# SPH, Section 7000, STAR+PLUS HCBS Program and Services

Revision 18-2; Effective September 3, 2018

## 7100 Adult Foster Care

Revision 18-2; Effective September 3, 2018

## 7110 Introduction

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Adult foster care (AFC) provides 24-hour living arrangements and personal care services and supports for persons who, because of physical or behavioral conditions, are unable to live independently. Services and supports may include assistance and/or supervision with daily living, including meal preparation, housekeeping, companion services, personal care, nursing tasks and provision of, or arrangement for, transportation. The STAR+PLUS Home and Community Based Services (HCBS) applicant or member who chooses AFC must reside with a contracted STAR+PLUS HCBS program AFC home provider that meets the minimum standards and licensure requirements found in [Appendix XXIV](https://hhs.texas.gov/laws-regulations/handbooks/appendices/appendix-xxiv-sph-minimum-standards-starplus-afc-homes-and-home-providers), Minimum Standards for STAR+PLUS AFC Homes and Home Providers.

AFC home providers must be contracted either directly with the member’s managed care organization (MCO) or with an AFC provider agency contracted with the member’s MCO. The individual qualified to provide AFC (AFC home provider) must be the primary caregiver. AFC home providers must live in the household and share a common living area with the member. Detached living quarters do not constitute a common living area. AFC home providers may serve up to three adult residents in a qualified AFC home without being licensed as a personal care home or assisted living facility (ALF), and may be the AFC home provider’s home or the STAR+PLUS HCBS program applicant’s or member’s home. AFC home providers with four or more residents, which are also contracted with the Texas Health and Human Services Commission (HHSC), are required to have a Type C Personal Care Home license. AFC homes with four to eight AFC residents must be licensed as an ALF, with limitations on the number of residents at each level who may reside in the home. The three levels of eligibility for AFC are explained in [Section 7133](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-7000-sph-waiver-program-services#7133), Classification Levels of Adult Foster Care Members. ALF licensure requirements are found in 40 Texas Administrative Code (TAC), Chapter 92.

Any reference to “resident” includes members receiving services in the STAR+PLUS HCBS program and AFC or private pay individuals. AFC home providers may serve a combination of STAR+PLUS HCBS program members and private pay individuals in a qualified or licensed AFC home as long as the AFC home provider continues to meet the minimum standards specified in Appendix XXIV, and additional other standards may be specified by the MCO.

When the AFC home provider moves in with the STAR+PLUS HCBS program member receiving AFC in the member’s home, the AFC home enrollment requirements indicated with an asterisk in Appendix XXIV may be waived at the discretion of the MCO or the MCO-contracted AFC provider agency, as appropriate. Other minimum standards, excluding home safety requirements, may be waived at the discretion of the MCO, or upon the recommendation by the MCO-contracted AFC provider agency as long as the MCO-contracted AFC provider agency has completed a home assessment and concluded the member’s needs can be appropriately met through the STAR+PLUS HCBS program and AFC-specific services. Such conclusions must be documented by the MCO-contracted AFC provider agency and approved by the MCO.

The MCO is responsible for ensuring the AFC member receives all necessary AFC services, including the authorization of other needed services and nursing tasks.

STAR+PLUS HCBS program AFC members are required to pay for their own room and board costs and, if able, contribute to the cost of AFC services through a copayment to the AFC home provider. The only time room and board is not required is when the AFC home provider moves in with the member and the member's home becomes the AFC home. Room and board arrangements must be documented in the member’s case file by the MCO or by the MCO-contracted AFC provider agency.

If an AFC home is contracted with HHSC to provide services to an applicant or member receiving AFC through HHSC, the MCO or the MCO-contracted provider agency may request a copy of the AFC home and AFC home provider qualification documents from HHSC, if applicable. These documents contain HHSC findings regarding the qualifications of the AFC home and AFC home provider.

## 7111 Purpose

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The purpose of the STAR+PLUS Home and Community Based Services (HCBS) program adult foster care (AFC) is to promote the availability of appropriate services in a home-like environment for members who are aging and who have disabilities to enhance the dignity, independence, individuality, privacy, choice and decision-making ability of a member.

The STAR+PLUS HCBS program requires each AFC member to have enough living space to guarantee his or her privacy, dignity and independence.

## 7112 MCO Contracting Options

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The managed care organization (MCO) provides STAR+PLUS Home and Community Based Services (HCBS) program adult foster care (AFC) through one of the two contracting methods:

* Contracting with an individual AFC home provider; or
* Contracting with an AFC provider agency that is responsible for:
  + qualifying the AFC home and AFC home provider;
  + ensuring ongoing compliance with AFC requirements and minimum standards found in [Appendix XXIV](https://hhs.texas.gov/laws-regulations/handbooks/appendices/appendix-xxiv-sph-minimum-standards-starplus-afc-homes-and-home-providers), Minimum Standards for STAR+PLUS AFC Homes and Home Providers, unless waived as described in [Section 7110](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-7000-sph-waiver-program-services#7110), Introduction; and
  + reporting any significant change in the member’s needs or status to the MCO.

If the MCO contracts with an AFC provider agency, the MCO has oversight over the AFC provider agency. The MCO retains responsibility for its member(s).

## 7113 Adult Foster Care Services

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The adult foster care (AFC) home provider must provide services, supports and supervision, as needed, around the clock in an AFC home that has either been qualified based on the minimum standards or licensed by the Health and Human Services Commission (HHSC) (for homes serving four or more residents). Services may include:

**Personal assistance** — Help with activities related to the care of the member's physical health that includes but is not limited to bathing, dressing, preparing meals, feeding, exercising, grooming (routine hair and skin care), toileting and transferring/ambulating.

A STAR+PLUS Home and Community Based Services (HCBS) program adult foster care (AFC) member may not receive STAR+PLUS HCBS program personal assistance services (PAS) while the member is a resident in a STAR+PLUS HCBS program AFC home. [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 any addendums to Form H2060 are completed by the managed care organization (MCO) to determine the needed tasks for completion by the AFC home provider. The MCO must provide a copy of the required PAS tasks to the AFC home provider and to the MCO-contracted AFC provider agency, if applicable.

**Transportation** — Arrangement of and/or direct transport of members to meet basic needs for food, clothing, toiletries, medications, medical care and necessary therapy.

**Supervision** — Periodic checks or visits by the provider to the member throughout the 24-hour period to assure the member is well and safe. For some members with more intensive medical needs or behavior problems, more frequent supervision is required.

**Meal preparation** — Preparation or provision of meals adequate to meet the needs of the member.

**Housekeeping** — Activities related to housekeeping that are essential to the member's health and comfort, such as changing bed linens, housecleaning, laundry, shopping, arranging furniture, washing dishes and storing purchased items.

AFC services, with the exception of 24-hour supervision that is provided to all STAR+PLUS HCBS program AFC members, are provided on an "as needed" basis, with the flexibility to meet the member's needs in the least restrictive way possible. For example, STAR+PLUS HCBS program AFC members may not need assistance with medication or help with transportation, but the services are available to all STAR+PLUS HCBS program members in AFC homes. PAS tasks must be provided as identified on Form H2060 and any addendums to Form H2060. The AFC home provider may provide more services for the member than are authorized, as the changing needs of the member may warrant, but may not reduce or discontinue services without prior consultation with the MCO.

STAR+PLUS HCBS program members, as recipients of Medicaid, are entitled to medical transportation services. Transportation is provided to Medicaid-covered medical appointments. Access to non-emergency medical transportation is available to members through the Medical Transportation program.

## 7114 Other Long Term Services and Supports Available to Adult Foster Care Members

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The managed care organization (MCO) may provide or arrange for the provision of the following services.

**Adaptive Aids and Medical Supplies** — Medical equipment and supplies that include devices, controls or appliances specified in the plan of care that enable individuals to increase their abilities to perform activities of daily living (ADLs) or to perceive, control or communicate with the environment in which they live.

**Nursing Services** — Services for members may be provided through the STAR+PLUS Home and Community Based Services (HCBS) program. Nursing services are assessment, planning and interventions provided by a person licensed to engage in professional nursing practice as a registered nurse (RN) or licensed vocational nursing (LVN) by the Texas Board of Nursing or licensed in a state that has adopted the Nurse Licensure Compact.

**Minor Home Modifications** — Services that assess the need, arrange for, and provide modifications and/or improvements to a residence to enable the member to reside in the community and to ensure safety, security and accessibility. Minor home modifications are limited to those modifications identified and approved by the MCO on the individual service plan (ISP).

If the adult foster care (AFC) home is the member’s home, the member must agree to have modifications made to the home. If the AFC home provider is the owner of the home, the AFC home provider must agree to have modifications made to the home. If the AFC home provider is the lessee of the home, the owner must be contacted and apprised of the needed modifications. Permission to make the modifications must be obtained from the home owner in writing and kept with [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.

When the AFC home provider and member or STAR+PLUS HCBS program applicant meet to interview each other and complete [Form 2327](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-2327-individualmember-provider-agreement), Individual/Member and Provider Agreement, the minor home modifications must be listed in "Miscellaneous Arrangements" if the AFC home is not the member’s home. Both the member and the AFC home provider must sign the form agreeing to all included information and stipulations.

To save the member from spending his or her allocation for minor home modifications unnecessarily, a minimum grace period of 30 days must be allowed for the individual to adjust to the AFC placement before any modifications are begun. If the health or safety of the member is jeopardized without the necessary modifications upon entry into the AFC home, a waiver of the 30 days can be made based on the recommendations of the interdisciplinary team and approved by the MCO.

Minor home modifications remain in a STAR+PLUS HCBS program AFC home even if the member for whom the modifications were made permanently leaves the home.

**Dental Services** — Services provided by a licensed dentist to preserve teeth and meet the dental need of the member.

**Occupational Therapy** — Interventions and procedures to promote or enhance safety and performance in the instrumental activities of daily living (ADLs), education, work, play, leisure and social participation. Services consist of the full range of activities provided by an occupational therapist or a licensed occupational therapy assistant under the direction of a licensed occupational therapist and within the scope of his/her state licensure.

**Physical Therapy** — Specialized techniques for the evaluation and treatment related to functions of the neuro-musculoskeletal systems. Services consist of the full range of activities provided by a physical therapist or a licensed physical therapist assistant under the direction of a licensed physical therapist and within the scope of his/her state licensure.

**Speech Pathology Services** — The evaluation and treatment of impairments, disorders or deficiencies related to a member’s speech and language. Services include the full range of activities provided by a speech and language pathologist under the scope of the pathologist's state licensure.

**Cognitive Rehabilitation Therapy** — A service that assists an individual in learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry in order to enable the individual to compensate for the lost cognitive functions. Cognitive rehabilitation therapy is provided when determined to be medically necessary through an assessment conducted by an appropriate professional. The assessment is not included under this service provision. Cognitive rehabilitation therapy is provided in accordance with the plan of care developed by the assessor, and includes reinforcing, strengthening or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems.

**Employment Assistance Services** — Services that assist the member with locating competitive employment or self-employment.

**Supported Employment Services** — Services that assist the member with sustaining competitive employment or self-employment.

**Day Activity and Health Services (DAHS)** — Includes nursing and personal care services, physical rehabilitative services, nutrition services, transportation services and other supportive services. These services are provided at facilities licensed or certified by the Texas Health and Human Services Commission (HHSC).

Each of the above services is provided according to the needs of the member as identified on the ISP, with the exception of DAHS, which is not included on the ISP. The MCO makes referrals for DAHS, coordinates delivery and advises the AFC home provider or MCO-contracted provider agency of any updates to the ISP or referrals for DAHS. Members who have nursing needs may be able to obtain nursing services at a DAHS facility. The MCO service coordinator will work with the AFC home provider or provider agency, if applicable, and the member to determine where the member’s needs can be most appropriately met. STAR+PLUS Home and Community Based Services (HCBS) program members residing in an AFC home without an RN as the AFC home provider may receive up to 10 units of DAHS per week. For Level III AFC homes, see [Section 7133.2](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-7000-sph-waiver-program-services#7133.2), AFC Homes Corresponding to AFC Member Levels, for DAHS eligibility.

## 7120 Minimum Standards for All Adult Foster Care Homes and Home Providers

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All adult foster care (AFC) homes and AFC home providers must be qualified initially and annually thereafter in accordance with the minimum standards outlined in [Appendix XXIV](https://hhs.texas.gov/laws-regulations/handbooks/appendices/appendix-xxiv-sph-minimum-standards-starplus-afc-homes-and-home-providers), Minimum Standards for STAR+PLUS AFC Homes and Home Providers.

## 7121 AFC Homes with Four or More Residents and Members

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An adult foster care (AFC) home provider must obtain an assisted living facility (ALF) license if the AFC home provider wants to serve four or more private pay residents and/or members. The AFC home provider may apply for an ALF license from the Texas Health and Human Services Commission (HHSC) Regulatory Services division. The license must be renewed annually and requires an annual fee. Licensing standards for various types of AL facilities are found in 40 Texas Administrative Code (TAC), Chapter 92.

The AFC home provider must submit a copy of the ALF license to the managed care organization (MCO) or MCO-contracted AFC provider agency before being credentialed and upon renewal. The AFC home provider must report to the MCO or MCO-contracted AFC provider agency any problem(s) identified by HHSC Regulatory Services. AFC home providers must meet all applicable requirements in the minimum standards for AFC. AFC home providers with an AL license must serve no more than a total of eight adult residents in a small group home.

AFC homes of four or more residents, without an HHSC contract, are also subject to the following two sets of regulations:

* [Appendix XXIV](https://hhs.texas.gov/laws-regulations/handbooks/appendices/appendix-xxiv-sph-minimum-standards-starplus-afc-homes-and-home-providers), Minimum Standards for STAR+PLUS AFC Homes and Home Providers; and
* Licensing Standards for Assisted Living Facilities, found in 40 TAC, Chapter 92.

The stricter requirements apply when requirements of the two sets of regulations conflict. **For example**, an AFC home licensed as a small group home must comply with the requirement that an attendant be present at all times when residents are in the facility. This requirement applies regardless of the number of members currently residing in the facility.

If the MCO uses a contracted AFC provider agency, the contracted AFC provider agency must provide copies of any licenses for AFC homes of four or more residents when the MCO requests them.

## 7122 Small Homes for One to Three Residents and Members

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An adult foster care (AFC) home provider who serves up to three residents, including STAR+PLUS Home and Community Based Services (HCBS) program members, may be a member's relative, excluding the spouse. While these small homes do not require licensure, AFC homes and AFC home providers must meet the standards found in [Appendix XXIV](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/appendices/sph-appendix-xxiv-minimum-standards-starplus-afc-homes-home-providers), Minimum Standards for STAR+PLUS AFC Homes and Home Providers. As outlined in [Section 7110](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-7000-sph-waiver-program-services), Introduction, if the AFC home provider moves into the AFC member's home, AFC home requirements in Appendix XXIV may be waived at the discretion of the managed care organization (MCO) or MCO-contracted AFC provider agency.

## 7123 MCO Responsibilities

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The managed care organization (MCO) responsibilities include:

* providing information to interested applicants about potential adult foster care (AFC) homes and coordinating visits to the homes;
* developing an individual service plan;
* acting as coordinator of the interdisciplinary team;
* authorizing AFC services;
* evaluating and coordinating services for the member;
* notifying the member, AFC home provider and AFC provider agency, if applicable, of room and board and copayment amounts, as outlined in [Section 3236](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-sph-waiver-eligibility-and-services#3236), Copayment and Room and Board;
* processing changes and conducting annual reassessments of the member;
* completing an assessment to ensure the potential or existing member’s needs can be met in a particular home;
* recruiting, contracting and credentialing AFC homes and home providers;
* processing AFC home and home provider applications;
* orienting and training AFC home providers;
* approving private pay residents;
* ensuring initial and ongoing compliance with AFC minimum standards;
* conducting annual re-qualification reviews of the AFC home and home provider;
* conducting administrative reviews; and
* processing AFC provider payments.

An MCO may also choose to contract with an AFC provider agency to facilitate AFC home and home provider management on behalf of the MCO. When this occurs, the contracted AFC provider agency is responsible for provisions stipulated in its contract with the MCO. However, the MCO retains overall responsibility for all requirements related to AFC service delivery and oversight of the MCO-contracted AFC provider agency and the member.

## 7130 Adult Foster Care Eligibility

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To be eligible for adult foster care (AFC), applicants and members must meet basic eligibility requirements for STAR+PLUS Home and Community Based Services (HCBS) program services as well as specific requirements related to AFC. Basic eligibility requirements for the STAR+PLUS HCBS program can be found in [Section 3230](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-sph-waiver-eligibility-and-services#3230), Financial Eligibility, and [Section 3240](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-sph-waiver-eligibility-and-services#3240), Waiver Requirements. AFC applicants or members are identified for the STAR+PLUS HCBS program AFC based on their assessed needs for care. Refer to [Section 7133](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-7000-sph-waiver-program-services#7133), Classification Levels of Adult Foster Care Members.

## 7131 AFC Intake, Assessment and Response to Request for Services

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Adult foster care (AFC) is appropriate for individuals who, because of physical, mental or behavioral conditions, are unable to live independently and who need and desire the support and security of family living. AFC may be appropriate for individuals who are:

* seeking alternatives to facility-based care; and
* interested in leaving institutional care but are unable to resume independent living.

When discussing AFC as an option for applicants or members, the managed care organization (MCO) or MCO-contracted AFC provider must explain the room and board requirements and ensure the applicant or member understands that he or she must pay a portion of the monthly income for room and board. If the AFC home provider moves into the member’s home, payment for room and board does not apply. The MCO must also explain that some members residing in an AFC home are additionally required to contribute to the cost of their AFC services by paying a copayment, regardless of whether the AFC home is the member's home. Refer to [Section 7152](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-7000-sph-waiver-program-services#7152), Copayment and Room and Board Requirements, for additional information.

## 7132 Assessing Potential Adult Foster Care Homes

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If the applicant or member appears to meet eligibility criteria, the managed care organization (MCO) or MCO-contracted provider agency provides information to the applicant or member about adult foster care (AFC) services, including potential AFC home providers and AFC homes. The MCO or MCO-contracted AFC provider agency can arrange visits to appropriate AFC homes or, if the applicant or member is capable or has family/supports available, the applicant or member and family may make the arrangements to visit potential AFC homes.

The purpose of the visits to potential AFC homes is to let the applicant or member assess the home and let the AFC home provider assess if the applicant or member will be an appropriate resident for the AFC home. The MCO or MCO-contracted AFC provider agency may contact the AFC home provider and share information about the applicant or member, including the applicant's or member’s particular needs and characteristics, to ensure the potential AFC home provider is fully aware of the responsibilities involved in caring for the applicant or member and to prevent a potential mismatch of the applicant or member and the AFC home provider.

As part of the assessment, MCO service coordinators must determine if the applicant or member can be left alone for up to three hours and document this on [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. The MCO service coordinator must inform the AFC home provider directly of this or through the MCO-contracted AFC provider agency, if applicable. If the applicant or member cannot be left alone, the AFC home provider will be responsible for providing or arranging for 24-hour supervision.

To guide the applicant or member in the selection of the AFC home, the MCO or MCO-contracted AFC provider agency relies on the recommendation of the registered nurse (RN) completing the STAR+PLUS Home and Community Based Services (HCBS) program assessment regarding the needs of the applicant or member. Refer to Section 7133 below. If the MCO is not contracting with an AFC provider agency, the MCO’s RN must also assess the ability of the applicant or member to safely evacuate the AFC home.

## 7133 Classification Levels

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Classification (payment levels) for adult foster care (AFC) members are used for identification of potential AFC applicant or member appropriateness, and are based on the member’s assessed needs for care as determined through the required face-to-face assessments for STAR+PLUS Home and Community Based Services (HCBS) program services and the individual service plan (ISP) completed by the managed care organization (MCO) service coordinator. Determine and document whether an applicant/member is appropriate for AFC based on the applicant’s or member’s condition and behavior. Develop a service plan appropriate to the applicant’s or member’s needs and specific to a given AFC home provider, taking into consideration the AFC home provider’s capabilities. The MCO-contracted AFC provider agency, if applicable, would be involved in a determination of AFC home provider capabilities.

## 7133.1 Levels of Adult Foster Care Members

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The managed care organization (MCO) will use the Medical Necessity and Level of Care (MN/LOC) assessment, Form H6516, Community First Choice Assessment, or [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 addendums. The registered nurse (RN) service coordinator determines a member’s classification level for adult foster care (AFC) services. MCOs must consider a need for limited or greater assistance with the performance of activities of daily living (ADLs) (transferring, walking, dressing, eating, toileting, bathing), and behaviors that occur at least once a week in the assessment and determination, as well as other identified needs of the member.

Below are the classification levels of a member’s daily assistance or supervision requirements.

### **Level I AFC Member**

A member who needs assistance with identified needs including a minimum of:

* one ADL and behavior(s) that occur at least once a week; or
* two ADLs.

### **Level II AFC Member**

A member who needs assistance with identified needs including a minimum of:

* two ADLs and behavior(s) that occur at least once a week; or
* three ADLs.

### **Level III AFC Members**

A member who needs assistance with identified needs including a minimum of:

* three ADLs and behavior(s) that occur at least once a week; or
* four ADLs.

## 7133.2 AFC Home Provider Corresponding to AFC Member Levels

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The adult foster care (AFC) home provider must be able to meet the member’s needs in the AFC setting in conjunction with the STAR+PLUS Home and Community Based Services (HCBS) program and other available supports. If the member’s needs for care exceed the capability of the AFC home provider, the managed care organization (MCO) service coordinator must reassess the member and offer alternate care options.

The AFC home provider who is a licensed registered nurse (RN) and the AFC home provider RN substitute must provide proof of current licensure to the MCO or MCO-contracted provider agency (if applicable) initially and annually thereafter.

The MCO RN service coordinator will complete the Medical Necessity and Level of Care (MN/LOC) assessment, both initially and annually. AFC home providers with STAR+PLUS HCBS program members may not care for more than one totally dependent AFC resident. The MCO RN service coordinator must respond to a request for a change in services within the individual service plan (ISP) year.

Health maintenance activities (HMAs) are tasks which may be exempt from registered nurse delegation based on the MCO RN assessment. HMAs may enable the member to remain in an independent living environment and go beyond activities of daily living (ADLs) because of the higher skill level required to perform them (as found in the Texas Board of Nursing rules in 22 Texas Administrative Code §225.4(8)).

For members residing in Level I, Level II and Level III AFC homes **not** operated by an RN, the skilled nursing needs must be:

* identified by the MCO service coordinator as HMAs;
* purchased as nursing services on the ISP;
* provided by Medicare, Medicaid home health or other resource;
* met by a nurse at a Day Activity and Health Services (DAHS) facility; or
* a combination of the above options.

For members residing in Level I, Level II and Level III AFC homes operated by an RN, the skilled nursing needs must be:

* identified by the MCO RN service coordinator as HMAs;
* met by the AFC home provider nurse or nurse substitute;
* provided by Medicare, Medicaid home health or other resource ; or
* a combination of the above options.

AFC members receiving nursing services and residing with an RN who is the AFC home provider are not eligible to receive day activity and health services (DAHS).

## 7134 Adult Protective Services and Adult Foster Care

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This section provides details regarding when Adult Protective Services (APS) staff request adult foster care (AFC) as a resource for individuals who may benefit from AFC.

## 7134.1 Placement of Adult Protective Services Clients in Adult Foster Care

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Adult Protective Services (APS) may want to move an adult foster care (AFC) individual into an AFC home where a STAR+PLUS Home and Community Based Services (HCBS) program member resides. The managed care organization (MCO) must approve and ensure the APS individual is appropriate and document this in the case record. This includes determining the:

* APS individual's medical and behavioral health needs are met;
* capacity of the AFC home provider to meet the APS individual's needs; and
* compatibility of service delivery to the APS individual with the delivery of services to existing AFC members who may reside in the AFC home.

If the MCO determines the APS individual's placement is not appropriate, the APS individual may not move into the AFC home and the APS worker must make other living arrangements.

## 7134.2 Adult Protective Services Investigations of Adult Foster Care Providers

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Any time managed care organization (MCO) staff of an MCO-contracted adult foster care (AFC) provider agency suspect abuse, neglect or exploitation (ANE) of an AFC member in an unlicensed AFC home, the staff must report it immediately to Adult Protective Services (APS). Reports of ANE in a licensed AFC home must be made to the Texas Health and Human Services Commission (HHSC) Regulatory Services Division. The MCO-contracted AFC provider agency must also notify the MCO.

If reports of ANE taking place in an unlicensed AFC home are made to APS by other parties, the MCO or MCO-contracted AFC provider agency staff may not be notified of member allegations against an AFC provider until after the allegations have been validated. However, APS staff may ask the MCO or MCO-contracted provider agency to assist with the delivery of alternative services during the course of the investigation if the alleged mistreatment poses an immediate threat to the safety of the member or other AFC residents.

The MCO handles disenrollment and corrective actions against the AFC home provider, as appropriate. HHSC takes necessary licensure actions for licensed AFC homes. If HHSC terminates the licensure of an AFC home and the MCO is unable to find a suitable alternative residence for the member, the member is referred to APS for assistance in moving from the AFC home.

A member in an unlicensed AFC home who has the capacity to consent may decide not to move from the AFC home, even though the allegation has been validated. In this instance, the member's AFC services will be denied, payments to the home will terminate and an MCO-contracted provider agency will withdraw from supporting ongoing management of the home. However, the member may continue to reside in the unlicensed AFC home by making private pay arrangements at that home.

If a member residing in an unlicensed AFC home who does not appear to have the capacity to consent refuses to move from an unlicensed AFC home in which an individual identified as the perpetrator in a case of validated abuse, neglect or exploitation lives and is in a state of abuse, neglect or exploitation, the MCO must make a referral to APS. The MCO-contracted AFC provider agency staff must send a referral to the MCO and APS if the agency staff identify this situation.

If the substantiated allegation of abuse, neglect, or exploitation is in a licensed AFC home, the perpetrator must be removed from the AFC home and the license holder must submit to HHSC a plan for the protection of the health and safety of all residents. The resident will not be required to move.

## 7135 Private Pay Individuals in Adult Foster Care

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Some adult foster care (AFC) home providers may wish to take private pay individuals. The AFC home provider must contact the managed care organization (MCO) when considering the admission of a private pay individual before he or she is accepted in the AFC home. The purpose of the approval is to determine the:

* appropriateness of AFC for the private pay individual based on the individual’s condition and behavior;
* capacity of the AFC home to meet the private pay individual’s needs; and
* compatibility of service delivery to the private pay individual and the delivery of services to AFC members.

If the MCO determines placement in an AFC home is inappropriate, the AFC home provider cannot accept the private pay individual. Any issues regarding placements must be resolved by the MCO.

## 7140 Adult Foster Care Managed Care Organization Procedures

Revision 18-2; Effective September 3, 2018

This section provides details for a managed care organization (MCO) when determining an applicant's eligibility for adult foster care (AFC) and for developing the applicant’s individual service plan (ISP).

## 7141 Eligibility Determination

Revision 18-2; Effective September 3, 2018

To determine eligibility for adult foster care (AFC), the managed care organization (MCO) must determine the applicant or member meets all criteria for the STAR+PLUS Home and Community Based Services (HCBS) program and complete an assessment to determine the applicant’s or member’s classification level. If the AFC placement is with an individual AFC home provider contracted with the MCO, the MCO must also ensure the applicant or member has an agreement with an enrolled AFC home provider and the applicant or member and AFC home or home provider are appropriately matched per the classification and needs of the applicant or member before the MCO pays for AFC services. If an MCO contracts with an AFC provider agency to perform AFC management services, the MCO-contracted provider agency may perform activities related to the qualification of the home and the home provider before the MCO pays for AFC services. Refer to [Section 7133](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-7000-sph-waiver-program-services#7133), Classification Levels.

## 7142 Service Planning

Revision 18-2; Effective September 3, 2018

The member’s plan of care must address functional, medical, social and emotional needs and how the needs will be met by the adult foster care (AFC) home provider. The managed care organization (MCO) must assess whether other resources in the community should be used to meet specialized needs of the member. Use of those resources must be documented in the member’s plan of care.

The MCO must complete Form H6516, Community First Choice Assessment, or [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, Part A, Functional Needs Assessment, to document the specific personal assistance tasks with which the AFC home provider must assist the member. The AFC home provider may provide more services for the member than are identified on Form H2060 as the changing needs of the member may warrant, but may not reduce or discontinue services without consultation with the MCO or MCO-contracted AFC provider agency.

Upon approval for AFC, the MCO determines if the member has any special needs that require additional monitoring in the AFC home. The MCO must document any special needs or interventions in the case record on [Form 2327](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-2327-individualmember-provider-agreement), Individual/Member and Provider Agreement. Use the "Other Special Arrangements" space under the "Miscellaneous Arrangements" section.

The MCO or MCO-contracted AFC provider agency contacts the member and the AFC home provider to arrange for the initial visit and a negotiated move-in date for the member or AFC home provider. If there are health concerns regarding the member, the MCO nurse may be consulted and a recommendation may be made for the member to have a physical or medical exam before moving into the AFC home. The MCO coordinates with the interdisciplinary team and the MCO-contracted AFC home provider, if applicable, regarding the AFC member’s care.

## 7150 ****Finalizing the Member’s Plan of Care****

Revision 18-2; Effective September 3, 2018

On or before the date the member begins to receive adult foster care (AFC) services, a face-to-face meeting with the member and the AFC home provider is required to discuss the member's plan of care (POC) and to complete [Form 2327](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-2327-individualmember-provider-agreement), Individual/Member and Provider Agreement. The interdisciplinary team, including the staff of the managed care organization (MCO)-contracted AFC provider, as applicable, and the member and/or family, authorized representative (AR) or guardian may be included in the meeting. The meeting should preferably take place in the AFC home.

The MCO must discuss the member's POC with the member and/or family, AR or guardian and reach understanding with them about how the AFC home provider will meet the member’s needs. This discussion should ensure the member and family, AR or guardian that the AFC home provider is adequately prepared to provide services to the member and that adjustments occur smoothly. The MCO must document the POC and any special needs of the member or special agreements between the member and AFC home provider on Form 2327.

If the applicant or member is already residing in the AFC home, Form 2327 must be completed by the MCO service coordinator face-to-face with the applicant or member and AFC home provider or provider agency, if applicable, before the MCO pays for AFC services initially and upon annual reassessment.

## 7151 ****Member and AFC Home Provider Agreement****

Revision 18-2; Effective September 3, 2018

The managed care organization (MCO) documents the service arrangements and the agreement of the room and board payment on [Form 2327](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-2327-individualmember-provider-agreement), Individual/Member and Provider Agreement.

The MCO or the MCO-contracted adult foster care (AFC) provider agency reviews all of the information on the agreement with the member, family, authorized representative (AR) or guardian and the AFC home provider. All conditions of the agreement and the following topics must be covered in the discussion:

* A full description of the care needs of the member and frequency of services needed.
* The need for and frequency of supervision.
* The beginning and ending date of the Individual/Member and Provider Agreement.
* A detailed description of the rights and responsibilities of the member and the AFC home provider.
* An explanation of the member's and AFC home provider's right to privacy and confidentiality.
* The monthly dollar amount the member agrees to pay the AFC home provider for room and board, as documented on Form 2327.
* The arrangements for a trust fund if the STAR+PLUS Home and Community Based Services (HCBS) program member requests such service from the AFC home provider.
* An inventory of the AFC member’s personal belongings.
* The names, addresses and telephone numbers of the persons to be notified in an emergency, including the member's physician, family members and/or AR or guardian.
* Any special habits and needs of the member and any special arrangements or agreements between the member and the AFC home provider.
* Any additional training needs of the AFC home provider and methods to obtain that training.
* The rights and responsibilities of both the member and the AFC home provider for notifying the MCO, MCO-contracted AFC provider agency, as applicable, of problems such as illnesses, adverse medication reactions, hospitalizations, acts of violence, accidents or complaints about abuse, neglect or exploitation. The Texas Health and Human Services Commission (HHSC) Managed Care Compliance & Operations (MCCO) must be notified if the member, MCO-contracted provider agency or AFC home provider have a complaint or issue regarding the health and safety of the member.
* Other conditions that reflect changes in the member's condition that might affect the appropriateness of AFC services.

The MCO or MCO-contracted provider agency must fully discuss with the AFC home provider the potential for transition issues arising after the member moves into the AFC home or when the AFC home provider moves into the member’s home. The discussion should include notification procedures and suitable actions to be taken to address issues and resolve problems, and the impact of a new living situation on family and other residents in the home.

The member and the AFC home provider must sign Form 2327 after all of the above issues are discussed and both parties are in agreement. Form 2327 must be completed and signed before authorizing and reauthorizing AFC. Any significant changes to the terms of the agreement must be reported by the AFC home provider within **five business days**. Any incidents, as referenced in [Appendix XXIV](https://hhs.texas.gov/laws-regulations/handbooks/appendices/appendix-xxiv-sph-minimum-standards-starplus-afc-homes-and-home-providers), Minimum Standards for STAR+PLUS AFC Homes and Home Providers, must be reported by the AFC home provider to the MCO service coordinator assigned to the member, and the MCO-contracted AFC provider agency, as applicable, within 24 hours of the occurrence.

## 7152 Copayment and Room and Board Requirements

Revision 18-2; Effective September 3, 2018

Copayment and room and board are applicable to adult foster care (AFC) members as described in [Section 3236](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-sph-waiver-eligibility-and-services#3236), Copayment and Room and Board. If the AFC service is provided in the member’s own home, the member is not required to pay room and board. It is the responsibility of the managed care organization (MCO) to ensure the member and the MCO-contracted AFC provider agency, as applicable, are notified in writing on [Form 2327](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-2327-individualmember-provider-agreement), Individual/Member and Provider Agreement, when room and board is waived. It is the MCO-contracted AFC provider agency’s responsibility to notify the AFC home provider when room and board is waived. Copayment, if applicable to the member, may be waived.

If copayment is applicable, the AFC member's copayment amount is listed on [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-starplus-program-services), Notification of Managed Care Program Services, which is sent to the member by Program Support Unit (PSU) staff and posted to TxMedCentral. Form H2065-D is used to report to the member the amount of the copayment for the first month of authorized service and subsequent months. The MCO furnishes a copy of Form H2065-D to the AFC home provider.

The room and board amount, as applicable, is entered on Form H2065-D and Form 2327. The member does not pay room and board if the AFC home provider moves in with the member into the member’s home. The MCO or MCO-contracted AFC provider agency must ensure the member and AFC home provider understand that the room and board arrangement with the AFC home provider is separate from the MCO payment for AFC services. The member pays the AFC home provider the room and board amount listed on Form 2327 and Form H2065-D. If the member is moving into the AFC home mid-month, the amount of room and board for the month is prorated and the member and AFC home provider will be advised of the prorated amount.

When the copayment and/or room and board amounts change, the MCO must notify the AFC home provider and the member of the new amount before the change, as described in [Section 3239](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-sph-waiver-eligibility-and-services#3239), Copayment Changes. The member must pay the copayment and room and board charge by the eighth day of the month. If the member does not pay the required fees, the member may not be eligible for STAR+PLUS Home and Community Based Services (HCBS) program AFC services.

The STAR+PLUS HCBS program AFC home provider must collect the copayment from the member. The AFC home provider must keep receipts for all copayments collected. The AFC home provider must deduct the copayment amount authorized on Form H2065-D from reimbursement claims submitted to the MCO or advise the MCO-contracted AFC provider agency of the amount collected. If a STAR+PLUS HCBS program AFC member does not pay the copayment and/or room and board, the MCO or MCO-contracted AFC provider agency must investigate the member's failure to pay, including contacting the member to learn the reason the fees were not paid. Even if there is a legitimate reason, such as the member's income check has not been received by the eighth day of the month, the member is still under obligation to pay the fees. Grievances between the member and the AFC home provider are not legitimate reasons for the member to withhold payments due. Such grievances must be resolved through the intervention of Texas Health and Human Services Commission (HHSC) Managed Care Compliance & Operations (MCCO) and the MCO.

If the member refuses to pay the fees or there is no legitimate reason for failing to pay, the MCO shall write a letter to the member or the member's responsible party explaining the consequences of continued refusal to pay. If the member does not pay the required fees within 30 days of the due date, the MCO can terminate AFC services to the member. If STAR+PLUS HCBS program AFC is being delivered in the AFC home provider’s residence, the member can then be evicted from the home, according to local eviction ordinances and procedures.

## 7153 Trust Funds

Revision 18-2; Effective September 3, 2018

The managed care organization (MCO) must offer money management assistance by the adult foster care (AFC) home provider to the member and document when the member either accepted or refused the assistance. If the member expresses an interest in money management, the MCO documents the expressed interest on [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-managed-care-programs-communication), Managed Care Programs Communication, and sends the form to the AFC home provider. The requirement for money management services may also be documented on [Form 2327](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-2327-individualmember-provider-agreement), Individual/Member and Provider Agreement.

The AFC home provider must maintain trust fund records. The AFC home provider must:

* have written permission from the member, their guardian, power of attorney, or applicable individual to handle the member’s personal financial affairs;
* keep member trust accounts separate from the AFC home provider's operating accounts. The separate account must be identified "Trustee (name of the STAR+PLUS Home and Community Based Services (HCBS) program AFC home provider), Member's Trust Fund Account." If the AFC home provider maintains a trust fund, the AFC home provider must:
  + deposit the member's monthly income into the account; and
  + write a check for the copayment and the room and board payment out of the trust fund account into the AFC home provider's operating account. Staff must not deposit the member's monthly income into the operating account and then deposit the personal needs and room and board allowance into the trust fund account;
* make the member trust fund records available for review by the MCO or AFC home provider agency during work hours without prior notice;
* not charge the member for services the AFC home provider is expected to provide for the member;
* not charge the member for banking service costs if the member’s trust fund is in a pooled account;
* obtain and maintain current written individual records of all financial transactions involving the member's personal funds that the AFC home provider is handling. The AFC home provider must include at least the following in the records:
  + member's name;
  + identification of member's representative payee or responsible party;
  + admission date;
  + member's earned interest; and
  + transactions – the AFC home provider may choose one of the following options:
    - maintain records of the date and amount of each deposit and withdrawal, the name of the person who accepted the withdrawn funds and the balance after each transaction. Each withdrawal must be signed by the member. If the member is unable to sign when funds are being withdrawn from his or her trust funds, the transactions or receipt must be signed by a witness other than the AFC home provider or employee/contractor of the provider; or
    - maintain signed receipts indicating the purpose for which any withdrawn funds were spent, the date of expenditure and the amount spent. The receipt must be signed by the person responsible for the funds and the member. If the member is unable to sign his or her name, a witness other than the AFC home provider or employee/contractor of the provider must sign the transaction or receipt; and
* distribute the interest earned on any pooled interest banking account in one of the following options:
  + prorated to each member on an actual interest earned basis; or
  + prorated to each member on the basis of his or her end-of-quarter balance.

The following information must be included on the receipt for all money that is received or deposited in the member’s trust fund:

* member's name;
* date the money was received;
* source of the money;
* amount received; and
* amount returned to the member, if any.

All records pertaining to the member's trust fund must be kept in the manner designated above, and available for monitoring without notice.

## 7154 Hospital Leave

Revision 18-2; Effective September 3, 2018

If a member is receiving adult foster care (AFC) services in an AFC home which is not the member’s home, the member may be required to reserve the space during hospital stays by paying the daily bedhold charge, if the provider requires such a charge, which is the negotiated daily rate the managed care organization (MCO) pays the AFC home provider or MCO-contracted provider agency. The AFC home provider does not bill the MCO for the days the STAR+PLUS Home and Community Based Services (HCBS) program AFC member is hospitalized. The AFC member's bedhold charge constitutes the entire payment to the AFC home provider or MCO-contracted AFC provider agency when an AFC member is hospitalized.

During the initial home visit, the MCO or MCO-contracted AFC provider agency reviews the information regarding the AFC member's responsibility to pay a bedhold charge when away from the home and documents this on [Form 2327](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-2327-individualmember-provider-agreement), Individual/Member and Provider Agreement. Hospital leave does not apply when the AFC home provider moves into the member’s home.

## 7155 Authorization of Adult Foster Care

Revision 18-2; Effective September 3, 2018

After STAR+PLUS Home and Community Based Services (HCBS) program eligibility is established and all additional adult foster care (AFC) procedures are completed, the managed care organization (MCO) authorizes AFC 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). Program Support Unit (PSU) staff send the member [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-starplus-program-services), Notification of Managed Care Program Services, and registers the Individual Service Plan (ISP) in the Service Authorization System Online (SASO).

The MCO sends the following completed documents to the AFC home provider and MCO-contracted AFC provider agency, if applicable:

* a copy of Form H1700-1;
* additional applicable ISP forms: [Form 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 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, Community First Choice Assessment;
* Medical Necessity and Level of Care Assessment; and
* [Form 2327](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-2327-individualmember-provider-agreement), Individual/Member and Provider Agreement.

## 7160 Monitoring Quality of Care

Revision 18-2; Effective September 3, 2018

The managed care organization (MCO) registered nurse (RN) service coordinator will monitor the quality of care and services provided to meet the needs of the STAR+PLUS Home and Community Based Services (HCBS) program members receiving adult foster care (AFC) services. The service coordinator will appropriately address any issues identified to protect the health and safety of the member.

During regular monitoring visits, the MCO RN service coordinator must contact the MCO management and MCO-contracted AFC provider agency, if applicable, if the AFC home provider is not meeting the member's needs or the home provider requires additional support or training to meet the member’s needs. The AFC member's physical and medical condition must be carefully monitored to determine whether initial problems are resolved and/or whether new problems are arising due to decreased functional capacity or illness.

[Form 2327](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-2327-individualmember-provider-agreement), Individual/Member and Provider Agreement (see No. 1 under Miscellaneous Arrangements), is used to document special monitoring schedules and other resources used in the plan of care. When the AFC home provider moves in with the AFC member, it is the MCO's responsibility to ensure the AFC member's needs are being met, and there are no health and safety concerns. If concerns are reported or identified, the AFC member's rights must be protected and adjustments to the care plan made accordingly.

## 7170 Significant Changes

Revision 18-2; Effective September 3, 2018

It is the joint responsibility of the managed care organization (MCO) and the contracted adult foster care (AFC) home provider, or MCO-contracted AFC provider agency, to ensure the AFC member is in an appropriate setting to meet his or her needs. When the AFC member has a change in functional need, medical status or behavior, it is the responsibility of the AFC home provider to notify the MCO or MCO-contracted AFC provider agency within 24 hours. The MCO must follow up with the member and AFC home provider to determine if changes to the care arrangement are needed.

The MCO must give particular attention to members who have significant changes in functional need, medical status or behaviors that may mean AFC services are no longer appropriate. Family members and/or authorized representative (AR) or guardian must be alerted to these changes, and the MCO service coordinator should discuss with them and the member the potential for the member to remain in the AFC home. If the member has had a decline in his or her medical condition or functional ability, the MCO RN service coordinator should determine if a visit should be made to assess the member’s medical status.

Long-range care plans must be discussed fully with the member and/or family, AR or guardian and the AFC home provider to ensure that all are aware of the capabilities and limitations of AFC services for members with deteriorating medical or functional conditions. Members who become inappropriate for AFC must be advised of other available options. Assistance must be provided to members and family, AR or guardian in this decision process and with transfer activities when necessary. If the AFC home provider decides the member is no longer appropriate for AFC, the AFC home provider must contact the MCO. The MCO is responsible for preparing the member for transition when the member becomes inappropriate for a particular AFC home or AFC services.

## 7171 Termination of Adult Foster Care Services

Revision 18-2; Effective September 3, 2018

During the course of a member's stay in an adult foster care (AFC) home, the member may experience changes in his or her condition or the care required. If the member begins to need services that cannot be provided by the AFC home provider, the managed care organization (MCO) must consult with the AFC home provider regarding increased needs of the member to assure the necessary care is obtained. Another provider, such as a home and community support services agency (HCSSA), may deliver skilled care in the AFC home.

If the skilled services provided in the home by the provider, such as an HCSSA, are not sufficient and other services are not available to support the member, the MCO, in conjunction with other members of the interdisciplinary team (IDT), should explore alternatives.

The AFC home provider is expected to take actions necessary if the member's condition deteriorates or the member is a threat to his or her own health and safety or the health and safety of others. The AFC home provider is required to notify the MCO and MCO-contracted AFC provider agency, as applicable, of actions taken on the same day of awareness. If necessary, the MCO must follow the procedures identified in [Section 7172](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-7000-sph-waiver-program-services#7172), Discharge and Termination Due to Health and Safety.

AFC home providers cannot reduce or terminate AFC services to members without the prior approval of the MCO and must follow procedures for providing a 30-day written notice, with an exception for a member whose behavior or condition threatens the health or safety of himself or herself or others. During the 30 days after written notice is provided to the member, the MCO is responsible for working with the member to assure alternative services are available.

Once a member is identified as inappropriate for AFC, the MCO must negotiate a time frame with the member, family, authorized representative (AR) or guardian and the AFC home provider for the member to have an alternate service plan. The time frame is determined on a case-by-case basis depending on the urgency and severity of the situation and how quickly an appropriate placement can be arranged. If the member has been a threat to the health and safety of other(s) or has exhibited inappropriate behaviors where the member must move immediately, the MCO must make every effort to locate another living arrangement as soon as possible. If other living arrangements are not readily available for the member, the MCO must refer the member to Adult Protective Services (APS) to assist in locating appropriate placement.

If there is resistance to the move from the member, family, AR, guardian or the AFC home provider, additional support from the IDT may be required to resolve the problem. The MCO advises Program Support Unit (PSU) staff to send the member [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-starplus-program-services), Notification of Managed Care Program Services, 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 to deny AFC services. The MCO follows up on this PSU action by advising the member and AFC home provider of the AFC services termination date specified on Form H2065-D. If the member transfers to another AFC home or STAR+PLUS Home and Community Based Services (HCBS) program living arrangement, the MCO must notify the member and AFC home provider of the change in services. If the member does not transfer to another AFC or STAR+PLUS HCBS program living arrangement and all STAR+PLUS HCBS program services are terminated, the MCO informs PSU staff by posting Form H2067-MC to TxMedCentral. PSU staff send the member Form H2065-D and posts a copy of the form to TxMedCentral within **three business days** of posting Form H2067-MC. If services are not provided in the member’s home, the AFC home provider has the right to begin eviction proceedings as specified in the AFC home provider's resident rights and responsibilities. The MCO must ensure that the member and responsible party understand the consequences of eviction. If the AFC home provider must use eviction procedures and the member has refused to make other living arrangements, the MCO must refer the member to APS.

If the member and AFC home provider decide that the member will remain in the home as a private pay member, the MCO must give approval. The MCO must also ensure the member and AFC home provider understand that there are no case management services or payment arrangements from the MCO for a private pay member.

Refer to Section 7172 below for more details on how to handle situations in which the AFC member threatens the health and/or safety of himself or herself or others in the AFC home.

## 7172 Discharge and Termination Due to Health and Safety

Revision 18-2; Effective September 3, 2018

Any member residing in the adult foster care (AFC) home provider’s residence, whose medical condition or behavior or mental health threatens the health and/or safety of himself or herself or others, is subject to discharge without notice from the AFC home.

The AFC home provider must take appropriate action if the member's medical condition deteriorates and requires more skilled intervention to ensure the member’s health and safety. Depending on the member's condition, appropriate action could include calling emergency medical services, the member's physician or the managed care organization (MCO) service coordinator working with the member or MCO-contracted AFC provider agency, as applicable. The AFC home provider must take action and must inform the MCO on the same day the AFC home provider becomes aware of the need to respond to a change in the member's medical condition.

The MCO must work with the AFC home provider or with providers of other services to arrange alternate services to meet the member's needs.

When the member's behavior causes the member to threaten the health and safety of himself or herself or others, the AFC home provider must take appropriate action which may include calling the police or sheriff's department, the member's physician, and does include the MCO service coordinator or MCO-contracted AFC provider agency, as applicable. The member must be removed from the AFC home as soon as possible if the member becomes a threat to the health or safety of himself or herself or others. In some instances, the MCO may call Adult Protective Services (APS) if hospitalization for psychiatric observation seems warranted.

The MCO must issue an Adverse Determination letter to the member within three days of receiving information regarding an incident which warranted the involuntary removal of the member from the AFC home. The effective date on the Adverse Determination letter is the date the form is dated and mailed/given to the member, even if the decision is appealed. Though the member may not be denied all services through the STAR+PLUS Home and Community Based Services (HCBS) program, the member has a right to appeal the decision of removal from the AFC home.

The member may not remain in the STAR+PLUS HCBS program AFC home during the appeal process. The MCO must work with APS or providers of other STAR+PLUS HCBS program services to arrange alternate placement for the member.

In circumstances in which the AFC home provider has moved in with the AFC member into the member’s home, the AFC member has the right to request termination of the arrangement at any time by contacting the MCO or MCO-contracted AFC provider, and request assistance with eviction of the AFC home provider. The MCO must ensure other STAR+PLUS HCBS program service options are offered should the AFC arrangement terminate.

## 7180 Annual Reassessment of the AFC

## Member

Revision 18-2; Effective September 3, 2018

In addition to the regular reassessment for the STAR+PLUS Home and Community Based Services (HCBS) program, which includes the managed care organization (MCO) registered nurse (RN) service coordinator completing the Medical Necessity and Level of Care, Form H6516, Community First Choice Assessment, or [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 addendums, and the individual service planning (ISP) documents, the MCO or MCO-contracted adult foster care (AFC) provider agency must also continue to meet all eligibility requirements and complete [Form 2327](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-2327-individualmember-provider-agreement), Individual/Member and Provider Agreement.

## 7200 Assisted Living Services

Revision 18-2; Effective September 3, 2018

## 7210 Introduction

Revision 18-2; Effective September 3, 2018

This section applies to the STAR+PLUS Home and Community Based Services (HCBS) program. Assisted living (AL) services provide a 24-hour living arrangement for persons who, because of physical or mental limitation, are unable to continue independent functioning in their own homes. Services are provided in personal care facilities licensed by the Texas Health and Human Services Commission (HHSC). STAR+PLUS HCBS program participants are responsible for their room and board costs and, if applicable, copayment for AL.

The purpose of AL services is to promote the availability of appropriate services for elderly and disabled persons in a home-like environment to enhance the dignity, independence, individuality, privacy, choice and decision making ability of the participant. The personal care facility must provide each participant a separate living unit to guarantee their privacy, dignity and independence.

## 7211 Housing Options in Licensed Personal Care Facilities

Revision 18-2; Effective September 3, 2018

The assisted living (AL) apartment may be an efficiency or one or two bedroom apartment, and each apartment must have a private bath and cooking facilities. An AL non-apartment setting is defined as a licensed personal care facility which has living units that do not meet the definition of an AL apartment, may be double occupancy, and must be:

* freestanding; and
* licensed for 16 or fewer beds.

STAR+PLUS Home and Community Based Services (HCBS) program AL contracts specify whether the facility has contracted to provide services under the housing options of AL or AL Non-Apartment. The provider may not deliver STAR+PLUS HCBS program services in a housing option for which the provider does not have a contract to deliver services. If a provider wishes to maintain both AL (single occupancy) and AL apartments (double occupancy) in one facility, the member’s contract must specify that information.

If the AL provider wishes to limit the types of apartments in the facility available to STAR+PLUS HCBS program participants, the provider must specify these limitations in the contract, either at the time of signature or by amendment. The apartments in question must meet all qualifications as specified in this section. If there are no such specifications in the contract, all types of apartments in the facility must be available to STAR+PLUS HCBS program participants.

If the provider limits the type of apartment available for STAR+PLUS HCBS program members and there is no apartment of that size available, they can refuse to accept any STAR+PLUS HCBS program member, based on not having space available. This would apply both for a member wanting to move into the facility from the outside, or to a private pay member currently in the facility who is becoming a STAR+PLUS HCBS program member. The member would then have the option of reviewing other available AL facilities (ALFs) in the area or adult foster care (AFC) homes.

"Freestanding" is defined as not physically connected to a licensed nursing facility, hospital or another licensed personal care facility, unless the total licensed capacity of both personal care facilities does not exceed 16 beds. At minimum, a covered walkway between buildings is required for physical connection.

At the member's request, portable kitchen units may be removed from the living area.

## 7211.1 Single Occupancy Apartments

Revision 18-2; Effective September 3, 2018

An assisted living (AL) apartment setting is defined as an apartment for single occupancy that is a private space with individual living and sleeping areas, a kitchen, bathroom and adequate storage space, as specified in the following:

* The apartment must have a minimum of 220 square feet, not including the bathroom. Apartments in pre-existing structures being remodeled must have a minimum of 160 square feet, not including the bathroom.
* The kitchen is an area equipped with a sink, refrigerator, a cooking appliance that can be removed or disconnected, adequate space for food preparation and storage space for utensils and supplies. A cooking appliance may be a stove, microwave or built-in surface unit.
* The bathroom must be a separate room in the individual's living area with a toilet, sink and an accessible bath.
* The bedroom must be single occupancy except when double occupancy is requested by the participant.

## 7211.2 Double Occupancy Apartments

Revision 18-2; Effective September 3, 2018

An assisted living (AL) apartment must be a double occupancy apartment with a connected bedroom, kitchen and bathroom area that provides a minimum of 350 square feet of space per participant, and meet the following specifications:

* Indoor common areas used by STAR+PLUS Home and Community Based Services (HCBS) program members may be included in computing the minimum square footage. The portion of the common area allocated must not exceed usable square footage divided by the maximum number of individuals who have access to the common areas.
* The kitchen must be equipped with a sink, refrigerator, a cooking appliance that can be removed or disconnected, adequate space for food preparation and storage space for utensils and supplies. A cooking appliance may be a stove, microwave or built-in surface unit.

## 7220 Description of Services

Revision 18-2; Effective September 3, 2018

The assisted living facility (ALF) must provide 24-hour care in a personal care facility licensed by the Texas Health and Human Services Commission (HHSC). Services include, but are not limited to:

* Home management — Assisting with activities related to housekeeping that are essential to the member's health and comfort, including changing bed linens, housecleaning, laundering, shopping, storing purchased items and washing dishes.
* Transportation and escort — Providing and/or arranging for transportation to:
  + local community shopping areas where a member may purchase items to meet his or her personal needs;
  + recreational activities, field/community trips; and
  + the nearest available provider that can provide medical care which may include medical appointments, therapies and other medical care, unless arrangements are made to transport the member to the medical care provider of the member's choice. Licensure as a personal care facility requires the facility to provide soap and toilet tissue at all times for member use. Other personal items must be purchased by the member. STAR+PLUS Home and Community Based Services (HCBS) program members receiving AL are entitled to receive medical transportation services through Medicaid for Medicaid-covered medical appointments. The ALF personnel are responsible for scheduling the transportation according to medical transportation procedure. If the STAR+PLUS HCBS program member wishes to attend an activity outside the facility, which is not a group activity sponsored by the facility, the member is responsible for paying for his or her own transportation.
* 24-Hour supervision — Periodic checks or visits to a member during each eight-hour shift to ensure that the member is safe and well.
* Meal services that include:
  + planning, cooking and serving three meals per day that are essential to the member's health and well-being. The meals must:
    - be suitable in quantity and adequacy to attain and maintain nutritional requirements, including those of special needs members; and
    - supply 100% of the recommended daily dietary allowance for adults, as recommended by the United States Department of Agriculture;
  + providing special diets, as required by the member's service plan;
  + offering dietary counseling and nutrition education for the member;
  + assisting the member with his or her meals, if necessary, which includes food texture modification, including grinding meats and mashing vegetables for members having trouble chewing; and
  + food management, including assistance with spoon feeding in instances when the member is temporarily ill, bread buttering, and milk opening for members with hand deformities, paralysis or hand tremors.
* Social and recreational activities that include:
  + organizing activities that require group and member-initiated activities;
  + providing opportunities to interact with other people;
  + providing interaction, cultural enrichment, educational or recreational activities, and other social activities on site or in the community in a planned program to meet the social needs and interests of the members;
  + providing four scheduled social activities per week; and
  + posting a monthly social or recreational activity at least one week in advance.

Personal care tasks must be provided, as identified on Form H2060, Needs Assessment Questionnaire and Task/Hour Guide, or Form H6516, Community First Choice Assessment, identified on the service plan and approved by the MCO. A registered nurse (RN) must perform the medication administration assessment.

The assisted living (AL) provider is responsible through its licensure requirements for providing the administration of medications, which is the direct administration of all medications, or the assistance with or supervision of medication. This includes injections, if needed. Only a licensed nurse can give injections. The personal care facility may provide more services for the member than are identified in the service plan, but not fewer services.

## 7221 Requirements Related to Assisted Living

Revision 18-2; Effective September 3, 2018

STAR+PLUS Home and Community Based Services (HCBS) program members who wish to reside in a personal care facility must reside in a licensed assisted living facility (ALF) which is contracted with the managed care organization (MCO) to provide STAR+PLUS HCBS program services. Licensing rules define a personal care facility as a facility that provides food, shelter and personal care services to four or more persons who are unrelated to the owner. The member is required to pay room and board, and possibly a copayment based on income in the AL setting. See [Section 3230](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-sph-waiver-eligibility-and-services#3230), Financial Eligibility, for detailed information.

## 7222 Initial Responsibilities for Members Residing in ALFs

Revision 18-2; Effective September 3, 2018

The managed care organization (MCO) is responsible for helping the applicant or member select an assisted living facility (ALF) that can meet his or her needs. The MCO sends an authorization to the ALF that the applicant or member selects.

The ALF staff must explain the copayment requirement and room and board charges, described in [Section 3236](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-sph-waiver-eligibility-and-services#3236), Copayment and Room and Board, and [Appendix VI](https://hhs.texas.gov/laws-regulations/handbooks/appendices/appendix-vi-sph-starplus-inquiries-chart), STAR+PLUS Inquiries Chart, to the applicant or member. Room and board must be paid by every STAR+PLUS Home and Community Based Services (HCBS) program ALF applicant or member. A copayment is not required of Supplemental Security Income (SSI) recipients. A copayment is required from those AL members whose financial eligibility was determined under the special institutional criteria. The MCO must:

* determine the applicant’s or member's room and board and copayment amounts, based on the [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-starplus-program-services), Notification of Managed Care Program Services, received from Program Support Unit (PSU) staff, for the initial month of service and ongoing copayment amount for subsequent months;
* document the amounts 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);
* verbally notify the applicant or member;
* send a copy of Form H2065-D to the provider as notification of the amounts to be collected; and
* assist the applicant or member and provider in resolving problems related to collection of the applicant’s or member's copayment and room and board contributions.

As described Section 3236, PSU staff may have to estimate the initial and ongoing copayment amounts for the initial ISP development. If Medicaid for the Elderly and People with Disabilities (MEPD) specialists are unable to provide an estimate on the amount available for copayment prior to the Medicaid eligibility determination, PSU staff estimate the copayments based on the member’s self-reported income from [Form H1200](https://hhs.texas.gov/forms/H1200/index.html), Application for Assistance – Your Texas Benefits. The estimated copayments must be generated prior to the member’s admission to the ALF. When the accurate amount available for copayment is received from MEPD specialists, PSU staff recalculate the copayment amounts. The MCO must explain to the applicant or member that failure to pay the room and board charges or copayment will result in termination of his or her STAR+PLUS HCBS program.

## 7223 Admission to Facility

Revision 18-2; Effective September 3, 2018

Before admission, the managed care organization (MCO) faxes or mails to the assisted living facility (ALF):

* [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);
* [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-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 H6516, Community First Choice Assessment, or Form H2060, Needs Assessment Questionnaire and Task/Hour Guide, and Form H2060-A, Addendum to Form H2060; and
* [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-starplus-program-services), Notification of Managed Care Program Services.

The STAR+PLUS Home and Community Based Services (HCBS) program ALF provider is expected to provide to the new member a tour of the facility, including staff and resident introductions. Members are encouraged to bring basic furnishings for bedroom areas with them.

In the event the member does not provide his or her own furnishings, the facility must provide for each member:

* a bed with mattress;
* chair;
* table or dresser;
* drawer space; and
* enclosed closet space for clothing and personal belongings.

Furnishings provided by the facility must be maintained in good repair.

## 7224 Personal Care 3

Revision 18-2; Effective September 3, 2018

STAR+PLUS Home and Community Based Services (HCBS) program applicants or members with heavy personal care needs who choose to reside in assisted living (AL) non-apartment settings may be approved for Personal Care 3 level services. Classification of a STAR+PLUS HCBS program applicant or member at the Personal Care 3 level is based on the applicant or member's assessed needs, as evidenced by a value of two or greater in one or more of the activities of daily living (ADLs) of transferring, eating or toileting, as assessed on the Medical Necessity and Level of Care (MN/LOC) Assessment, Section G, Physical Functioning and Structural Problems, Column A, Self Performance.

During the initial pre-enrollment assessment and annual reassessment, the managed care organization (MCO) nurse completes the MN/LOC Assessment and uses the information recorded for transferring, eating or toileting to make a recommendation regarding the applicant’s or member's need for the Personal Care 3 level. The recommendation is recorded 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).

At the initial certification and each annual reassessment, the MCO must check Form H1700-1 to determine if the applicant or member who chooses to reside in an AL non-apartment setting is identified as meeting the Personal Care 3 level. If the provider nurse does not provide a recommendation for Personal Care 3 level, the MCO must contact the nurse to obtain a Personal Care 3 level. The MCO documents the nurse's recommendation in the case record. The MCO must inform the applicant or member that he or she meets the Personal Care 3 level, and ensure the applicant or member is aware of all facilities contracted to provide care at the Personal Care 3 level by presenting a choice list of AL facilities that specifically identifies the Personal Care 3 facilities. The MCO authorizes the Personal Care 3 reimbursement rate if the applicant or member meets the Personal Care 3 level and chooses to reside in a contracted Personal Care 3 facility.

Changes may occur in a STAR+PLUS HCBS program member's health during the individual service plan (ISP) year that may cause the member to require a greater level of care in an AL facility (ALF), or move to an AL setting from a community setting. The MCO must review the most current MN/LOC Assessment to determine the provider clinician’s recommendation regarding the member's Personal Care 3 level and ensure the member is presented with a choice of ALFs that are contracted at the Personal Care 3 level to provide a higher level of care.

Designation of an ALF as a Personal Care 3 facility is determined in the contracting process. To qualify as a Personal Care 3 facility, the **ALF must** meet the following requirements:

* be a personal care facility licensed for four to 16 beds in a non-apartment setting;
* provide 60 percent or more of its STAR+PLUS HCBS program members with a single occupancy bedroom;
* maintain a minimum staffing ratio of one direct care staff member for every four members during the day and evening shifts, and a minimum of one direct care staff member for every eight members during the night shift; and
* at least 60 percent of the total members served each month must require a minimum of one-to-one staff assistance as evidenced by a value of three or greater in one or more of the activities of daily living (ADLs) of transferring, eating or toileting, as assessed on the MN/LOC Assessment.

## 7230 Other Services Available to Members

Revision 18-2; Effective September 3, 2018

Each of the following services are provided according to the needs of the member, as authorized on the individual service plan (ISP), as a STAR+PLUS Home and Community Based Services (HCBS) program service and not included in the assisted living (AL) daily rate. The managed care organization (MCO) makes referrals for the services and coordinates delivery.

**Adaptive Aids and Medical Supplies** — The STAR+PLUS HCBS program AL member is eligible to receive needed adaptive aids and medical supplies underthe STAR+PLUS HCBS program. Adaptive aids and medical supplies are defined as medical equipment and supplies that include devices, controls or appliances specified in the plan of care (POC) that enable members to increase their abilities to perform activities of daily living (ADLs) or to perceive, control or communicate with the environment in which they live. See [Section 6410](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/sph-section-6000-specific-starplus-waiver-services#6410), List of Adaptive Aids and Medical Supplies, for a list of adaptive aids and supplies that can be purchased through the STAR+PLUS HCBS program.

**Minor Home Modifications** — Services that assess the need, arrange for and provide modifications, and/or improvements to a member’s residence to enable the member to reside in the community and ensure safety, security and accessibility. Minor home modifications are limited to those modifications identified and approved by the MCO on the ISP and apply to Type A facilities only. (See Texas Administrative Code §92.3, Types of Assisted Living Facilities.)

**Occupational Therapy (OT)** — Interventions and procedures to promote or enhance safety and performance in the instrumental activities of daily living, education, work, play, leisure and social participation. OT services consist of the full range of activities provided by a licensed occupational therapist or a licensed occupational therapy assistant (OTA), if under the direction of a licensed occupational therapist, within the scope of state licensure.

**Physical Therapy** **(PT)** — Specialized techniques for the evaluation and treatment related to functions of the neuro-musculo-skeletal systems. PT services consist of the full range of activities provided by a licensed physical therapist or a licensed physical therapy assistant (PTA), under the direction of a licensed physical therapist and within the scope of state licensure.

**Hearing and Language Therapy** — The evaluation and treatment of impairments, disorders or deficiencies related to a member's speech and language. Services include the full range of activities provided by licensed speech and language pathologists under the scope of the pathologist's state licensure.

**Nursing Services** — Services provided by a licensed registered nurse (RN) or licensed vocational nurse (LVN) within the scope of state licensure. Nursing services can be brought into the personal care facility for the member. If the projected cost of the member's services exceeds the annual cost limit, the MCO meets with the member to discuss the options for care, such as other living arrangements in adult foster care (AFC) or Title XIX Day Activity and Health Services. The member's choice for service delivery is given first priority as long as the cost for the service does not exceed the annual cost limit. STAR+PLUS services are also explored by the MCO for the delivery of all waiver services.

The use of self-administered oxygen is allowed in a STAR+PLUS HCBS program AL facility (ALF). Since oxygen is a flammable substance, precautions must be taken to ensure that smoking is prohibited in or around the area where the oxygen is being self-administered.

## 7240 Room and Board and Copayment Requirements

Revision 18-2; Effective September 3, 2018

The member must pay the required fees to be eligible for assisted living (AL) services. Refusal to pay the required fees can result in termination of services.

The facility must designate a due date for copayment and room and board in writing. The due date must be during the same month the copayment and room and board is applied. The facility must collect the entire copayment and room and board on or before the due date. If the due date falls on a weekend or a holiday, the facility must collect the entire copayment and room and board on or before the **first business day** thereafter.

## 7241 Room and Board Requirements

Revision 18-2; Effective September 3, 2018

All 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 a member for a lower amount. STAR+PLUS Home and Community Based Services (HCBS) program policy does not direct the facility to accept or reject the member. The room and board charge is based on the Supplemental Security Income (SSI) federal benefit rate (FBR), minus a personal needs allowance of $85. This is a set rate unless there is a change in the FBR. Generally, the FBR only changes annually on January 1. The room and board charge is adjusted accordingly based on that change. For the initial month of entry, the monthly rate is divided by the number of days in that month, then multiplied by the number of days the member is in the facility. The applicant or member must be notified of the initial amount of room and board to pay and the ongoing amount of room and board to pay.

## 7241.1 Copayment Requirements

Revision 18-2; Effective September 3, 2018

The amount of copayment the member is required to pay is determined by Medicaid for the Elderly and People with Disabilities (MEPD) specialists through use of the MEPD copayment worksheet. MEPD specialists make the determination of the amount available. The managed care organization (MCO) communicates the amount of copayment each member is to pay the provider.

Program Support Unit (PSU) staff send [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-starplus-program-services), Notification of Managed Care Program Services, to the member. Once received, the MCO sends a copy to the assisted living facility (ALF), detailing the first month's copayment amount and the subsequent months' amounts.

## 7242 Personal Leave

Revision 18-2; Effective September 3, 2018

The member is entitled to 14 days of personal leave from the assisted living facility (ALF) each year. The member is responsible for the room and board charge and copayment for personal leave days.

A day of personal leave is defined as 24 continuous hours. STAR+PLUS Home and Community Based Services (HCBS) program assisted living (AL) members must sign out when leaving the facility and sign in upon returning. The sign-in log must have at minimum the following information:

* name of the person;
* time and date of departure;
* destination;
* emergency contact; and
* type of leave (**for example**, personal leave or hospital leave).

## 7243 Nursing Services for Members in an Assisted Living Facility

Revision 18-2; Effective September 3, 2018

If a member is residing in an assisted living (AL) setting, all of the administration of medications, including injections, are provided by the nurse. It is possible that a member residing in an AL setting does not need any nursing tasks that are to be delivered by the STAR+PLUS Home and Community Based Services (HCBS) program. Examples of when this may occur include when the member's only nursing need is for medication administration that is provided by the nurse or when the member is receiving nursing services through Medicare.

## 7244 Response to Assisted Living Member Condition Change

Revision 18-2; Effective September 3, 2018

If the member experiences a change in health or conditions related to the amount and type of care the member requires, the managed care organization (MCO), in conjunction with the other members of the interdisciplinary team (IDT), the provider, and the member or authorized representative (AR) may explore other means to serve the member adequately in his or her current setting. The use of day activity and health services (DAHS) for daily nursing tasks or the direct provision of nursing by provider nurses may be explored as alternatives that would avoid disrupting the member's living arrangement. Nursing tasks cannot be delegated in assisted living (AL) settings.

If a member exhibits behavior or degradation of mental health that threatens the health or safety of himself or herself or others, or the member’s needs exceed the licensed capacity of the facility, the AL provider must take appropriate action and notify the MCO orally by the **next business day**. The provider must confirm the verbal report in writing within seven days. The MCO must take appropriate actions based on the oral notification to assess the member's continued eligibility for the STAR+PLUS Home and Community Based Services (HCBS) program. See [Section 7251](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-7000-sph-waiver-program-services#7251), Facility Reporting and Notification Requirements.

If a STAR+PLUS HCBS program member living in an AL apartment becomes a safety hazard to the member or others due to the member’s operation of the stove or cooking unit in the apartment, the AL provider can disconnect the unit and must notify the MCO by the **next business day**. The MCO must investigate the situation and document any recent or previous incident which indicates a threat to the health or safety of the member or others. The MCO, in cooperation with the IDT, the AL provider, and the member's family or AR, if any, makes a decision regarding reconnection or continued disconnection of the cooking unit. The decision is documented on [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-managed-care-programs-communication), Managed Care Programs Communication, which is sent to the AL provider within **three business days** of the IDT meeting.

## 7245 Hospital and Nursing Facility Stays

Revision 18-2; Effective September 3, 2018

**Hospital Stays**

To reserve bedhold during hospital stays, the member must pay the daily room and board charge.

The facility's bedhold charge or the negotiated bed hold charge for reserving a member's space during hospital stays may not exceed the maximum amount established by the managed care organization (MCO).

The facility does not bill the MCO for days the member is hospitalized. The member's room and board charge, used as a bedhold charge, constitutes the entire payment to the facility when a member is hospitalized.

The facility must notify the 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, when the member has been in the hospital for 30 days. The MCO monitors the member's situation every month up to four months to determine if the stay will become permanent. If the member stays in the hospital longer than four months, the member is systemically disenrolled.

A hospital includes a rehabilitation hospital or a rehabilitation floor or wing of a medical hospital.

### **Nursing Facility Stays**

For issues related to nursing facility payment see the Medicaid for the Elderly and People with Disabilities Handbook, [Section H-1700](https://hhs.texas.gov/laws-regulations/handbooks/chapter-h-co-payment/mepd-h-1000-general-information-co-payment#1700), Deduction for Home Maintenance.

The MCO must follow the Uniform Managed Care Contract, Attachment B.1, Section 8.3.2.6, Nursing Facilities, related to nursing facility (NF) stays.

## 7246 Termination Due to Failure to Pay the Required Contribution to the Cost of Care

Revision 18-2; Effective September 3, 2018

If the member or authorized representative (AR) fails to pay the entire copayment and room and board by the facility's due date, the facility must notify the member or AR and the managed care organization (MCO) in writing that payment was not received. The facility must make an oral notification no later than the **first business day** after the due date. The facility follows up in writing within five days of when the member or AR fails to pay the required payments.

Upon receipt of the written notice, the MCO:

* coordinates with the facility to convene a meeting of the interdisciplinary team (IDT) within **five business days** of receipt of the written notification. The IDT must include the member, a facility representative, the MCO and the AR, if applicable;
* explores with the member and IDT if there are new circumstances preventing the member from making the required payment. Circumstances to consider are:
  + the member has a situation involving a mandatory recoupment or other changes in income requiring an adjustment in countable income;
  + circumstances indicate that the member is being exploited by another person; and
  + other situations exist in which the member and facility can work out an agreement for the member to pay the required payments;
* makes every effort to resolve the problem with the member and the facility;
* advises the member of the consequences that result from refusal to make the required payments to the assisted living facility (ALF), including:
  + termination of eligibility;
  + eviction; and
  + being placed at the end of the interest list if the member reapplies for services in the future; and
* asks the member to read and sign [Form 2119](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-2119residential-care-or-assisted-living-contribution-acknowledgement), Residential Care or Assisted Living Contribution Acknowledgement, if the situation cannot be resolved and the member continues to refuse to pay the required payments. The form states that the member refuses to pay the required payments and understands the consequences of not meeting this eligibility requirement. If the member refuses to sign, document the refusal on the form and have a witness sign. Leave the member a copy of the form and retain the original copy with the signature in the member's case record. Advise the member that he or she will receive a notice to terminate services. Also advise the member that he or she will not be allowed to move to another ALF while the member has an outstanding balance at the current facility, and the current facility may evict the member for refusal to pay.

After the IDT meeting, the MCO:

* makes any appropriate referrals to adjust countable income;
* refers to Adult Protective Services (APS), if exploitation is suspected; or
* coordinates the notice of termination with the facility and Program Support Unit (PSU) staff by sending written notification within five days of the IDT meeting.

If the situation cannot be resolved and the member refuses to pay for any reason, within **three business days** of the MCO's notification, PSU staff:

* sends the member [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-starplus-program-services), Notification of Managed Care Program Services, giving the member notice that services will be terminated effective the end of the month following the end of the 30 day notification period, as indicated on Form H2065-D unless the member pays the required payments. In the comments section of the form, advise the member that services will end and the facility may evict the member if payment is not made by date indicated on Form H2065-D;
* sends the facility and Medicaid for the Elderly and People with Disabilities (MEPD) a copy of Form H2065-D;
* posts to TxMedCentral in the XXXSPW folder, using the appropriate naming convention and a copy of Form H2065-D; and
* emails Managed Care Services Operations (MCSO) Program Enrollment Support (PES) a copy of Form H2065-D.

If the member does not appeal:

* the facility may initiate eviction proceedings by giving the member an eviction notice in writing stating eviction will be effective the date indicated on the Form H2065-D.
* and the member has not made other living arrangements by the denial date, the facility makes a referral to APS.
* and the facility is in compliance with the provisions of its license and contract regarding the eviction of members, the facility evicts the member on the date provided on the written eviction notice.

If the member does appeal by the effective date of the action on Form H2065-D, PSU staff notify the MCO, MEPD specialists and Managed Care Compliance & Operations (MCCO). The member may receive other services, but remains ineligible for AL until all outstanding payments are made.

## 7250 Standards for Operation

Revision 18-2; Effective September 3, 2018

Assisted living facilities (ALFs) must:

* provide each member the choice of a private or semi-private room;
* reserve space for up to three days from the agreed-upon entry date for each referred member before requesting another referral;
* designate a separate bedroom area for members in dual facilities where nursing home members are co-housed in the facility; and
* accept all managed care organization (MCO) referrals if space is available.

The only reason a STAR+PLUS Home and Community Based Services (HCBS) program assisted living (AL) provider could refuse to accept a referral is if the member's condition makes the member inappropriate for the facility according to the facility's personal care licensure.

Having a communicable disease does not necessarily make a member inappropriate for placement in an AL setting. Transmission of communicable diseases and conditions can be prevented through the implementation of infection control procedures, including universal precautions. Licensure standards for personal care facilities require facilities to have Infection Control Policy and Procedures, including universal precautions, in operation to safeguard employees and residents from these and other diseases, and contagious conditions. If transmission of the condition or disease cannot be controlled, the member cannot be placed in a STAR+PLUS HCBS program AL setting.

To receive AL services under the STAR+PLUS HCBS program, the applicant must first be determined eligible for the STAR+PLUS HCBS program. Program Support Unit (PSU) staff coordinate with Medicaid for the Elderly and People with Disabilities (MEPD) specialists, where applicable, to complete the Medicaid eligibility determination.

The MCO discusses residential options with the member, allowing the member to choose his or her preference. If AL is chosen, a verbal referral is made to the provider as an alert that space is needed. The starting date for services is a negotiated date between the MCO, the member and the AL provider. The initial copayment amount is computed based on the starting date. [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 applicable attachments are sent as follow-up, along with a copy of [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-starplus-program-services), Notification of Managed Care Program Services, which authorizes the provider to deliver STAR+PLUS HCBS program services, and [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-managed-care-programs-communication), Managed Care Programs Communication, confirming the negotiated service initiation date.

**Note:** Appropriate action must be taken if the facility finds that a member threatens the health and safety of himself or herself or others. If a stove or cooking unit needs to be disconnected, the service coordinator, in cooperation with the interdisciplinary team (IDT), makes this decision. The IDT must also include the MCO, the AL provider and the member's family or authorized representative (AR), if any.

The AL provider can disconnect the stove or cooking unit if the member exhibits a behavior that threatens the health and safety of himself or herself or others. He must inform the service coordinator of the disconnection by the **next business day** after it occurs. The MCO investigates the situation and documents any recent or previous incidents that indicate a threat to the health or safety of the member or others. If the decision is made to approve a disconnection, the service coordinator documents it on Form H2067-MC that is sent to the AL provider within three days.

**Note:** The facility must make oral notification no later than the **first business day** after the due date. Within **five business days** of the MCO receiving notification from the provider that the member has failed to pay the copayment or room and board, the MCO posts Form H2067-MC to TxMedCentral in the XXXSPW folder using the appropriate naming convention. Form H2067-MC serves as notification to PSU staff of the member's failure to pay the copayment or room and board. Within **three business days**, PSU staff must send the member Form H2065-D stating services will be terminated if the member fails to pay the copayment and/or room and board within 30 days of the date on Form H2065-D.

If a STAR+PLUS HCBS program member does not pay his or her copayment and/or room and board within 30 days of the date on Form H2065-D, the MCO contacts the member to learn the reason the fees were not paid. Even if there is a legitimate reason (such as the member's income check has not been received by the 10th day of the month) for the non-payment of the required fees, the member is still under obligation to pay the fees.

If the member simply refuses to pay the fees, or there is no legitimate reason for his or her failing to pay, the MCO writes a letter to the member, with copies to the facility manager and to the member's responsible party, if applicable, explaining the possible consequences of continued refusal to pay.

The MCO is responsible for working with the member during this time period to assure alternative services will be available. If the member refuses to leave the facility when his or her services are terminated, the facility must follow its written eviction procedures.

In addition, ALFs must:

* conduct a health assessment with the member within three days of admission to the facility;
* provide each member with training in the emergency or disaster procedures and evacuation plan within three days from the date of service initiation. The training must be documented in the member's record. The facility must also document all training and orientation provided to members and facility staff;
* provide services according to the member's health assessment or individual service plan (ISP);
* document the member's daily activity and service delivery on the daily census record;
* obtain written approval from the MCO before discharging a member, except when MCO staff cannot be reached and the member threatens the health or safety of himself or herself or others;
* help the member to prepare for transfer or discharge;
* provide a minimum of four social and recreational activities per week;
* collect payment from the member according to copayment and room and board policies. If payment is not made by the 10th day of the month, the facility must send notice to the member by the 11th day of the same month;
* allow the member to manage his or her finances and/or trust funds. The facility must provide assistance to the member in managing his or her finances only if the member requests assistance in writing;
* refund, within **five business days** after the member has been discharged, the full balance of the member's personal funds that the facility deposited in an account. This applies to copayments and trust funds; and
* inform the member verbally and in writing, before or at the time of admission, of bedhold policies for hospital or nursing facility (NF) stays, personal leave, eviction procedures, all available services in the facility, and charges for services not paid by the MCO and/or not included in the facility's basic daily rate.

Examples of charges not paid by the MCO could be the destruction of facility property or any additional charges, such as pet deposits. Items not required to be provided by the AL provider through the ALF licensing standards (for example, returned check fees, service deposits) may be charged to the member if listed in the admission agreement. The MCO may contact Regional Regulatory Services regarding any questionable items charged to the member.

## 7251 Facility Reporting and Notification Requirements

Revision 18-2; Effective September 3, 2018

The facility must verbally report to the managed care organization (MCO) the following occurrences pertinent to member services by the **next business day** after they occur. These occurrences must be followed up in writing within **five business day**s after they occur and may lead to MCO intervention and/or termination of services, including but not limited to:

* significant changes in the member's health and/or condition, such as:
  + the member enters a hospital, nursing home, state school or state hospital;
  + death of a member; or
  + serious occurrences or emergencies involving the member or facility staff; and
* changes based on member actions, such as the member:
  + is discharged because he or she threatens the health or safety of himself or herself or other members in the facility;
  + leaves the state;
  + requests that services end;
  + refuses to comply with the service plan;
  + fails to pay the copayment;
  + exceeds personal leave days; and
  + requests to move to another facility.

If a member exhibits behavior that threatens the health or safety of himself or herself or others, or the member’s needs exceed the licensed capability of the facility, the provider's written notice must explain the situation and the reasons the member is no longer appropriate for the services. With the concurrence of the MCO, discharge can be as soon as practical when:

* the health or safety of individuals in the facility would be endangered if the member would remain in the facility; or
* the member's medical needs escalate beyond the capability of the facility to meet the member’s needs. For example, the member's mental condition may deteriorate to the point that involuntary commitment to a mental institution is necessary.

## 7252 Member Documentation

Revision 18-2; Effective September 3, 2018

The facility must maintain records for each member that include at least the following information:

* health assessment;
* serious occurrences or emergencies involving members or facility staff;
* incidents when a member threatens the health or safety of himself or herself or other residents in the facility;
* documentation when the member has used 10 personal leave days during the member's current individual service plan effective period;
* documentation when the member's needs exceed the licensed capability of the personal care facility;
* termination of services to a member;
* hospitalization of a member;
* death of a member; and
* documentation when a member requests to move to another facility.

## 7260 Staffing and Training Requirements

Revision 18-2; Effective September 3, 2018

The facility must provide all staff with training in the fire, disaster and evacuation procedures within **three business days** of employment. The training must be documented in the facility records.

## 7270 Copayment and Trust Fund Records

Revision 18-2; Effective September 3, 2018

## 7271 Copayment

Revision 11-3; Effective September 1, 2011

The facility must keep receipts for all copayments collected. The facility must deduct the copayment amount as documented on [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-starplus-program-services), Notification of Managed Care Program Services.

The facility must maintain a current member copayment ledger system that reflects all charges and all payments made by or on behalf of each member. This system must reflect all copayment charges, payments and balances; it must be maintained in accordance with generally accepted accounting principles. If a member copayment is paid from a trust fund, the facility still must prepare a receipt.

The ledger must also reflect room and board charges and payments, and the member must be given a receipt for the room and board payments.

## 7272 Trust Fund Records/Written Receipts

Revision 18-2; Effective September 3, 2018

The facility must maintain trust fund records based on recognized fiscal and accounting principles, and have written permission from the member to handle his or her personal financial affairs.

Members must be informed that:

* funds will be commingled with the funds of other members if the facility will handle the member's trust fund; and
* the facility may review trust fund records of all members whose funds are commingled.

If the member is unable to sign or initial the transaction, or if the member signs his or her name with a mark (x), the transaction must be signed by a witness. The facility must:

* keep the member's trust fund accounts separate from the facility's operating accounts. The separate account must be identified "Trustee, (name of facility), Member's Trust Fund Account";
* make the member's trust records available for review by the facility during work hours without prior notice;
* not charge the member for services that the facility is expected to provide for the member;
* refrain from charging the member for banking service costs if the member's trust fund is in a pooled account;
* obtain and maintain current written individual records of all financial transactions involving the member's personal funds that the facility is handling; and
* include at least the following in the trust fund records:
  + member's name;
  + identification of member's representative payee or responsible party;
  + transactions; and
  + member's earned interest.

The facility may choose one of the following options:

* records of the date and amount of each deposit and withdrawal;
* the name of the person who accepted the withdrawn funds; and
* the balance after each transaction.

Each withdrawal must be signed by the member. If the member is unable to sign when funds are being withdrawn from his or her trust fund, the transaction or receipt must be signed by a witness or signed receipts indicating the purpose for which any withdrawn funds were spent, the date of expenditure and the amount spent. The receipt must be signed by the person responsible for the funds and the member. If the member is unable to sign his or her name, a witness must sign the transaction or receipt.

* distribute the interest earned on any pooled interest banking account in one of the following options:
  + prorated to each member on an actual interest earned basis;
  + prorated to each member on the basis of his or her end-of-quarter balance; or
  + prorated to each member's account monthly if interest is paid on a monthly basis.

If the facility earns interest on any pooled interest account, the interest earned must be prorated to each member's account. Deposit entries should be documented as "interest" in the member's ledger. All transactions must be posted by the middle of the following month. The facility may:

* keep a running balance; or
* compute a balance at the end of the month.

If the facility maintains a trust fund, the facility staff must:

* give the member a receipt for the money deposited into the trust fund;
* deposit the member's monthly income into the account; and
* write a check for the copayment and the room and board payment out of the trust fund account into the facility operating account.

Staff must not deposit the member's monthly income into the operating account and then deposit the personal needs and room and board allowance into the trust fund account. If the member writes a check to be deposited into his or her trust fund account and there are insufficient funds to cover the check, the facility can charge the member only the actual insufficient funds fee charged by the bank.

There is no requirement that the deposit into the trust fund be made on the same date the money is received. However, the facility must ensure that the deposit slip/bank statement reflects the same amount recorded on the receipt.

## 7273 Records and Receipts

Revision 18-2; Effective September 3, 2018

The facility must ensure that records include written receipts for all purchases made by or for members. A receipt is a written or computer-generated, signed record of payment prepared at the time of payment. If the payment is in person, the written or computer-generated receipt must be signed and contemporaneous with the payment. If the payment is by mail, a statement at the end of the month satisfies the requirement for a written receipt and a bill for the next month. If a single receipt is written for different items, the receipt must clearly describe what the receipt covers.

The record or receipt must include the:

* name of member;
* date the money was received;
* coverage period;
* purpose of payment;
* amount received;
* source of the money;
* amount returned, if any; and
* signature of the facility representative.

The facility is required to have both a trust fund ledger and a copayment ledger. A current member copayment ledger system must be maintained that reflects all charges and all payments made by or on behalf of each member. This system must reflect all copayment charges, payments and balances, and be maintained in accordance with generally accepted accounting principles.

The facility must maintain both receipts for monies received from members and bank deposit slips showing the money deposited. These amounts must correspond to amounts recorded in the member’s trust fund ledger. This system must be maintained in accordance with generally accepted accounting principles.

Vendor withdrawal records must be maintained, regardless of how facility staff account for trust fund transactions (withdrawals on a ledger, cash envelope or individual checkbook register). They must retain receipts for any payment out of a trust fund account that is more than $1.00. The receipt, cash register tape or sales statement is documentation of who actually received the money that was withdrawn from the trust fund account, and that the money was spent as authorized. Any unused money returned to the trust fund custodian must be redeposited to the member's trust fund account and appropriately documented. The prerequisites that allow withdrawal from the member's trust fund are:

* the purchase must be authorized by and for the benefit of the member;
* the cost must be reasonable; and
* facility staff do not profit from the transaction. For example, purchasing items in bulk and selling them at a higher price; or the member authorized the purchase of a TV, stereo, refrigerator, and staff are using it.

## 7274 Vendor Receipts

Revision 11-3; Effective September 1, 2011

The following information must be included on all trust fund vendor receipts (other than long-term payments):

* name of the member;
* date the receipt was written;
* store name;
* amount of money spent or received; and
* item purchased.

## 7275 Group Purchases

Revision 18-2; Effective September 3, 2018

Often, a single purchase is made for goods to be distributed among specific members (for example, cigarettes). In such a case, the invoice or receipt should show the:

* names of the members for whom the purchase was made; and
* portion of the total price charged to each individual account.

Group purchases are only allowable if they can be traced to the member.

## 7276 Payment of Copayment and Room and Board from Trust Fund

Revision 18-2; Effective September 3, 2018

It is an acceptable and recommended practice to deposit the member's income into the trust fund account and then pay the copayment and room and board from the trust fund account. In this way, the member's monthly payments can be traced to the trust fund. When the copayment and room and board is paid from the trust fund account, the corresponding member's account receivable ledger must show proper credit to the member's account.

### **Long-term Payments**

For long-term payments, facility staff must obtain a signed statement from the member or responsible party authorizing long-term payments on the member’s behalf. Examples of long-term payments include insurance premiums, church tithe and cable TV. If the facility:

* has a signed statement from the member authorizing the facility to pay long-term payments on the member’s behalf, they do not need a monthly receipt from the vendor; or
* does not obtain a signed statement from the member or authorized representative (AR) authorizing it to pay the monthly payment on the member's behalf, the facility must have a vendor receipt that includes all items previously identified.

### **Daily Withdrawals for Minor Purchases or Petty Cash Withdrawals**

Members usually require small amounts of money to meet their daily needs for items such as soft drinks, snacks, etc. It is often difficult to keep supporting documents for all such minor purchases.

The member's signature or authorization for a cash withdrawal must be on the individual member ledger, the cash envelope or on a receipt.

### **Bulk Purchases**

Bulk purchase of the same items may be made by the facility. In this case, the member's signature and the amount of the purchase must be on the member ledger or a receipt.

## 7277 Member Authorization

Revision 18-2; Effective September 3, 2018

If the member is unable to sign or initial the transaction, or if the member signs his or her name with a mark (X), the transaction must be signed by a witness. A witness is anyone other than the:

* facility employee who is responsible for managing the trust fund accounts;
* supervisor of the employee who manages the trust fund account; or
* person who is receiving payment for services to the member.

## 7278 Refunds to Discharged or Deceased Members

Revision 18-2; Effective September 3, 2018

The facility must refund the full balance of the member's monies deposited in his or her trust fund account within five days after the member is discharged. If the member dies, there should be no payment from his or her trust fund account other than the refund to the responsible party. No funds may be dispensed to reimburse the facility for damages caused by the member to an assisted living (AL) apartment. If there is a responsible party, the facility may request voluntary reimbursement prior to the refund, but the responsible party is not obligated to agree.

Maintenance to the facility is included in the cost report as an allowance expense.

The two types of refunds are listed below:

**Check** — If the refund was made by check, the cancelled check or a copy of the receipt must be signed by the member or responsible party.

**Cash** — If the refund was made by cash, the receipt must be signed by the member or responsible party.

## 7300 Respite Care

Revision 18-2; Effective September 3, 2018

Respite services in the STAR+PLUS Home and Community Based Services (HCBS) program are available on an emergency or short-term basis to relieve those persons normally providing unpaid care for a STAR+PLUS HCBS program member unable to care for himself or herself.

## 7310 Service Coordination Duties Related to Respite Care

Revision 18-2; Effective September 3, 2018

To be eligible for respite services, the member must live in his or her own home or with relatives or other individuals. The member may not live in an adult foster care (AFC) or assisted living (AL) setting.

The respite provider must not be a primary caregiver, whether or not the respite provider is related to the member, and must not live with the STAR+PLUS Home and Community Based Services (HCBS) program member for whom respite is needed. If the member's primary caregiver is the paid attendant who also provides uncompensated care, in-home respite may be provided only during those hours the primary caregiver would be providing uncompensated care to the member. If the primary caregiver is the paid attendant and will be absent during hours for which the primary caregiver is normally paid, it is the employer of record who has the obligation to provide a substitute attendant during this period.

Respite services is intended to relieve the primary caregiver during emergency or planned short-term periods. Respite must be authorized on the individual service plan (ISP) before it can be delivered. The respite rate for out-of-home settings includes payment for room and board. There are no member copayment or room and board charges for respite in out-of-home settings.

The service coordinator is responsible for documenting the respite care services needed by the member. For example, a member needs respite every Friday afternoon so the primary caregiver can attend class, or a member's primary caregiver has three four-day trips planned during the ISP year, or a caregiver has a history of emergency hospitalizations. Documentation must also support that the member meets the eligibility criteria for respite. The service coordinator should provide supporting documentation regarding the number of hours requested or authorized when the 30-day maximum is requested or authorized. Respite cannot be authorized retroactively. For STAR+PLUS HCBS program members who have an emergency need for respite and respite is not authorized on the ISP, the provider must contact the managed care organization (MCO) for authorization prior to delivery of respite services.

The member must be given the opportunity to choose from the contracted providers that are appropriate considering the member’s needs and the licensed capabilities of the provider. In-home respite is provided by licensed providers contracting with the MCO and/or a Home and Community Support Services Agency (HCSSA) that is contracted with the MCO to provide services. Out-of-home respite is provided by licensed nursing facilities, licensed personal care facilities and licensed AFC homes.

The provider who delivers in-home respite is responsible for providing the personal assistance services authorized on the ISP, with the possible exception of delegated nursing tasks. When a member is receiving in-home respite and the attendant providing the personal care is not the same attendant to whom the nursing tasks were delegated, the nurse may directly provide the nursing care. It is necessary for the MCO to modify the ISP to include the increased direct nursing based on information provided by the provider. Other services (for example, physical therapy or minor home modifications) may continue to be delivered at the same time as the in-home respite.

Respite services can be authorized as often as needed for caregiver relief or emergency absences of the caregiver up to the 30-day maximum per ISP year, within the limit of the member's cost limit. Respite must be authorized 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), in daily units. For example, if two hours of respite are to be used per week, the ISP authorization is for five units. The calculation is two hours per week times 52 weeks = 104 hours divided by 24 hours = 4.33 units, rounded to next higher unit, or 5. The annual limit on respite services is 30 days, equivalent to 720 hours (30 days times 24 hours per day), unless approval to exceed the 30-day limit is given by the MCO. The MCO, who has overall responsibility for the coordination of STAR+PLUS HCBS program services, must keep track of the units a member has used. The provider may use [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-managed-care-programs-communication), Managed Care Programs Communication, to notify the MCO of the dates and duration of respite services delivered so the MCO can track the number of respite days used.

## 7311 MCO Approval to Exceed the Respite Service Cap

Revision 18-2; Effective September 3, 2018

To request approval to exceed the annual individual service plan (ISP) 30-day limit on respite services, the provider must send a written request to the managed care organization (MCO) documenting the:

* need for additional respite units;
* number of additional units needed;
* cost estimate considering the location(s) in which the respite services will be delivered;
* overall service plan is within the member's ISP cost limit; and
* service plan is adequate and meets the individual's needs in the community.

The provider includes his/her telephone number and address in the written request. The MCO provides written approval or disapproval of the request.In reviewing requests to exceed the respite limit, the MCO must consider the intent of respite services to relieve the caregiver during emergency or planned short-term periods. Approval to exceed the 30-day maximum should be related to situations such as:

* members whose caregivers become ill, hospitalized or have a family emergency;
* extenuating circumstances that cause care to be required beyond routine or periodic respite relief; or
* a breakdown in member and/or family support, causing an increased risk of institutionalization because of the physical burden and emotional stress of providing continuous support and care to a dependent person.

## 7320 In-Home Respite Care

Revision 18-2; Effective September 3, 2018

In-home respite care offers services provided by managed care organization (MCO) contracted providers, on a short-term basis, to members unable to care for themselves because of the absence or need of relief for their unpaid caregiver.

In-home respite care is provided in the member's own home, as authorized on the member's [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 the unpaid caregiver needs relief. The provider is responsible for providing the tasks authorized on the member's ISP and [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, during the time the member is receiving in-home respite care.

The provider must document in the member's clinical record:

* the in-home respite services provider was given a briefing on the member's status, needs and preferences prior to delivering services; and
* dates and duration of the services delivered.

In-home respite services helps prevent member and/or family support breakdown and the consequent institutionalization, which may result from the physical burden and emotional stress of providing continuous support and care to a dependent person.

The in-home respite services provider must deliver the personal assistance services. The MCO may allow the in-home respite services provider's registered nurse (RN) the option of either directly providing any needed nursing services or delegating the nursing task(s) to the in-home respite services provider.

In-home respite services is not intended to be used when the caregiver needs to be out of the house for short periods of time (for example, to go to the pharmacy or grocery store to pick up medications or grocery items). The caregiver should be encouraged to be out of the house for brief respite when the attendant is providing the personal assistance services.

## 7330 Out-of-Home Respite Services

Revision 18-2; Effective September 3, 2018

Out-of-home respite services provide a 24-hour living arrangement in an adult foster care (AFC) home, a licensed personal care facility or a licensed nursing facility (NF) for persons who, because of the unavailability of their primary caregiver, have no one to meet their needs on a short-term basis. Services may include meal preparation, housekeeping, personal care and nursing tasks, help with activities of daily living (ADLs), supervision, and the provision or arrangement of transportation.

Nursing tasks may be directly provided by licensed nurses in out-of-home respite services or may be delegated as determined by the professional judgment of the provider's registered nurse (RN), unless facility licensure prohibits delegation.

## 7331 Member Eligibility

Revision 18-2; Effective September 3, 2018

The respite services member must:

* meet all eligibility criteria, as specified in [Section 3200](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-sph-waiver-eligibility-and-services#3200), Eligibility;
* reside in his or her own home;
* have a caregiver who needs relief either on an emergency or planned short-term basis; and
* not reside in adult foster care (AFC) or a personal care facility.

The applicant for STAR+PLUS Home and Community Based Services (HCBS) program respite services must complete the same eligibility determination process as other STAR+PLUS HCBS program members.

## 7332 Provider Qualifications

Revision 18-2; Effective September 3, 2018

Out-of-home respite services providers must be a:

* licensed nursing facility (NF);
* licensed personal care facility; or
* Texas Health and Human Services Commission (HHSC) licensed adult foster care (AFC) home.

In order to deliver STAR+PLUS Home and Community Based Services (HCBS) program out-of-home respite services, the provider must complete and sign a contract with the managed care organization (MCO). The contract must be signed by both the provider and MCO prior to the provider serving members.

## 7333 Description of Services

Revision 18-2; Effective September 3, 2018

The STAR+PLUS Home and Community Based Services (HCBS) program member may receive out-of-home respite services in a nursing facility (NF), a personal care facility or a Texas Health and Human Services Commission (HHSC) licensed adult foster care (AFC) home, with services to be delivered as authorized on the individual service plan (ISP) and in accordance with facility licensure and contract requirements. The STAR+PLUS HCBS program member may take any adaptive aids he or she is using to the out-of-home respite setting.

The managed care organization (MCO) provides the out-of-home respite provider with the assessments and ISP attachments pertinent to the services the member will receive while in the facility or home. The provider must deliver services as identified on the member's ISP attachments.

## 7334 Respite Services in a Personal Care Facility or AFC Home

Revision 18-2; Effective September 3, 2018

The STAR+PLUS Home and Community Based Services (HCBS) program member receiving respite services in a personal care facility or adult foster care (AFC) home may receive nursing services or therapy services from outside providers while residing in the respite setting. The need for any service must be authorized on the individual service plan (ISP) before the member receives the service.

The STAR+PLUS HCBS program member receiving respite services in an AFC home must qualify for placement in the particular level of AFC home by meeting the specific criteria for that level of home.

Nursing services provided in a Level I or Level II AFC home may be delegated, according to the professional judgment of the provider's registered nurse (RN). Personal care facility licensure prohibits delegation of nursing tasks. In assisted living (AL) out-of-home respite settings, nursing services must be provided directly by licensed nurses.

## 7335 Respite Services in a Nursing Facility

Revision 18-2; Effective September 3, 2018

The STAR+PLUS Home and Community Based Services (HCBS) program member receiving respite services in a nursing facility (NF) may receive therapy services from outside providers. The member's need for any service must be authorized on the individual service plan (ISP) before receiving the service. The NF is responsible for providing the needed nursing services to the member.

## 7340 Room and Board

Revision 18-2; Effective September 3, 2018

Room and board charges are not allowable charges to the STAR+PLUS Home and Community Based Services (HCBS) program member receiving out-of-home respite services. Room and board charges are included in the rates for the respite services.

## 7400 Emergency Response Services

Revision 18-2; Effective September 3, 2018

## 7410 Introduction to ERS

Revision 18-2; Effective September 3, 2018

Emergency response services (ERS) are provided through an electronic monitoring system and are used by functionally impaired adults who live alone or who are functionally isolated in the community. In an emergency, the member can press a call button to signal for help. The electronic monitoring system, which has a 24-hour, seven-days-a-week monitoring capability, helps to ensure the appropriate person or service provider responds to an alarm call from a member.

## 7420 ERS Program Purpose

Revision 18-2; Effective September 3, 2018

The purpose of emergency response services (ERS) under the STAR+PLUS Home and Community Based Services (HCBS) program is to:

* enable aged and disabled persons to maintain dignity, independence, individuality, privacy, choice and decision-making ability; and
* prevent or reduce inappropriate institutional care by providing home-based care and other forms of less intensive care.

## 7430 Member Eligibility

Revision 18-2; Effective September 3, 2018

In order to be eligible for emergency response services (ERS) through the STAR+PLUS Home and Community Based Services (HCBS) program, a member must:

* have been determined eligible for the STAR+PLUS HCBS program;
* be mentally alert enough to operate the equipment properly, in the judgment of the managed care organization service coordinator;
* have a telephone with a private line, if the system requires a private line to function properly;
* be willing to sign a release statement that allows the responder to make a forced entry into the member's home if he or she is asked to respond to an activated alarm call and has no other means of entering the home to respond; and
* live in a place other than an assisted living (AL) or adult foster care (AFC) setting, institution or any other setting where 24-hour supervision is available.

Members eligible for Community First Choice (CFC) must receive ERS through CFC, not through the STAR+PLUS HCBS program.

Program Support Unit (PSU) staff will not accept or approve an initial or reassessment ISP with a "From" date of January 1, 2016, or later that includes personal assistance services (PAS) or ERS for non-medical assistance only (MAO) STAR+PLUS HCBS program members.

MCOs must post Form H2067-MC, Managed Care Programs Communication, to TxMedCentral to notify PSU if a member is receiving both STAR+PLUS HCBS program and CFC services concurrently. This is required for all non-MAO STAR+PLUS HCBS program members who also receive CFC, regardless of whether the individual service plan (ISP) is manually posted or electronically submitted.

## 7440 Referral and Selection of Providers

Revision 18-2; Effective September 3, 2018

If the member is considered eligible for emergency response services (ERS), the managed care organization (MCO) shares its contracted list of all ERS providers with the member, who selects a provider from the list. The member can request a provider change; however, the member must contact his or her service coordinator to request the change.

The MCO follows the procedures in [Section 3600](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-sph-waiver-eligibility-and-services#3600), Ongoing Service Coordination, and gives members an explanation of the service and requirements.

## 7450 Duties Related to ERS

Revision 18-2; Effective September 3, 2018

If the member wants and appears to be in need of emergency response services (ERS), the service coordinator determines if the member meets the general criteria for participating in ERS, as described in [Section 7430](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-7000-sph-waiver-program-services#7430), Member Eligibility. The managed care organization (MCO) may involve other members of the interdisciplinary team in the decision regarding the member's physical and mental ability to participate in the ERS program. ERS may be authorized through the STAR+PLUS Home and Community Based Services (HCBS) program when it appears the member may need the capability to notify a respondent of an emergency. ERS services are limited to those individuals who:

* live alone;
* are alone for significant parts of the day;
* have no regular caregiver for extended periods of time and who would otherwise require extensive supervision; or
* live with someone who is too incapacitated to call for help should the need arise.

During the course of the services, the MCO and the provider have the joint responsibility of keeping each other informed of changes or problems.

## 7460 Provider Duties

Revision 18-2; Effective September 3, 2018

Managed care organization contracted providers' duties specific to emergency response services are described in Texas Administrative Code, Part 1, Chapter 52, Subchapter D.

## 7500 Home-Delivered Meals

Revision 18-2; Effective September 3, 2018

## 7510 Description

Revision 18-2; Effective September 3, 2018

The home-delivered meal benefit provides hot, nutritious meals that are served in the member's home. Meals provided by contracted agencies are approved by a dietitian consultant who is either a registered dietitian licensed by the Texas State Board of Examiners of Dietitians or has a baccalaureate degree with major studies in food and nutrition, dietetics or food service management.

## 7520 Provider Responsibilities

Revision 18-2; Effective September 3, 2018

Home-delivered meals are delivered to the member’s home as authorized by the managed care organization (MCO). The individual delivering the meal reports any member illnesses, potential threats to his or her safety or observable changes in the member’s condition to the provider. The provider must notify the service coordinator about the report within 24 hours.

The provider also informs the service coordinator whenever:

* the home-delivered meal is found uneaten or untouched and the member cannot be found; or
* the meals are repeatedly found to be uneaten or untouched.

This report must also reach the MCO within 24 hours of the event.

The MCO must notify the provider on the day that meals services are suspended. The MCO must suspend services in any of the following situations:

* The member enters an institution.
* The member requests that services be suspended or terminated.
* The member dies.
* The service coordinator directs the provider to suspend services.

Unless the interruption is the result of one of the above situations, the provider must obtain the service coordinator's approval for service interruptions of more than two consecutive days. When the member requests that services be suspended and specifies a date for services to resume, the provider is not required to notify the service coordinator.

## 7520.1 Frozen or Shelf-Stable Meals

Revision 10-0; Effective September 1, 2010

A provider that contracts with the managed care organization (MCO) to provide home-delivered meals must agree to provide services:

* for a specific number of service days, with a minimum of five meals per week; and
* to all eligible members in the service area unless services are suspended or the provider is unable to provide a certain therapeutic medical diet.

Providers of home-delivered meals must submit a waiver request to the MCO if the provider determines that delivery of frozen or shelf-stable meals is required for certain individuals within the provider’s contracted service area. Any waiver granted is effective for a period not to exceed one fiscal year. The provider must not implement the waiver for delivery of a hot meal five days a week before MCO approval of the waiver request.

## 7600 Transition Assistance Services

Revision 18-2; Effective September 3, 2018

## 7610 Introduction

Revision 18-2; Effective September 3, 2018

Transition Assistance Services (TAS) is a STAR+PLUS Home and Community Based Services (HCBS) program service designed to assist Medicaid members who are transitioning from a nursing facility (NF) to the community. An NF resident discharged from the facility into a waiver program is eligible to receive up to $2,500 in TAS for assistance with setting up a household. TAS is available on a one-time only basis and is not available to residents moving from an NF who are approved for assisted living (AL) services or adult foster care (AFC) services.

**7611 Service Description**

Revision 18-2; Effective September 3, 2018

Transition Assistance Services (TAS) pays for non-recurring, set-up expenses for members transitioning from nursing facilities to a home in the community. TAS is a benefit to cover basic and essential household items. Allowable expenses are those necessary to enable the member to establish a basic household and may include:

* payment of security deposits required to lease an apartment or home;
* set-up fees or deposits to establish utility services for the home, including telephone, electricity, gas and water;
* purchase of essential furnishings for the apartment or home, including table, chairs, window blinds, eating utensils, food preparation items and bath linens, cleaning supplies and toiletries;
* payment of moving expenses required to move into or occupy the home or apartment; and
* payment for services to ensure the health and safety of the member in the apartment or home, such as pest eradication, allergen control or a one-time cleaning before occupancy.

TAS does not include relocation services and is not available to assist the applicant in locating a residence.

## 7620 Procedures at the Initial Interview

Revision 18-2; Effective September 3, 2018

All STAR+PLUS Home and Community Based Services (HCBS) program applicants who are in a nursing facility (NF) must be advised of the availability of Transition Assistance Services (TAS) and screened for the potential need for services.

Within **14 business days** of learning of a request to move to the community, the managed care organization (MCO) service coordinator discusses the applicant's or member’s available living arrangements in the community and asks the applicant or member where he or she intends to live upon discharge from the NF.

TAS may be considered when the applicant or member:

* plans to rent an unfurnished apartment;
* plans to rent an unfurnished house;
* has a home, but all the utilities have been off while in the NF;
* has a home, but it may need cleaning, pest eradication or allergen control before it can be occupied again; or
* needs his or her belongings moved to the new residence.

If these or any other situations exist in which the applicant could benefit from TAS services, continue with the screening for TAS.

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## 7630 Identification of Needed Items and Services

Revision 18-2; Effective September 3, 2018

The managed care organization (MCO) conducts the interview with the applicant or authorized representative (AR) to identify the applicant's needs and determine if other resources are available to meet the needs. The MCO service coordinator completes Form 8604, Transition Assistance Services (TAS) Assessment and Authorization, by marking each identified need and writing a description of the exact need.

Example: If the applicant needs a deposit made for electricity, the MCO enters the name and address of the utility company and the amount required.

The applicant selects a TAS agency from the list of contracted agencies.

## 7640 Items and Services Included Under TAS

Revision 18-2; Effective September 3, 2018

[Form 8604](https://hhs.texas.gov/laws-regulations/forms/8000-8999/form-8604-transition-assistance-services-tas-assessment-authorization), Transition Assistance Services (TAS) Assessment and Authorization, is divided into three main categories: deposits, household needs and site preparation needs.

## 7640.1 Deposits

Revision 18-2; Effective September 3, 2018

Deposits include security deposits for rental and utilities, including basic telephone service. Security deposits or utility deposits must be in the applicant’s or member’s name.

Security deposits may be paid as long as the payment is specifically called a security deposit and not rent, the payment is for a one-time expense, and the amount of the payment is no more than the equivalent of two months rent. Transition Assistance Services (TAS) cannot pay for rent.

TAS can be used to pay for arrears on previous utilities if the account is in the member's name and the member will not be able to get the utilities unless the previous balance is paid. TAS cannot pay the first month's payment on utilities.

TAS can be used to pay for a telephone since it is a basic need, but minutes or services on the telephone are not allowable expenses.

TAS cannot pay for any charges for upgraded services beyond the basic service.

TAS funds can be used to pay for initial setup or reconnection fees for propane or butane service, including the minimal supply of fuel if the utility company has a policy that requires a minimal supply of fuel to be delivered during the initial or reconnection service call. TAS funds cannot be used to top off a tank with fuel when the member’s home is connected and has a supply of butane or propane.

## 7640.2 Household Needs

Revision 18-2; Effective September 3, 2018

Household needs include basic furniture/appliances. This includes bedroom furniture, living room furniture, kitchen furniture, refrigerator, stove, washer, dryer, cleaning supplies and toiletries, etc.

An applicant or member may request a specific brand or type of appliance, furniture or other Transition Assistance Services (TAS) item as long as the applicant's or member’s needs are met within the cost limit.

TAS items may be placed in a home other than the applicant’s or member’s only when furnishings are not available and are necessary for the applicant or member to transition to the community. TAS cannot pay for items that would only be used by the other person.

If existing items are not usable and the lack of a usable basic or essential item creates a barrier keeping the individual from returning to the community, the item is considered a need.

## 7640.3 Housewares

Revision 18-2; Effective September 3, 2018

Housewares can include pots, pans, dishes, silverware, cooking utensils, linens, towels, clock and other small items required for the household.

## 7640.4 Small Appliances

Revision 18-2; Effective September 3, 2018

Small appliances include a microwave oven, electric can opener, coffee pot, toaster, etc.

## 7640.5 Cleaning Supplies

Revision 18-2; Effective September 3, 2018

Cleaning supplies include a mop, broom, vacuum, brushes, soaps and cleaning agents.

## 7640.6 Other Items Not Listed

Revision 18-2; Effective September 3, 2018

Any special requests from the applicant or member not covered in the general list that meet the criteria as basic essential items to move to the community may be considered.

## 7641 Services and Items Not Included in Transition Assistance Services

Revision 18-2; Effective September 3, 2018

Transition Assistance Services (TAS) does not include any items or services that are included under STAR+PLUS Home and Community Based Services (HCBS) program services such as adaptive aids, minor home modifications, medical supplies or medications.

TAS does not include any recreational items or appliances, including televisions, VCR or DVD players, games, computers, cable TV, satellite TV, exercise equipment, vehicles or other modes of transportation.

TAS does not cover the cost of repairs or expansion on the member’s dwelling. TAS is not used for remodeling or renovation, upgrading of existing items or purchase of non-essential items.

TAS funds cannot be used for food. The managed care organization may refer the individual to emergency Supplemental Nutrition Assistance Program (SNAP) or local food pantry resources.

Room and board are not allowable TAS expenses.

TAS does not pay for monthly rental or mortgage agreements or ongoing utility charges.

## 7642 Site Preparation

Revision 18-2; Effective September 3, 2018

Site preparation can include the following services:

* moving expenses, which include the cost of moving the applicant's or member’s items from another location, or delivery charges on large purchased items;
* pest eradication, if the applicant's or member’s place of residence has been unattended and some type of extermination is needed;
* allergen control, if the applicant's or member’s place of residence has been unattended or the applicant or member is moving into a place that poses a respiratory health problem; or
* one-time cleaning, if the applicant's or member’s place of residence has been unattended or the applicant or member is moving into a private home or apartment where pre-move-in cleaning should not be expected (for example, a family friend has an empty house available, but cannot provide the cleaning).

Transition Assistance Services cannot pay for septic systems.

## 7650 Estimated Cost of Items and Services

Revision 18-2; Effective September 3, 2018

The managed care organization (MCO) service coordinator provides a description and estimated cost of each item identified as needed under each service category on [Form 8604](https://hhs.texas.gov/laws-regulations/forms/8000-8999/form-8604-transition-assistance-services-tas-assessment-authorization), Transition Assistance Services (TAS) Assessment and Authorization. The actual cost of an item may be used, if known. The amounts, either actual or estimated, must be less than or equal to $2,500.

The service coordinator must be as specific as possible when describing what items are needed and the estimated cost. The description must include size, color, specific types or any other identifying information, as specified by the member, which will assist the TAS agency in meeting the member’s needs.

## 7651 Totaling the Estimated Cost and Authorization of Transition Assistance Services

Revision 18-2; Effective September 3, 2018

The MCO service coordinator totals each section of [Form 8604](https://hhs.texas.gov/laws-regulations/forms/8000-8999/form-8604-transition-assistance-services-tas-assessment-authorization), Transition Assistance Services (TAS) Assessment and Authorization, and enters the amounts in the totals section to arrive at the final amount to be authorized under the TAS program. The $2,500 total amount is not entered as a flat rate.

The applicant or member must sign the form stating that the items listed are the basic, essential needs required to move into the community, and he or she agrees that the TAS agency selected is authorized to make the purchases for him or her.

The applicant or member selects a TAS agency from the list of contracted agencies.

The MCO service coordinator must explain to the applicant that the service will not be authorized until the applicant is determined eligible for STAR+PLUS Home and Community Based Services (HCBS) program services, and notified in writing that he or she is eligible. The MCO service coordinator must contact the applicant or authorized representative (AR) before certification to verify the applicant has made arrangements for relocating to the community and has finalized a projected discharge date.

The MCO service coordinator includes TAS on Form H1700-1, Individual Service Plan (Pg. 1). The MCO service coordinator sends the applicant the notification of eligibility and sends the TAS agency Form 8604 and the authorization. The completion date on the authorization is **two business days** before the projected nursing facility (NF) discharge date. Allow at least **five business days** between the authorization date and the completion date. The TAS agency is expected to have all services and items completed by that date. For situations in which a shorter completion date is needed, the MCO service coordinator must contact the TAS agency and negotiate an earlier date. The MCOs will code those items as delivered prior to the arrival date.

Additional applicant information to the TAS agency may be included on Form 8604 or [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-managed-care-programs-communication), Managed Care Programs Communication. Form 8604 is mailed after the applicant or member is determined eligible for waiver services.

The TAS agency may only obtain items or services for which the agency has received authorization on Form 8604. If the TAS agency identifies other items or services that the applicant or member may need, the TAS agency must obtain prior approval from the MCO. Refer to Section 7652 below.

## 7652 Changes to the Authorization

Revision 18-2; Effective September 3, 2018

If the Transition Assistance Services (TAS) agency or the member identifies additional items required by the member after the TAS authorization has been sent, the TAS agency must obtain approval from the managed care organization (MCO) on [Form 8604](https://hhs.texas.gov/laws-regulations/forms/8000-8999/form-8604-transition-assistance-services-tas-assessment-authorization), Transition Assistance Services (TAS) Assessment and Authorization, prior to obtaining the item/service.

The TAS agency must stay within the total dollar amount authorized on Form 8604. If the total amount of the items or services needed is more than the total amount authorized, the TAS agency must obtain prior approval and an updated Form 8604 from the MCO. The MCO service coordinator must update Form 1700-1, Individual Service Plan (Pg. 1), to reflect the change in the amount for funds authorized.

The MCO must send an amended Form 8604 updating the authorization to the TAS agency within **two business days** with the additional items and amounts authorized.

MCO approval is required to authorize delivery of TAS services.

## 7660 Transition Assistance Services Agency Responsibilities

Revision 18-2; Effective September 3, 2018

The Transition Assistance Services (TAS) agency accepts all members referred by the managed care organization (MCO). Upon receipt of the authorization, the TAS agency must review the forms carefully and contact the MCO if there are any questions regarding what has been authorized. This contact must occur by the **next business day** of receipt of the forms, and before any TAS purchase is made. The MCO contacts the member, if necessary, to discuss the item in question. The MCO provides a revised TAS authorization form within **two business days** if it clarifies an item is authorized or approves a change to the authorization.

The TAS agency purchases the authorized items or services and arranges and pays for the delivery of the purchased items, if applicable. The TAS agency only purchases services or items within the dollar amount authorized by the MCO. The TAS agency contacts the member or authorized representative (AR), if necessary, to coordinate service delivery.

The TAS agency delivers the authorized services by the completion date recorded on the TAS authorization form. The agency provides a copy of the purchase receipts and any original product warranty information to the member. The TAS agency maintains the original purchase receipts, including sales tax, delivery or installation charges.

The TAS agency orally notifies the MCO of a delivery delay before the completion due date and documents the delay. The agency also contacts the member or AR by the completion date to confirm that all authorized TAS services were delivered.

## 7670 Three-Day Monitor Required

Revision 10-0; Effective September 1, 2010

The managed care organization (MCO) monitors the member within **three business days** after the discharge date to assure that all services and items authorized through the Transition Assistance Services (TAS) agency have been received. If the member reports that any items have not been delivered or services not performed, the MCO contacts the TAS agency by telephone and follows up in writing. Written documentation must be maintained in the member’s case record.

## 7680 Failure to Leave the Facility

Revision 18-2; Effective September 3, 2018

While the managed care organization (MCO) makes every effort to confirm that the member has definite plans to leave the facility, there may be situations in which the member changes his or her mind or has a change in his or her health making it impossible for the member to relocate to the community as planned. In this situation, the MCO notifies the Transition Assistance Services (TAS) agency that the member is no longer moving and no further items are to be purchased.

The TAS agency must attempt to return any item(s) purchased on behalf of the individual and collect a refund for the amount of the purchase. The TAS agency also must attempt to recoup security, utility and other deposits paid on behalf of the individual.

* If the TAS agency is unsuccessful in returning the item(s) for the amount of monies paid, or the deposits paid on behalf of the member cannot be recouped, the TAS agency is entitled to cost of the item(s) and/or reimbursement for deposits paid, not to exceed the authorized amount. The TAS agency sends the MCO written notice stating the item(s) could not be returned or the deposits could not be recouped. The MCO contacts a local charity to donate the items and makes arrangements for pick up. The charity must serve individuals whose needs are similar to those of the individual for whom the items were purchased or must be dedicated to assisting individuals establish a home.
* If the TAS agency is able to return the item(s) or receives the deposits back, the TAS agency is not entitled to reimbursement. If the TAS agency recoups part of the monies paid, the TAS agency is entitled to the costs of the item(s) or deposits less any monies recouped. Any claims that had been filed and paid for the item(s) or deposits would need to be adjusted by the TAS agency to pay the monies back to the MCO.
* If a service has already been provided (for example, pest eradication), the TAS agency is entitled to the costs of the service, not to exceed the authorized amount.

If the member is only in the community for a few days and returns to the nursing facility (NF), the member keeps the item(s) purchased through TAS.

## 7690 Member Notifications and Appeals

Revision 18-2; Effective September 3, 2018

The purpose and limitations of Transition Assistance Services (TAS) must be explained to the applicant or member when determining the applicant's or member’s needs. The applicant or member may appeal a decision regarding a needed item or service, but services should not be delayed due to the appeal.

[Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-starplus-program-services), Notification of Managed Care Program Services, must be sent advising the applicant or member of the date of eligibility for the STAR+PLUS Home and Community Based Services (HCBS) program service before the authorization of any services. If the applicant or member has finalized the discharge plans, [Form 8604](https://hhs.texas.gov/laws-regulations/forms/8000-8999/form-8604-transition-assistance-services-tas-assessment-authorization), Transition Assistance Services (TAS) Assessment and Authorization, may be sent to the TAS provider on the same day Form H2065-D is sent to the applicant or member. If discharge plans are not finalized at the time of eligibility, Form 8604 may be sent at a later date. TAS information may be addressed in the Form H2065-D comments section.

The managed care organization (MCO) notifies the applicant or member in writing of any changes in TAS services or items. The TAS provider is given provider authorization to deliver TAS services on Form 8604.