services before termination of the STAR+PLUS HCBS program.

3610 Revising the Individual Service Plan

Revision 18-2; Effective September 3, 2018

It may be necessary to revise the individual service plan (ISP) within the ISP period due to changes in the needs of the member or changes in the services offered or emergency situations. The managed care organization (MCO) documents revision to the ISP on [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-pg-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 case record.

3611 MCO Required Notifications from the Provider

Revision 18-2; Effective September 3, 2018

The provider must notify the managed care organization (MCO) when one or more of the following circumstances occur:

* the member leaves the service area for more than 30 days;
* the member has been legally confined in an institutional setting. An institution includes legal confinement, an acute care hospital, state hospital, rehabilitation hospital, state supported living center, nursing home or intermediate care facility for individuals with an intellectual disability 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 member's medical and nursing needs cannot be met adequately in the member's residence;
* the member or someone in the member's home refuses to comply with mandatory program requirements, including the determination of eligibility and/or the monitoring of service delivery;
* the member fails to pay her or his qualified income trust (QIT) copayment;
* the situation, member or someone in the member's home is hazardous to the health and safety of the service provider, but there is no immediate threat to the health and safety of the provider;
* the member or someone in the member's home openly uses illegal drugs or has illegal drugs readily available within sight of the service provider; or
* the member requests that services end.

3611.1 Immediate Suspension or Reduction of Services

Revision 18-2; Effective September 3, 2018

If the member or someone in the member's place of residence exhibits reckless behavior that may result in imminent danger to the health and safety of service providers, the managed care organization (MCO) and MCO-contracted provider are required to make an immediate referral for appropriate crisis intervention services to the Texas Department of Family and Protective Services (DFPS) and/or the police and suspend services. The MCO must immediately provide written notice of temporary suspension of service to the member, and the right of appeal to a fair hearing must be explained to the member. The written notification must specify the reason for denial or suspension, the effective date, the regulatory reference and the right of appeal.

The provider must verbally inform the MCO by the **following business day** of the reason for the immediate suspension, and follow up with written notification to the MCO within **two business days** of verbal notification. The MCO must make a face-to-face visit to initiate efforts to resolve the situation. If the temporary suspension of services constitutes a threat to the health and safety of the individual, then community alternatives or placement in an institutional setting must be offered and facilitated by the MCO.

With prior authorization by the MCO, the STAR+PLUS HCBS program provider may continue providing services to assist in the resolution of the crisis. If the crisis is not satisfactorily resolved, the MCO follows the established denial procedures. Services do not continue during the appeal process.

3611.2 Required Notification of Service Denial from the Managed Care Organization

Revision 18-2; Effective September 3, 2018

If the managed care organization (MCO) determines that documentation supports initiation of denial, the MCO provides written notification of denial to the member within **five business days**. The MCO, within **five business days**, sends [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, to the member.

Form H2065-D must specify the reason for denial, the effective date of the denial, the regulatory reference and provide written notice of the right to appeal. The MCO forwards a copy of the notification to the provider within **two business days**.

If the member appeals the notification of denial within the 10-day adverse action period, the MCO must continue the STAR+PLUS Home and Community Based Services (HCBS) program until notification of the decision by the state fair hearings officer. The MCO must not reduce the STAR+PLUS HCBS program until the outcome of the appeal is known.

3620 Reassessment

Revision 18-2; Effective September 3, 2018

3621 Reassessment Procedures

Revision 18-2; Effective September 3, 2018

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

* check TxMedCentral to determine if the managed care organization (MCO) has submitted [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-pg-1), Individual Service Plan (Pg. 1), before the ISP end date;
* verify the case has an approved medical necessity and level of service (MN/LOC) (both must have the same end date as the ISP being registered; if not, extend the medical necessity and level of service record through the end of the ISP being registered);
* confirm ongoing Medicaid eligibility;
* verify continuing enrollment in SASO reflects any plan change;
* verify the ISP is within the cost limit;
* determine if the ISP was submitted on time and if:
  + on time, enters service group (SG) 19 service code (SC) 12;
  + not on time, enters SG 19 SC 13 for the month(s) for which the ISP was late and SG 19 SC 12 for the remaining ISP period; and
* enter the ongoing ISP in SASO within **five business days** of receipt, not to exceed the ISP end date.

The Supplemental Security Income (SSI)-denied Medicaid program types referenced in [Section 3330](https://hhs.texas.gov/laws-regulations/handbooks/case-manager-community-care-aged-and-disabled-handbook/cm-ccad-section-3000-eligibility-services#3300), STAR+PLUS Members Requesting an Upgrade to the STAR+PLUS Home and Community Based Services (HCBS) Program, do not change in the Texas Integrated Eligibility Redesign System (TIERS) either during the initial or annual review 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 is not required to request MEPD test an individual for the additional criteria, or request a change in the Medicaid program type.

If the reassessment ISP is being submitted due to the participant's timely appeal of a STAR+PLUS HCBS program denial, staff enter the information from the old ISP, extending the end date an additional four months. Services continue using this ISP until a decision is received from the hearing officer. At that time, changes are made, if necessary, to comply with the hearing officer's decision.

3622 Notification Requirements

Revision 18-2; Effective September 3, 2018

If the member continues to meet STAR+PLUS Home and Community Based Services (HCBS) program requirements, it is not necessary to send [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, at the reassessment as notification of continuing services. If the member does not meet STAR+PLUS HCBS program requirements, Program Support Unit (PSU) staff must, within **two business days** of notification:

* send Form H2065-D to the member indicating why the case is being terminated;
* post a copy of Form H2065-D in TxMedCentral to the XXXSPW folder using the appropriate naming convention; and
* after the effective date of the action on Form H2065-D, send a copy of Form H2065-D to [Enrollment](mailto:HPO_STAR_PLUS@hhsc.state.tx.us" \o "HPO STAR PLUS) Resolution Services (ERS).

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

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

* send [Form H1746-A](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1746-a-mepd-referral-cover-sheet), MEPD Referral Cover Sheet, for cases in the Centralized Representation Unit, which forwards the information to the appropriate Medicaid for the Elderly and People with Disabilities (MEPD) specialist;
* post [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-managed-care-programs-communication), 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 appeal (if services have already ended, the MCO reinitiates services immediately);
* extend the end date of the current ISP an additional four months; and
* send an email to ERS on medical assistance only (MAO) cases as notification that a timely appeal was submitted and enrollment should remain open.

ERS, within 10 days of receiving the fair hearings officer's decision, carries out the decision. See [Section 4234](https://hhs.texas.gov/laws-regulations/handbooks/case-manager-community-care-aged-and-disabled-handbook/cm-ccad-section-4000-specific-ccad-services#4234), Hearing Decision.

3623 STAR+PLUS Home and Community Based Services Program Eligibility Date on Form H2065-D

Revision 18-2; Effective September 3, 2018

Program Support Unit (PSU) staff must adhere to the following policy when establishing the eligibility date for STAR+PLUS Home and Community Based Services (HCBS) program cases on [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services. The effective date varies. The possible scenarios include:

* upgrades and interest list releases;
* members transitioning out of children's programs; and
* transfers from a nursing facility (NF) using Money Follows the Person (MFP).

3623.1 Upgrades and Interest List Releases

Revision 18-2; Effective September 3, 2018

The start of care (SOC) date for a STAR+PLUS Home and Community Based Services (HCBS) program applicant being released from the interest list or a member requesting/being processed for an upgrade is based on the:

* Medicaid eligibility effective date;
* date the approved medical necessity and level of care (MN/LOC) was submitted through the Texas Medicaid & Healthcare Partnership (TMHP) Long Term Care Online Portal; and
* date the member's individual service plan (ISP) was posted to TxMedCentral.

Program Support Unit (PSU) staff determine the effective date based on the later of the above dates. If the date falls on the first day of the month, the effective date on [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, is the first day of that month. If the date falls between the second and the last day of the month, the effective date is the first date of the following month.

3623.2 Members Transitioning Out of Children's Programs

Revision 17-5; Effective September 1, 2017

The effective date on [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, for members transitioning out of the programs below is the 1st of the month following 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 until age 22.  In this scenario, the effective date is the 1st of the month following their 22nd birthday.

3623.3 Money Follows the Person Nursing Facility Releases

Revision 18-2; Effective September 3, 2018

The effective date on [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, for members transferring from nursing facilities (NFs) to the STAR+PLUS Home and Community Based Services (HCBS) program via the Money Follows the Person (MFP) process is the date of discharge. Service Authorization System Online (SASO) registration for MFP releases from NFs must occur as follows:

* NF Service Group 1 SAS registrations must be closed the day before the discharge.
* STAR+PLUS HCBS program Service Group 19 SAS registrations begin with a one-day registration to set the managed care organization (MCO) capitation payment, which must be the first day of the month of the discharge. The ongoing registration covers the entire individual service plan period. The effective date on Form H2065-D is the date of discharge. Exception: If the discharge occurs on the first day of the month, STAR+PLUS HCBS program Service Group 19 registration is the first day of that month and the one-day registration is not needed.

3630 Denial or Termination Procedures

Revision 18-2; Effective September 3, 2018

This section provides information, procedures and references pertaining to denial or termination of the STAR+PLUS Home and Community Based Services (HCBS) program for active members, along with adequate notice of members' rights and opportunities to due process.

The following citation from the Code of Federal Regulations (CFR) specifies situations in which an adverse action period is not required:

CFR §431.213, Exceptions from advance notice.

The agency may mail a notice not later than the date of action if —

(a) The agency has factual information confirming the death of a recipient;

(b) The agency receives a clear written statement signed by a recipient that —

(1) He no longer wishes services; or

(2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;

(c) The recipient has been admitted to an institution where he is ineligible under the plan for further services;

(d) The recipient's whereabouts are unknown and the post office returns agency mail directed to her or him indicating no forwarding address (See §431.231 (d) of this subpart for procedure if the recipient's whereabouts become known);

(e) The agency establishes the fact 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 citation for the following rule, which appears in Texas Administrative Code, Title I, Part 15, Chapter 353, Subchapter G, §353.607, appears on [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services. It is the basis for all STAR+PLUS case action.

"The *STAR+PLUS Handbook* includes policies and procedures to be used by all health and human services agencies and their contractors and providers in the delivery of STAR+PLUS Program services to eligible members. The *STAR+PLUS Handbook* can be found on the Texas Health and Human Services Commission website."

3631 10-Day Adverse Action Notification

Revision 18-2; Effective September 3, 2018

The *Code of Federal Regulations (CFR)* requires that the Health and Human Services Commission (HHSC) provide a notice to the member at least 10 days before the action effective date. The member must be given the full 10-day adverse action period to give her or him time to file an appeal.

CFR, Subpart E, Sec. 431.230, Maintaining services.

(a) If the agency mails the 10-day or 5-day notice as required under Sec. 431.211 or Sec. 431.214 of this subpart, and the member requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing unless —

(1) It is determined at the hearing that the sole issue is one of federal or state law or policy; and

(2) The agency promptly informs the member in writing that services are to be terminated or reduced pending the hearing decision.

(b) If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or member to recoup the cost of any services furnished the recipient, to the extent they were furnished solely by reason of this section.

Instructions on how to calculate time periods is provided in §311.014 of the *Code Construction Act*. It specifies that:

* in computing a period of days, the first day is excluded and the last day is included; and
* if the last day of any period is a Saturday, Sunday or legal holiday, the period is extended to include the next day that is not a Saturday, Sunday or legal holiday.

The 10-day adverse action period is extended based on whether the 10th day of the period is a Saturday, Sunday or legal holiday. A legal holiday that falls in the middle of the 10-day adverse 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 full adverse action period may be waived if the member signs a statement to waive the adverse action period.

3631.1 Denial of Medical Necessity/Level of Care/Individual Service Plan (MN/LOC/ISP)

Revision 18-2; Effective September 3, 2018

| **Date Informed Eligibility Lost** | **Date Form H2065-D Sent** | **Current ISP End Date** | **10-Day Adverse Action Expiration Date** | **Form H2065-D Termination Date** | **Service Authorization System Online (SASO) Action** |
| --- | --- | --- | --- | --- | --- |
| April 10 | April 12 | May 31 | April 22 | May 31 | None |
| May 20 | May 21 | May 31 | May 31 | May 31 | None |
| May 20 | May 22 | May 31 | June 1 | June 30 | ISP must be extended to June 30. |
| June 5 | June 7 | May 31 | June 17 | June 30 | ISP must be extended to June 30. |
| June 22 | June 24 | May 31 | July 4 | July 31 | ISP must be extended to July 31. |

3631.2 Denial of Medicaid Eligibility

Revision 18-2; Effective September 3, 2018

| **Actual Date of Medicaid Eligibility Denial** | **Date Informed Eligibility Lost** | **Current Individual Service Plan (ISP) End Date** | **Date Form H2065-D Sent** | **Form H2065-D Termination Date** | **Service Authorization System Online (SASO) Action** |
| --- | --- | --- | --- | --- | --- |
| December 31 | December 31 | May 31 | January 2 | December 31 | ISP and medical necessity and level of care (MN/LOC) must be corrected to December 31. |
| December 31 | October 31 | May 31 | November 2 | December 31 | ISP and MN/LOC must be corrected to December 31. |
| December 31 | February 5 | May 31 | February 7 | December 31 | ISP and MN/LOC must be corrected to December 31. |

Notes:

* If eligibility for Medicaid is reestablished with a gap of over four months, this must be treated as an interest list release. The managed care organization (MCO) processes initial assessments.
* If eligibility for Medicaid is reestablished 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 is allowed to do a reassessment without penalty.

3631.3 Members No Longer in the Service Area

Revision 18-2; Effective September 3, 2018

| **Actual Date of Move** | **Date Health and Human Services Commission (HHSC) Informed** | **Current Individual Service Plan (ISP) End Date** | **Date Form H2065-D Sent** | **Form H2065-D Termination Date** | **Service Authorization System Online (SASO) Action** |
| --- | --- | --- | --- | --- | --- |
| December 31 | December 31 | May 31 | January 2 | January 31 | ISP and medical necessity and level of care (MN/LOC) must be corrected to January 31. |
| October 31 | December 31 | May 31 | January 2 | January 31 | ISP and MN/LOC must be corrected to January 31. |
| April 22 | June 9 | May 31 | June 11 | June 30 | ISP and MN/LOC must be corrected to June 30. |
| May 22 | May 22 | May 31 | May 24 | June 30\* | ISP and MN/LOC must be corrected to June 30. |
| June 30 | June 9 | May 31 | June 11 | June 30 | Managed care organization should have submitted an ISP and MN/LOC for June 1. If these forms are not submitted, enter Service Group 19/Service Code 13 for June 1 through June 30. |

\*The 10-day adverse action period expires after the end of the month.

3631.4 Unable to Locate

Revision 18-2; Effective September 3, 2018

| **Date HHSC Informed** | **Current Individual Service Plan (ISP) End Date** | **Date Form H2065-D Sent** | **Form H2065-D Termination Date** | **Service Authorization System Online (SASO) Action** |
| --- | --- | --- | --- | --- |
| December 31 | May 31 | January 2 | January 31 | ISP and medical necessity and level of care (MN/LOC) must be corrected to January 31. |
| May 3 | May 31 | May 5 | May 31 | None |
| May 5 | May 31 | May 27 | June 30\* | ISP and MN/LOC must be corrected to June 30. |
| June 9 | May 31 | June 11 | June 30 | Managed care organization should have submitted an ISP and MN/LOC for June 1. If these forms are not submitted, enter Service Group 19/Service Code 13 for June 1 through June 30. |

\*The 10-day adverse action period expires after the end of the month.

3632 Program Support Unit Initiated Denials or Terminations

Revision 18-2; Effective September 3, 2018

The following sections contain policy citations that must be included on [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, when the denial or termination action is initiated by Texas Health and Human Services Commission (HHSC) staff.

3632.1 Denial or Termination Due to Death

Revision 18-2; Effective September 3, 2018

Upon learning of the death of a member, Program Support Unit (PSU) staff must send to the managed care organization (MCO) within **two business days** of verification:

* [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-managed-care-programs-communication), Managed Care Programs Communication; or
* [Form H1746-A](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1746-a-mepd-referral-cover-sheet), MEPD Referral Cover Sheet.

Form H1746-A must be sent to the Medicaid for the Elderly and People with Disabilities (MEPD) specialist, if appropriate. Do not send a notice to the member's address or family. The effective date is the date of death.

If the member was receiving Supplemental Security Income (SSI) and the eligibility records reflect that SSI has been denied, PSU staff must use the same effective date of denial as the SSI denial date. If the eligibility records reflect SSI is still active, PSU staff must contact the Social Security Administration (SSA) to notify it of the date of the member's death.

If a member's Medicaid eligibility has been denied due to death in the Texas Integrated Eligibility Redesign System (TIERS), the appropriate entries must be made to end enrollment in the Service Authorization System Online (SASO).

Services must be denied or terminated once death of the member has been confirmed by PSU staff via:

* TIERS;
* obituaries in the local newspaper;
* contact with family or friends;
* notification from the MCO; or
* other reliable sources.

A 10-day adverse action period is not required for death denials.

3632.2 Denial or Termination Due to Residence in a Nursing Facility

Revision 18-2; Effective September 3, 2018

Following the 90th day that the member is not returning to the community when a member resides in a nursing facility (NF) for 90 days or more, the managed care organization (MCO) or Medicare-Medicaid Plan (MMP) notifies the Program Support Unit (PSU) within 14 days. The MCO sends this notice to PSU staff by posting [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-managed-care-programs-communication), Managed Care Programs Communication, in TxMedCentral.

PSU staff deny 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 member [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services;
* posting the form on TxMedCentral in the MCO or MMP's SPW folder, following the instructions in [Section 5110](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/sph-section-5000-automation-payment-issues-starplus#5110), TxMedCentral Naming Convention and File Maintenance;
* sending to Medicaid for the Elderly and People with Disabilities (MEPD) [Form H1746-A](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1746-a-mepd-referral-cover-sheet), 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 Denial or Termination Due to Member Request

Revision 18-2; Effective September 3, 2018

When the Program Support Unit (PSU) has been notified by the Texas Health and Human Services Commission (HHSC) that the member does not want STAR+PLUS HCBS program services or no longer wishes to receive the STAR+PLUS HCBS program, PSU staff must send [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services. Notification must be sent within **two business days** of notification. PSU staff must not initiate denial or termination until notified by HHSC.

3632.4 Denial or Termination of Financial Eligibility

Revision 18-2; Effective September 3, 2018

A member's continued receipt of STAR+PLUS services is dependent on financial eligibility determined by Supplemental Security Income (SSI) or medical assistance only (MAO) program requirements.

The member is notified of denial of financial eligibility by either Social Security Administration (SSA) staff for SSI or the Medicaid for the Elderly and People with Disabilities (MEPD) specialist for MAO. The member may appeal the financial denial using SSA or MEPD processes, as appropriate. Program Support Unit (PSU) staff must send [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, within **two business days** of notification. Notification can come from:

* monthly reports;
* Enrollment Resolution Services (ERS);
* a managed care organization (MCO); or
* other reliable sources.

The chart below describes how to proceed if financial eligibility is denied.

| **When the individual is denied SSI:** | **When the individual is denied MAO:** |
| --- | --- |
| * disenrollment from the STAR+PLUS program will occur effective the last date of Medicaid eligibility, which is usually the last day of the current or following month. * the right to appeal to SSA is available to the individual. * the local Texas Health and Human Services Commission (HHSC) office must be contacted to request other long-term services and supports (LTSS) (for example, Community Attendant Services, Family Care, Title XX programs or state-funded programs). * depending on the availability of local services, the individual may be placed on the interest list if Medicaid eligibility cannot be established according to the date of the request. | * disenrollment from the STAR+PLUS program will occur effective the last date of Medicaid eligibility, which is usually the last day of the current or following month. * the right to appeal to the MEPD specialist is available to the individual. * the local HHSC office must be contacted 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 individual may be placed on the interest list if Medicaid eligibility cannot be established according to the date of the request. |

For SSI members, the termination date must match the SSA termination date.

For MAO members, the termination date must match 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 Denial or Termination of MN/LOC

Revision 18-2; Effective September 3, 2018

The STAR+PLUS Home and Community Based Services (HCBS) program must be denied or terminated when the member's Medical Necessity and Level of Care (MN/LOC) Assessment is denied. Program Support Unit (PSU) staff must send [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Services, within **two business days** of notification. Notification can come from:

* the Monthly ISP Expiring Report;
* Enrollment Resolution Services (ERS);
* a managed care organization (MCO); or
* other reliable sources.

The MN/LOC Assessment status of "MN Denied" in the Texas Medicaid & Healthcare Partnership (TMHP) Long-term Care (LTC) Online Portal is the period when the STAR+PLUS HCBS program applicant's or member's physician has 14 days to submit additional information. Once an MN/LOC Assessment status is in "MN Denied" status, several actions may occur:

* MN Approved: The status changes to "MN Approved" if the TMHP physician overturns the denial because additional information is received;
* Overturn Doctor Review Expired: The status changes to "Overturn Doctor Review Expired" when the 14 day period for the TMHP physician to overturn the denied MN has expired. No additional information was submitted for the physician review. The denied MN remains in this status unless a fair hearing is requested; or
* Doctor Overturn Denied: The status changes to "Doctor Overturn Denied" when additional information is received but the TMHP physician does not believe the information submitted is sufficient to approve an MN. The denied MN remains in this status unless a fair hearing is requested.

The PSU staff must not mail Form H2065-D to deny the STAR+PLUS HCBS program case until after 14 days from the date the "MN Denied" status appears in the TMHP LTC Online Portal. The PSU staff must meet initial certification and annual assessment time frames unless the time frames cannot be met due to the pending MN status. All delays must be documented.

3632.6 Denial or Termination Due to Inability to Locate the Member

Revision 18-2; Effective September 3, 2018

The STAR+PLUS Home and Community Based Services (HCBS) program must be denied or terminated when Program Support Unit (PSU) staff are notified that a member cannot be found. PSU staff must send [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, within **two business days** of notification. Notification can come from:

* monthly reports;
* Enrollment Resolution Services (ERS);
* a managed care organization (MCO); or
* other reliable sources.

3632.7 Denial or Termination Due to Failure to Meet Other STAR+PLUS HCBS Program Requirement

Revision 18-2; Effective September 3, 2018

Use this denial citation if the applicant does not meet a STAR+PLUS Home and Community Based Services (HCBS) program requirement mentioned in Section 3632.1 through Section 3632.6. For example, this citation would be used if the applicant applying for services does not require at least one STAR+PLUS HCBS program service. Program Support Unit (PSU) staff must send [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, within **two business days** of notification. Notification can come from:

* monthly reports;
* Enrollment Resolution Services (ERS);
* a managed care organization (MCO); or
* other reliable sources.

3632.8 Denial or Termination for Other Reasons

Revision 18-2; Effective September 3, 2018

Use this citation if initiating denial or termination for a reason not covered in Section 3632.1 through Section 3632.7. Program Support Unit (PSU) staff must send [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, within **two business days** of notification. Notification can come from:

* monthly reports;
* Enrollment Resolution Services (ERS);
* a managed care organization (MCO); or
* other reliable sources.

3633 Denial or Termination Initiated by the Managed Care Organization

Revision 18-2; Effective September 3, 2018

Section 3633.1 through Section 3633.7 contains policy citations that must be included in denial notifications when the action is initiated by managed care organization (MCO) staff. After notification by the MCO, Program Support Unit staff must send [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, within **two business days** of notification from HHSC.

3633.1 Denial or Termination Due to Threats to Health and Safety

Revision 18-2; Effective September 3, 2018

The managed care organization (MCO) and provider staff must take special precautions when an applicant's or member's comments or behavior appears to be threatening, hostile or of a nature that would cause concern for the safety of the applicant or member, an MCO-contracted provider or an MCO employee. If an applicant exhibits such behavior, the staff member must immediately notify her or his manager.

The Texas Health and Human Services Commission (HHSC) reviews these situations on a case-by-case basis and determines the most appropriate action to be taken. If the applicant's or member's safety may be at risk, the MCO must follow current policy regarding notification to the Department of Family and Protective Services (DFPS). If the staff member believes there is a potential threat to others, HHSC management should determine the best method for notifying the MCO and/or the contracted provider and for addressing the applicant's or member's needs without placing an MCO or provider staff member at risk.

After notification by the MCO, Program Support Unit staff must send [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, within **two business days** of notification from HHSC. The 10-day adverse action notification period does not apply in this situation.

3633.2 Denial or Termination Due to Hazardous Conditions or Reckless Behavior

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When there is no immediate threat to the health or safety of the service provider, but the situation, member or someone in the member's home is hazardous to the health and safety of the service provider, appropriate documentation of denial is essential. For example, a situation where the member has a large dog that may bite if let loose could be resolved if the member or a neighbor or family member will agree to restrain the dog during times of service delivery.

However, if the provider shows up on numerous occasions at the designated time and the dog is loose and the provider has documented a substantial pattern of being unable to deliver services due to this, services could be terminated.

Similarly, if there are illegal drugs in the member's home used by the member or others, the service provider may not be in immediate danger, yet the situation still poses a threat. It is imperative that all available interventions are presented and the opportunity offered for the member to get rid of the illegal drugs and/or users, and agree to refrain and not allow the illegal drug use to resume. A staffing should be held if the illegal drug usage occurs again, and the member must be warned in writing of the potential loss of services for allowing this activity to continue.

After notification by the managed care organization, Program Support Unit staff must send [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, within **two business days** of notification from the Texas Health and Human Services Commission (HHSC). The 10-day adverse action notification period does not apply in this situation.

3633.3 Denial or Termination Due to Harassment, Abuse or Discrimination

Revision 18-2; Effective September 3, 2018

A substantial demonstrated pattern of verbal abuse or discrimination must be clearly established and documented by the managed care organization (MCO) before services can be denied for either of these reasons. This means multiple occurrences of the inappropriate behavior, which have been followed up with face-to-face discussions 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 must be sought. This may include counseling, referral to other case management agencies and possibly changes to the individual service plan (ISP), such as attending Day Activity and Health Services for nursing.

There must be meetings of the Texas Health and Human Services Commission (HHSC) staff that include outside agencies, when appropriate, such as the Department of Family and Protective Services (DFPS) Adult Protective Services. The results must be documented in letters sent to the member that offer an opportunity to stop the behavior, with clear indication that failure may result in loss of service. Copies of written warnings must be sent to all who attend the meetings and a copy must be retained in the case file.

If the situation persists and results in an inability to deliver services, the MCO may request disenrollment from HHSC, as described in the Uniform Managed Care Manual (UMCM) Chapter 11.5. After HHSC approves the disenrollment, HHSC notifies the Program Support Unit (PSU) supervisor via email. PSU staff send [Form H1746-A](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1746-a-mepd-referral-cover-sheet), MEPD Referral Cover Sheet, to the Medicaid for the Elderly and People with Disabilities (MEPD) specialist.

PSU staff must send [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, within **two business days** of notification from HHSC. The 10-day adverse action notification period does not apply in this situation.

If the denial or termination is being considered due to verbal abuse or harassment of the service provider, HHSC must determine if this behavior is directly related to the member's disability. If the member produces a letter from her or his physician indicating the behavior stems from the member's disability, services cannot be denied for this reason. Appropriate interventions to ensure service delivery as noted above should still be pursued.

3633.4 Denial as a Result of Exceeding the Cost Limit

Revision 18-2; Effective September 3, 2018

The managed care organization (MCO) must consider all available support systems in determining if the STAR+PLUS Home and Community Based Services (HCBS) program is a feasible alternative that ensures the needs of the applicant are adequately met. If the STAR+PLUS HCBS program is not a feasible alternative, the MCO must notify Program Support Unit (PSU) staff of the denial and maintain appropriate documentation to support the denial. The MCO's documentation of this type of denial is based on the inadequacy of the plan of care, including both the STAR+PLUS HCBS program and non-STAR+PLUS HCBS program services, to meet the needs of the member within the cost limit.

If [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-pg-1), Individual Service Plan (Pg. 1), is over the cost limit, PSU staff must send [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, within **two business days** of receipt of Form H1700-1 to TxMedCentral.

3633.5 Denial or Termination Due to Failure to Comply with Mandatory Program Requirements and Service Delivery Provisions

Revision 18-2; Effective September 3, 2018

If the member repeatedly and directly, or knowingly and passively, condones the behavior of someone in her or his home and thus refuses more than three times to comply with service delivery provisions, services may be denied or terminated. Refusal to comply with service delivery provisions includes actions by the member or someone in the member's home that prevent determining eligibility, carrying out the service plan or monitoring services. The Texas Health and Human Services Commission (HHSC) will notify Program Support Unit (PSU) staff to send [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, within **two business days** of notification.

3633.6 Denial or Termination Due to Failure to Pay Room and Board/Copay/Qualified Income Trust

Revision 18-2; Effective September 3, 2018

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 denied. After notification by the managed care organization (MCO), Program Support Unit (PSU) staff must send [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, within **two business days** of notification and must provide a 10-day adverse action period.

3633.7 Denial or Termination Due to Other Reasons

Revision 18-2; Effective September 3, 2018

Use this denial or termination citation if initiating denial for a reason not covered above. After notification by the managed care organization (MCO), Program Support Unit (PSU) staff must send [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, within **two business days** of notification.

3640 Disenrollment Request Policy

Revision 18-2; Effective September 3, 2018

Mandatory STAR+PLUS members may request a case review for disenrollment from STAR+PLUS. Disenrollment of a mandatory member is only approved if a determination is made that a member would be better served under fee-for-service (FFS) than participating in managed care.

Members who request to disenroll from STAR+PLUS must submit a written request with supporting documentation of medical condition 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  
P.O. Box 149030, Mail Code W-516  
Austin, TX 78714-9030

HHSC conducts a case review and makes a final determination. The member and Program Support Unit (PSU) staff will be notified in writing of the decision and any available alternatives. If the member is disenrolled, HHSC will make the necessary system adjustments and notify the respective managed care organization (MCO) and enrollment broker.

The member can only re-enter the STAR+PLUS system and the STAR+PLUS HCBS program using Money Follows the Person (MFP) procedures. See [Section 3510](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3510), Money Follows the Person and Managed Care, for additional information.

3641 Services for Members Disenrolled from STAR+PLUS

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In some situations, a STAR+PLUS member or her or his managed care organization (MCO) may request, and be granted, disenrollment of the member from managed care. Whether the disenrollment is voluntary or involuntary, disenrolled members can receive available services from the Texas Health and Human Services Commission (HHSC) Medical and Social Services (MSS) Division, if determined eligible. For additional information, see [Section 3640](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3640), Disenrollment Request Policy.