SPH, Section 1000, State of Texas Access Reform Plus (STAR+PLUS) Managed Care

Revision 18-2; Effective September 3, 2018

1100 Program Overview

Revision 18-2; Effective September 3, 2018

The 74th Texas Legislature implemented the State of Texas Access Reform Plus (STAR+PLUS) program to create a cost-neutral managed care system to combine acute care with long-term services and supports (LTSS). The STAR+PLUS program does not change Medicaid eligibility or services. It does change the way Medicaid services are delivered.

The STAR+PLUS program combines acute care and LTSS, such as assisting in a member's home with activities of daily living (ADL), home modifications, respite (short-term supervision) and personal assistance. These services are delivered through providers contracted with managed care organizations (MCOs).

The STAR+PLUS program provides a continuum of care with a wide range of options and increased flexibility to meet individual needs. The program has increased the number and types of providers available to Medicaid members.

Service coordination, available to all members, is the main feature of the STAR+PLUS program. It is a specialized case management service for program members who need or request it. Service coordination means that plan members, family members, and providers can work together to help members get acute care, LTSS, Medicare services for dually-eligible members and other community support services.

The STAR+PLUS Home and Community Based Services (HCBS) program is a program approved for the managed care delivery system, designed to allow individuals who qualify for nursing facility (NF) care to receive LTSS in order to be able to live in the community.

Elements of the STAR+PLUS system are different from traditional service delivery. See the [Glossary](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/glossary) for the definition of terms specific to the STAR+PLUS program. For a dictionary of acronyms used in the STAR+PLUS Program, refer to [Appendix VII](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/appendices/appendix-vii-acronyms), Acronyms.

1110 Legal Basis

Revision 18-2; Effective September 3, 2018

Statutory basis for the STAR+PLUS program:

* Texas Administrative Code (TAC) §353.601-607 and §353.1153
* Government Code, Title 4, Executive Branch, Subtitle I, Health and Human Services, Chapter 533, Medicaid Managed Care Program

1120 Values

Revision 18-2; Effective September 3, 2018

The principles and practices that form the foundation for the STAR+PLUS Home and Community Based Services (HCBS) program are based on the following values:

* Members receive services based on their choices and ongoing assessment of their medical and functional needs.
* The service delivery system is accessible to the member, responsive to his or her needs and preferences, and flexible in honoring choices regarding living arrangement, services and mode of service delivery.
* Members use available family, community and third-party services and resources, as well as those provided through the STAR+PLUS HCBS program to meet their needs and identified goals.
* Services provided to the member must provide safe, cost-effective, and medically or functionally necessary alternatives to nursing facility (NF) placement that allow the member the opportunity to use and maintain family and community contacts and services.
* The service plan reflects the member's active participation in the assessment and planning process and his or her responsibility to provide as much self-care as possible.
* Services must support the member's efforts to retain or regain as much independence as possible in the activities of daily living (ADLs), living arrangement and other areas of personal choice, and in meeting any goals.
* Individuals and members are provided the education, support and services needed to support the member's efforts to remain in or return to the community.
* Within the constraints imposed by the cost limit on a member's individual service plan (ISP), the program promotes the member's active involvement and choices regarding the services provided.

1130 Service Model

Revision 18-2; Effective September 3, 2018

1131 Service Delivery Model

Revision 18-2; Effective September 1, 2018

Individuals enrolled in the STAR+PLUS program may select a delivery model for personal assistance services (PAS) or Community First Choice (CFC) services identified on [Form H2060](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-needs-assessment-questionnaire-taskhour-guide), Needs Assessment Questionnaire and Task/Hour Guide, [Form H6516](https://hhs.texas.gov/laws-regulations/forms/6000-6999/form-h6516-community-first-choice-assessment), Community First Choice Assessment, and [Form H2060-A](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-a-addendum-form-h2060), Addendum to Form H2060. Individuals receiving STAR+PLUS Home and Community Based Services (HCBS) program services may reside alone, with family members or others at locations of their choice in the community, in adult foster care (AFC) homes or in licensed assisted living facilities (ALFs).

The STAR+PLUS HCBS program provides individuals with an array of services, as identified on the individual service plan (ISP), necessary to allow the individual to remain in or return to a community setting. Services are delivered by providers contracted with managed care organizations (MCOs) to provide STAR+PLUS HCBS program services. The MCO completes all initial and annual service planning activities, and verifies, authorizes, coordinates and monitors services. Program Support Unit (PSU) staff coordinate with Medicaid for the Elderly and People with Disabilities (MEPD) specialists to determine financial eligibility for those individuals not already eligible for Supplemental Security Income (SSI) and use financial determinations by the Social Security Administration (SSA) for those individuals already eligible for SSI. (See [Section 3110](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3110), Medicaid, Medicare and Dual-Eligibles.)

STAR+PLUS members choose to participate in the agency option (AO), consumer-directed services (CDS) option or service responsibility option (SRO) delivery models.

* Members who choose the AO work with the MCO to coordinate service delivery for each service in the ISP.
* Members who choose the CDS model are given the authority to self-direct designated services. If the member chooses to self-direct designated services, the MCO coordinates delivery of non-member-directed designated services. In the CDS model, providers employed by the member or authorized representative (AR) must be qualified personnel to provide all authorized services when services are necessary. These personnel may be employed directly by or through personal service agreements or subcontracts with the providers. A member's services and service providers must be based on an MCO assessment of the member’s individual needs. More information is available in [Appendix XXVIII](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/appendices/appendix-xxviii-consumer-directed-services-cds-training-service-coordinators-cds-training-manual), Consumer Directed Services (CDS) Training for Service Coordinators and CDS Training Manual.
* In the SRO model, the provider is the attendant's employer and handles the business details (for example, paying taxes and doing the payroll). The provider also orients attendants to provider policies and standards before sending them to members' homes. The member or designated representative (DR) is responsible for most of the day-to-day management of the attendant's activities, beginning with interviewing and selecting the person who will be the attendant.

1140 Program Services

Revision 18-2; Effective September 3, 2018

1141 Services Available Under STAR+PLUS

Revision 18-2; Effective September 3, 2018

If there is a need identified by a service coordinator or a request for additional services from the member, the managed care organization (MCO) assesses the member to determine his or her needs and to develop an appropriate service plan. Since MCOs are at risk for paying for a range of acute care and long-term services and supports (LTSS), there is an incentive to provide innovative, cost-effective care from the onset in order to prevent or delay the need for more costly institutionalization.

STAR+PLUS members who do not have Medicare are required to choose an MCO and a primary care provider (PCP) in the MCO's network. These individuals can choose a specialist to be their PCP and they receive all services, both acute care and LTSS, from the MCO.

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

The STAR+PLUS program serves as an insurance policy if members have a need for LTSS at a future time. See [Section 3110](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-3000-waiver-eligibility-services#3110), Medicaid, Medicare and Dual-Eligibles, for additional information on dual-eligible coverage.

Medicaid-only members (those who do not receive Medicare) receive traditional Medicaid acute care services plus an annual check-up. For these members, the cost of acute care services is included in the capitation payment to the MCO. For dual-eligible members, the MCO’s capitation payment does not include the cost of acute care.

1142 Long-term Services and Supports

Revision 17-5; Effective September 1, 2017

Day Activity and Health Services (DAHS) and Personal Attendant Services (PAS) are available to STAR+PLUS members who meet functional eligibility requirements. Community First Choice (CFC) services are available to STAR+PLUS members who meet an institutional level of care, meet functional eligibility requirements, and who receive Supplemental Security Income (SSI) or receive SSI-related Medicaid. Additional services are available under the STAR+PLUS Home and Community Based Services (HCBS) program. For a complete list of services provided under the STAR+PLUS program, refer to the managed care contracts governing the STAR+PLUS program at <https://hhs.texas.gov/services/health/provider-information/managed-care-contracts-manuals>.

1143 STAR+PLUS Services

Revision 17-1; Effective March 1, 2017

STAR+PLUS program members have access to medically and functionally necessary services available in the state plan. In addition, some members are eligible for additional services available in the STAR+PLUS Home and Community Based Services (HCBS) program services, in addition to their traditional state plan STAR+PLUS services. See:

* [Section 1143.1](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-1000-sph-state-texas-access-reform-plus-starplus-managed-care#1143.1), Services Available to STAR+PLUS Members; and
* [Section 1143.2](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-1000-sph-state-texas-access-reform-plus-starplus-managed-care#1143.2), Services Available to STAR+PLUS Home and Community Based Services (HCBS) Program Members.

## 1143.1 Services Available to STAR+PLUS Members

Revision 18-2; Effective September 3, 2018

The Texas Health and Human Services Commission (HHSC) contracts with Medicaid managed care organizations (MCOs) for the provision of STAR+PLUS services. These Medicaid MCOs are responsible for providing a benefit package to members that includes all medically-necessary services covered under the traditional, fee-for-service (FFS) Medicaid programs, with the exception of non-capitated services provided to Medicaid members outside of the MCO capitation and listed in each managed care contract. (For example, Attachment B-1, Section 8.2.2.8, of the [Uniform Managed Care Contract (UMCC)](https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/UniformManagedCareContract.pdf)).

STAR+PLUS members also receive enhanced benefits compared to the traditionalFFS Medicaid coverage:

* waiver of the three-prescription per month limit for members not covered by Medicare;
* waiver of spell illness limitation for members admitted to a facility as a result of their severe and persistent mental illness.

Medicaid MCO contractors are responsible for providing a benefit package to members that includes an annual adult well check for members age 18 and over, and prescription drugs. STAR+PLUS MCO contractors should refer to the current *Texas Medicaid Provider Procedures Manual* (TMPPM) and the *Texas Medicaid Bulletin* postings for a more inclusive listing of limitations and exclusions that apply to each Medicaid benefit category. (These documents can be accessed online at: [www.tmhp.com (link is external)](http://www.tmhp.com/Pages/default.aspx).)

The services listed in the managed care contracts (for example, UMCC) are subject to modification based on federal and state laws and regulations and program policy updates.

1143.1.1 Services Included Under the MCO Capitation Payment

Revision 18-2; Effective September 3, 2018

Services included under the managed care organization (MCO) capitation payment include:

* ambulance services;
* audiology services, including hearing aids;
* behavioral health services, including:
  + - inpatient mental health services;
    - outpatient mental health services;
    - outpatient chemical dependency services;
    - mental health rehabilitation for non-duals;
    - mental health targeted case management for non-duals;
    - detoxification services;
    - psychiatry services; and
    - counseling services;
* birthing services provided by a certified nurse midwife in a birthing center;
* chiropractic services;
* dialysis;
* durable medical equipment (DME) and supplies;
* emergency services;
* family planning services;
* home health care services for acute conditions;
* hospital services;
* laboratory;
* long-term services and supports (LTSS) (See Section 1143.1.2 below);
* medical checkups and Comprehensive Care Program (CCP) services for Medicaid for Breast and Cervical Cancer (MBCC) members under age 21;
* oncology services;
* optometry, glasses and contact lenses, if medically necessary;
* podiatry;
* prenatal care;
* prescription drugs;
* primary care services;
* preventive services including an annual adult well check;
* radiology, imaging and X-rays;
* specialty physician services;
* therapies, including physical, occupational and speech for acute conditions;
* transplantation of organs and tissues; and
* vision services.

1143.1.2 Long-term Services and Support Listing

Revision 18-2; Effective September 3, 2018

The following is a non-exhaustive, high-level listing of long-term services and supports (LTSS) included under the STAR+PLUS program:

* Community First Choice (CFC) - Available to all Medicaid-eligible members (members who are considered medical assistance only (MAO) are not eligible for CFC) who meet an institutional level of care for a hospital, nursing facility (NF), intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID), or psychiatric hospital (also called an institution for mental disease) (under age 21 or 65 or older). CFC services include:
  + Personal assistance services (PAS), which provide assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hands-on assistance, supervision or cueing, including nurse-delegated tasks;
  + Habilitation services, which provide acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks;
  + Emergency response services (ERS), which are back-up systems and supports, including electronic devices with a backup support plan to ensure continuity of services and supports; and
  + Support management, which is training provided to members or the authorized representatives (ARs) on how to manage and dismiss their attendants.
* Personal Assistance Services (PAS), formerly known as Primary Home Care (PHC) — All members may receive medically and functionally necessary PAS. PAS includes assisting the member with the performance of activities of daily living (ADL) and household chores necessary to maintain the home in a clean, sanitary and safe environment. The level of assistance provided is determined by the member's needs and the plan of care (POC). To be eligible for state plan PAS, the MCO must assess applicants in a face-to-face visit. Members are assessed using [Form H2060](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-needs-assessment-questionnaire-taskhour-guide), Needs Assessment Questionnaire and Task/Hour Guide or [Form H6516](https://hhs.texas.gov/laws-regulations/forms/6000-6999/form-h6516-community-first-choice-assessment), Community First Choice Assessment. In order to be eligible for PAS through programs other than CFC or STAR+PLUS Home and Community Based Services (HCBS) program, members must score at least 24 on Form H2060.  
    
  PAS includes three service delivery options:
  + Agency Option (AO);
  + Consumer Directed Services (CDS) Option; and
  + Service Responsibility Option (SRO).
* Day Activity and Health Services (DAHS) — All members of a STAR+PLUS managed care organization (MCO) may receive medically and functionally necessary DAHS. DAHS includes nursing and personal assistance services (PAS), therapy extension services, nutrition services, transportation services and other supportive services. These services are provided at facilities licensed by the state.
* STAR+PLUS HCBS program is for those members who qualify for such services — The state also provides an enriched array of services to members who would otherwise qualify for NF care through an HCBS program. The MCO must also provide medically necessary services that are available to members who meet the functional and financial eligibility for the STAR+PLUS HCBS program.
* NFs — Institutional care to members whose physician has certified that the member has a medical condition that requires 24 hour nursing care that meets medical necessity (MN) requirements. The need for custodial care solely does not constitute MN for an NF placement. Institutional care includes coverage for the medical, social and psychological needs of each resident, including room and board, social services, medications not covered by Medicare Part B or D, medical supplies and equipment, rehabilitative services and personal needs items.

1143.2 Services Available to STAR+PLUS Home and Community Based Services Program Members

Revision 18-2; Effective September 3, 2018

Services necessary for the individual to remain in or return to the community are identified from the array of services available through the STAR+PLUS Home and Community Based Services (HCBS) program. STAR+PLUS HCBS program services include:

* Adaptive Aids and Medical Supplies — Medical equipment and supplies that include devices, controls or appliances specified in the plan of care (POC) 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.
* Adult Foster Care (AFC) — A 24-hour living arrangement for persons who, because of physical or mental limitations, are unable to continue residing in his or her own homes. Services may include meal preparation, housekeeping, personal care, help with ADL, supervision and the provision of or arrangement of transportation.
* Assisted Living (AL) Services — A 24-hour living arrangement in licensed personal care facilities in which personal care, home management, escort, social and recreational activities, 24- hour supervision, provision or arrangement of transportation, and supervision of, assistance with and direct administration of medications are provided. Under the STAR+PLUS HCBS program, personal care facilities may contract to provide services in two distinct types of living arrangements:
  + AL apartments; or
  + AL non-apartment settings.
* Cognitive Rehabilitation Therapy (CRT) — 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. CRT 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. CRT is provided in accordance with the POC 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.
* Dental Services — Services provided by a dentist to preserve teeth and meet the medical need of the member. Allowable services include emergency dental treatment necessary to control bleeding, relieve pain and eliminate acute infection; preventative procedures required to prevent the imminent loss of teeth; the treatment of injuries to teeth or supporting structures; dentures and the cost of preparation and fitting; and routine procedures necessary to maintain good oral health.
* Emergency Response Services (ERS) — An electronic monitoring system for use by functionally impaired individuals who live alone or are isolated in the community or at high risk of institutionalization. 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 capability, helps insure that the appropriate persons or service provider respond to an alarm call from the member.
* Employment Assistance Services (EAS) — Services that assist the member with locating competitive employment or self-employment.
* Financial Management Services (FMS) — Assistance to members with managing funds associated with services elected for the Consumer Directed Services (CDS) option and is provided by the financial management services agency (FMSA). This service includes initial orientation and ongoing training related to the responsibilities of being an employer and adhering to legal requirements for employers.
* Home-Delivered Meals — Services that provide nutritionally sound meals delivered to the member’s home.
* Minor Home Modifications — Services that assess the need for, arrange for and provide modifications or improvements to an individual's residence to enable the individual to reside in the community and to ensure safety, security and accessibility.
* Nursing Services — Includes, but is not limited to, assessing and evaluating health problems and the direct delivery of nursing tasks, providing treatments and health care procedures ordered by a physician or required by standards of professional practice or state law, delegating nursing tasks to unlicensed persons according to state rules promulgated by the Texas Board of Nursing, developing the health care plan and teaching individuals about proper health maintenance.
* Occupational Therapy (OT) Services — Interventions and procedures to promote or enhance safety and performance in instrumental activities of daily living (IADLs), education, work, play, leisure and social participation. Services include the full range of activities provided by an occupational therapist or a licensed OT assistant under the direction of a licensed occupational therapist, within the scope of the therapist’s state licensure.
* Personal Assistance Services (PAS) — Includes assisting the member with the performance of ADL and household chores necessary to maintain the home in a clean, sanitary and safe environment. The level of assistance provided is determined by the member’s needs and the POC. Services may also include the provision of nursing tasks delegated by a registered nurse in accordance with state rules promulgated by the Texas Board of Nursing and protective supervision provided solely to ensure the health and welfare of a member with cognitive/memory impairment and/or physical weakness. To be eligible for STAR+PLUS HCBS program PAS, the MCO must assess applicants in a face-to-face visit. Members are assessed using [Form H2060](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-needs-assessment-questionnaire-taskhour-guide), Needs Assessment Questionnaire and Task/Hour Guide, or [Form H6516](https://hhs.texas.gov/laws-regulations/forms/6000-6999/form-h6516-community-first-choice-assessment), Community First Choice Assessment. STAR+PLUS HCBS program PAS eligibility only requires that the applicant or member needs assistance with at least one personal care task identified on Form H2060. The 24-point scoring eligibility for state plan PAS does not apply to STAR+PLUS HCBS program PAS.
* Physical Therapy (PT) Services — Specialized techniques for the evaluation and treatment related to functions of the neuro-musculo-skeletal systems. Services include the full range of activities provided by a physical therapist or a licensed PT assistant under the direction of a licensed physical therapist, within the scope of the therapist’s state licensure.
* Respite Care Services — Temporary relief to persons caring for functionally impaired adults in community settings other than Adult Foster Care (AFC) homes or Assisted Living Facilities (ALF). Respite services are provided in-home and out-of-home and are limited to 30 days per individual service plan (ISP) year. Room and board is included in the payment for out-of-home settings.
* Speech and/or Language Pathology Services — The evaluation and treatment of impairments, disorders or deficiencies related to a Member’s speech and language. Services include the full range of activities provided by speech and language pathologists under the scope of his or her state licensure.
* Supported Employment Services — Services that assist the member with sustaining competitive employment or self-employment.
* Transition Assistance Services (TAS) — Assists members with non-recurring set-up expenses for transitioning from nursing homes to the community. Services may include assistance with security deposits for leases on apartments or homes, essential household furnishings, set-up fees for utilities, moving expenses, pest eradication or one-time cleaning.

1200 Service Coordination Through the MCO

Revision 18-2; Effective September 3, 2018

Managed care organizations (MCOs) are required to contact all members upon enrollment and at least annually thereafter. If a member receives long-term services and supports (LTSS), has a history of behavioral health issues or substance use disorders (SUD), or is dual eligible, the identified MCO service coordinator must contact the member at least once telephonically and at least once face-to-face per year. If the member receives STAR+PLUS Home and Community Based Services (HCBS) program, or has a complex medical condition, the identified MCO service coordinator must visit with the member face-to-face at least twice a year. If a member resides in a nursing facility (NF), the MCO service coordinator must meet with the member face-to-face at a minimum of four times per year.

All applicants or recipients of LTSS receive service coordination from the MCO. Service coordination is intended to bring together acute care and LTSS. Service coordination includes development of a service plan with the individual, family members and provider, as well as authorization of LTSS for the member. MCO service coordination is responsible for working with the member and his or her acute care and LTSS providers to ensure all of a member's medically and functionally necessary services are provided. This includes, but is not limited to, referring and assisting the member in obtaining appointments with specialists, participating in discharge planning for members in hospitals and/or NFs, referring members to community organizations for services, and assistance not covered by Medicaid. Service coordination requirements for members receiving STAR+PLUS HCBS program can be found in [Section 3000](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/sph-section-3000-waiver-eligibility-services), Waiver Eligibility and Services, [Section 6000](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/section-6000-specific-starplus-waiver-services), Specific STAR+PLUS Waiver Program Services, [Section 5000](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/sph-section-5000-automation-payment-issues-starplus), Automation and Payment Issues in STAR+PLUS, and [Appendices](https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/sph-appendices). Service coordination requirements for members receiving Medicaid state plan LTSS can be found in the Uniform Managed Care Contract.

The following sections detail MCO service coordinator responsibilities for members in certain facilities or programs.

1210 Service Coordinators and Nursing Facilities

Revision 18-2; Effective September 3, 2018

Members residing in a nursing facility (NF), (except members receiving hospice care or living outside the managed care organization (MCO) service area), must receive at least quarterly face-to-face visits for assessment purposes. NF staff should invite MCO service coordinators to their resident care planning meetings or other interdisciplinary team meetings, as long as the resident does not object. These meetings are not mandatory but are strongly recommended and participation may be in person or telephonically. The MCO must maintain and make available upon request documentation verifying the occurrence of required face-to-face service coordination visits, which may coincide with or include participation in care planning or other interdisciplinary team meetings.

Service coordination activities for members residing in an NF include, but are not limited to:

* Visiting members at least quarterly;
  + Assessing the member within 30 days of entry into an NF or enrollment into the health plan;
  + Visiting within 14 days of hearing that a significant change in condition of the member has occurred;
  + Visiting within 14 days of learning that a resident requests a transition to the community;
* Developing a plan of care (POC) to transition the individual to the community (if appropriate and the resident’s choice);
  + If initial review doesn’t support return to the community, a second assessment will be conducted 90 days after the initial assessment;
* Transitioning the member to the community in adherence with the Texas Promoting Independence Initiative, including Money Follows the Person (MFP), as appropriate;
  + Notifying the Relocation Contract specialist within **three business days** after meeting with the member;
  + Notifying the Local Authority for residents meeting Pre-Admission Screening and Resident Review (PASRR) requirements (Local Intellectual and Developmental Disability Authority (LIDDA) or Local Mental Health Authority (LMHA)), as appropriate;
  + Working in conjunction with the NF discharge planning team;
  + Coordinating transition with community partners;
  + Coordinating transition if the resident is moving into a service area not served by this MCO, by setting up Single Case Agreements, as needed;
* Identifying and addressing residents’ physical, mental or long term needs;
* Assisting residents and families to understand benefits;
* Ensuring access to and coordination of needed services;
* Finding providers to address specific needs;
* Coordinating and notifying of add-on services not included in the daily rate; and
* Assistance with collection of applied income.
  + NF Business Office manager (BOM) is responsible for collecting applied income.
    - The BOM can notify MCO service coordinator if he or she has made two unsuccessful collection attempts.  The MCO SC’s role is to educate the resident and his or her responsible party on the rules regarding payment of applied income to the NF and the potential ramifications of not doing so. If a member participating in the STAR+PLUS Home and Community Based Services (HCBS) program is admitted to an NF, the NF service coordinator must notify the Program Support Unit (PSU) within **three business days** of the admission using [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-managed-care-programs-communication), Managed Care Programs Communication.

1220 Service Coordinators and Waivers Serving Members with Intellectual or Development Disabilities

Revision 18-2; Effective September 3, 2018

Individuals who have intellectual or developmental disabilities (IDD) and live in a community-based intermediate care facility for individuals with an intellectual disability or related conditions (ICF-IID) or who receive services through one of the following IDD waivers receive their acute care services only through STAR+PLUS and continue to receive their long-term services and supports (LTSS) through the 1915(c) HCBS waivers:

* Community Living Assistance and Support Services (CLASS);
* Deaf Blind with Multiple Disabilities (DBMD);
* Home and Community-based Services (HCS); or
* Texas Home Living (TxHmL).

Individuals who receive services through one of these four programs and receive Medicare Part B (dual eligible) are not included in STAR+PLUS.

Members with IDD that meet the above criteria have a named managed care organization (MCO) service coordinator. The number of required service coordination visits or telephone calls and level of service coordination varies by acuity and the member's or authorized representative's (AR’s) personal preference.

These members also have a LIDDA provider that is a person(s) outside of the MCO who develops and implements a service plan and monitors LTSS service delivery. The MCO service coordinator must respond to requests from the member's waiver case manager or service coordinator. The member's waiver case manager or service coordinator should invite MCO service coordinators to the care planning meetings or other interdisciplinary team meetings, as long as the member does not object. These meetings are not mandatory but are strongly recommended and participation may be in person or telephonically. The MCO service coordinator is responsible for the coordination of the member's acute care services.

1230 Service Coordinators and Home and Community Based Services - Adult Mental Health Program

Revision 18-2; Effective September 3, 2018

The Home and Community Based Services - Adult Mental Health (HCBS-AMH) program serves individuals who have severe and persistent mental illness (SPMI) and:

* a history of extended (three cumulative or consecutive years of the past five years) institutional stays in psychiatric facilities;
* SPMI and frequent visits to the emergency department; and
* SPMI and frequent arrests and stays in a correctional facility.

HCBS-AMH provides an array of enhanced community-based services, including residential assistance, targeted to the program's population. HCBS-AMH is operated on a fee-for-service (FFS) basis through the Texas Health and Human Services Commission (HHSC). Each participant is assigned a recovery manager (RM), who monitors and coordinates HCBS-AMH services through recovery plan meetings. Members enrolled in HCBS-AMH receive their acute care services through their managed care organization (MCO) and their enhanced community-based services from providers contracted with HHSC. Additional information about HCBS-AMH can be found at: [https://www.dshs.state.tx.us/mhsa/hcbs-amh/ (link is external)](https://www.dshs.state.tx.us/mhsa/hcbs-amh/).

Program Point of Contact

* Each managed care organization (MCO) must have a designated Program Point of Contact (PPOC) for the AMH program. The PPOC is responsible for the following:
  + Ensuring MCO service coordinators are aware of HCBS-AMH services offered and their coordination responsibilities; and
  + Responding within **three business days** to concerns from HHSC or RMs to mitigate any issues with service coordination including uncooperative MCO service coordinators, missed teleconferences, or other concerns regarding MCO participation in the AMH program.

MCO Service Coordination Responsibility

* MCO service coordination must participate in telephonic recovery plan meetings, as scheduled by HHSC or RMs, and provide any requested member-specific information prior to the meeting. Service coordinators must:
  + Send requested information to the RM or HHSC **three business days** prior to the scheduled recovery plan meeting. This information includes, but is not limited to the following:
    - updates regarding member condition;
    - sharing relevant authorizations, such as an authorization or provider contact information when an HCBS-AMH member receives Community First Choice (CFC) services;
    - upcoming MCO service coordinator face-to-face appointments and/or scheduled dates for telephonic contacts with the member; and
    - relevant member treatment documents as requested by the RM or HHSC.
  + Respond to ad-hoc requests from the RM or HHSC with "urgent" in the subject line within **one business day**.
  + Respond to non-urgent ad-hoc requests in a timely manner.
  + Coordinate with the Program Support Unit and RM or HHSC when a member transfers from STAR+PLUS Home and Community Based Services (HCBS) program to HCBS-AMH.

HCBS-AMH may provide transitional planning for individuals who reside in an institution and who are also enrolled in a STAR+PLUS MCO. MCO service coordinators must participate in planning meetings with an RM, telephonically or in-person, during the member's stay.  Planning meetings focus on coordination of services upon discharge from the inpatient psychiatric institution.  MCO service coordinators are responsible for providing the RM requested treatment information for transition planning purposes. STAR+PLUS MCOs must follow all discharge planning requirements as outlined in [Uniform Managed Care Contract (UMCC),](https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/UniformManagedCareContract.pdf) Section 8.3.2.5.

1240 Service Coordinators and the Section 811 Project Rental Assistance Program

Revision 18-2; Effective September 3, 2018

The Section 811 Project Rental Assistance (PRA) program provides subsidized rental housing in coordination with supports to individuals with disabilities. Each tenant in the Section 811 PRA program has a “Section 811 service coordinator.” Managed care organization (MCO) service coordinators are the Section 811 service coordinators for STAR+PLUS members discharging from nursing facilities (NFs).

**Provision of Services**

Once an individual has occupied a Section 811 PRA housing unit, the MCO service coordinator must ensure STAR+PLUS Home and Community Based Services (HCBS) are in place so that the member will be successful in maintaining his or her tenancy. Continued participation in these services is voluntary and not a prerequisite for remaining in Section 811 PRA housing.

The Section 811 PRA program relies on Medicaid services and service coordination to provide the supports an individual needs to remain safely in the community. The MCO service coordinator is responsible for informing individuals in NFs about the availability of this program and if they are interested, to assist them in submitting an application and required documentation. The MCO may delegate this responsibility to the relocation specialist. If eligible, the MCO service coordinator must assist eligible individuals in accessing funding available to assist with relocations.

**Communication between MCO and Texas Health and Human Services Commission (HHSC)**

The MCO service coordinator must coordinate with the HHSC Section 811 Point of Contact (HHSC POC) on an ongoing basis regarding members participating in the Section 811 PRA program. The HHSC POC is listed on the Texas Department of Housing and Community Affairs (TDHCA) Section 811 PRA webpage: [https://www.tdhca.state.tx.us/section-811-pra/contact.htm (link is external)](https://www.tdhca.state.tx.us/section-811-pra/contact.htm).

**MCO Responsibilities – Helping Potential Applicants**

Information on such laws and requirements will be conveyed at training provided by TDHCA and in the *Texas Section 811 PRA Program Service Coordinator Manual*. Specific responsibilities of the Section 811 service coordinator are listed below:

* Assist in recruiting and pre-screening potential participants;
* The MCO service coordinator or relocation specialist will assist individuals in accessing Section 811 PRA housing;
  + Inform NF residents who have indicated an interest in moving to the community about the availability of the Section 811 PRA program;Inform individuals who transitioned from an NF to the community within the past 12 months about the availability of the Section 811 PRA program;
  + Assist interested individuals in reviewing available properties and their leasing criteria on the TDHCA website ([http://tdhca.state.tx.us/section-811-pra/participating-properties.htm (link is external)](http://tdhca.state.tx.us/section-811-pra/participating-properties.htm));
  + Using information provided by TDHCA, inform interested individuals about the potential wait time for an available unit;
  + Assist interested individuals in completing an application for tenancy and compiling necessary documentation;
  + Ensure that all methods of outreach and referral are consistent with fair housing and civil rights, laws and regulations, and affirmative marketing requirements; and
* Assist residents in maintaining their housing.

**MCO Point of Contact Requirements – for Potential Applicants**

For members who have applied to the Section 811 PRA program, the MCO must update information that was collected at the time of application to the program, if anything changes. This will ensure the member can be contacted and the information on file with TDHCA is accurate. The MCO must ensure the HHSC Section 811 POC and the TDHCA POC have the means to identify and contact the member within **one business day** of receiving a notice that a Section 811 PRA program unit is available.

**MCO Responsibilities – For Existing Tenants**

Once an individual has been accepted for tenancy in a Section 811 PRA program unit, the MCO service coordinator will provide the following support to assist individuals in maintaining his or her housing:

* Subject to an individual's agreement to share this information, respond to any inquiry from the HHSC Section 811 POC relating to a member's participation in the Section 811 PRA program, including the services the member is receiving and who the service providers are;
* Fulfill the obligations of the Section 811 service coordinator in the Conflict Management process set forth in the *Texas Section 811 PRA Program Service Coordinator Manual* (<https://www.tdhca.state.tx.us/section-811-pra/docs/ServiceCoordinatorManual.doc> (link is external)), including:
  + Working with the Section 811 POC and the Section 811 PRA program property owner or the property owner's designated agent (such as the property management company) in the event there is an incident, including a lease violation which could jeopardize the individual's ability to maintain his or her tenancy in a Section 811 PRA program; and
  + Work with the Section 811 POC and the Section 811 PRA program owner or the owner's designated agent to support the member in such a way that they do not lose his or her housing as a result of a lack of services or a lack of coordination of services. As a tenant in a Section 811 PRA program unit, a member may refuse services and this does not place his or her housing at risk.

The MCO must ensure the HHSC POC and the TDHCA POC have the means to identify and contact an individual's Section 811 service coordinator within **one business day** of receiving notice of a concern from the Section PRA program owner, owner's designee, or TDHCA POC.

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**MCO Point of Contact Requirements – for Existing Tenants**

MCO service coordinators serving members who are participating in the Section 811 PRA program must ensure that the HHSC POC has the MCO service coordinator’s contact information. If the MCO service coordinator information changes or is no longer fulfilling the roles and responsibilities associated with the Section 811 PRA program for a member, the MCO service coordinator must notify the HHSC POC.

**Additional references for Section 811 Program Requirements for MCOs**

MCO service coordinators serving members exiting an NF or other institution and who are participating in the Section 811 PRA program must comply with the roles and responsibilities assigned to them in the Inter-Agency Partnership Agreement (HHSC Contract No. 529-12-0134-00001), as amended and as applicable, and MCO service coordinators agree to fulfill the obligations assigned to Section 811 service coordinators in accordance with the *Texas Section 811 PRA Program* *Service Coordinator Manual*.

MCO service coordinators serving members who are participating in the Section 811 PRA program may download and read the *Texas Section 811 PRA Program* *Service Coordinator Manual*, available on TDHCA's webpage: <http://www.tdhca.state.tx.us/section-811-pra/referral-agents.htm>.

If requested by HHSC, the MCO service coordinator or designee must attend training on the Section 811 PRA program. Trainings can include, but are not limited to, in-person training, webinars, conference calls or responding to requests via email.

1250 Service Coordinators and the Medicaid for Breast and Cervical Cancer Program

Revision 18-2; Effective September 3, 2018

Individuals eligible for Medicaid through the Medicaid for Breast and Cervical Cancer (MBCC) program are a mandatory population in STAR+PLUS. This program provides Medicaid services including, but not limited to, the treatment of cancer and precancerous conditions for individuals with qualifying diagnoses between age 18 and their 65th birth month. Individuals in MBCC receive their Medicaid services through their STAR+PLUS managed care organization (MCO). The individual will be assigned a named service coordinator and receive at a minimum one telephonic contact and one face-to-face visit annually, unless otherwise requested by the MBCC member.

The MCO service coordinator assists the MBCC member with coordinating care. Coordination can include, but is not limited to, assistance with renewing Medicaid eligibility by reminding and assisting with paperwork. Continued participation in MBCC requires a completed MBCC renewal application and physician attestation the individual requires continued, active treatment for breast or cervical cancer or precancer. The physician attestation and eligibility paperwork must be submitted every six months.