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State/Territory Name: TX

State Plan Amendment (SPA) #: 21-0053

This file contains the following documents in the order listed:

1) Approval Letter
2) Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

March 7, 2022

Stephanie Stephens, Medicaid Director
Texas Health & Human Services Commission
PO Box 13247
Austin, TX 78711

RE: TX 21-0053 Adult Mental Health §1915(i) home and community-based services (HCBS) state plan amendment (SPA)

Dear Ms. Stephens:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's request to amend its 1915(i) state plan home and community-based services (HCBS) benefit, transmittal number TX 21-0053. The effective date for this amendment is October 1, 2021. With this amendment, the state is updating the review time for several performance measures.

Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- TX 21-0053 Section 3.1-i pages (as attached)

The state has identified its intent to use money realized from section 9817 of the American Rescue Plan (ARP). Approval of this action does not constitute approval of the state's spending plan. The state must have an approved spending plan to use the money realized from section 9817 of the ARP.
It is important to note that CMS' approval of this change to the state's 1915(i) HCBS state plan benefit solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

If you have any questions concerning this information, please contact me at (410) 786-7561. You may also contact Lynn Ward at lynn.ward@cms.hhs.gov or (214) 767-6327.

Sincerely,

George P. Failla, Jr., Director
Division of HCBS Operations and Oversight

Enclosure

cc: Kathi Montalbano, TX HHSC
HHSC Mailbox
Ford Blunt, CMS DPO
Matthew Weaver, CMS DLTSS
Dianne Kayala, CMS DLTSS
Cynthia Nanes CMS, DHCBSO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **21-0053**

2. STATE: **TEXAS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **October 01, 2021**

5. TYPE OF PLAN MATERIAL *(Circle One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Title XIX of the SSA; 42 CFR §441.745(b)

7. FEDERAL BUDGET IMPACT: **SEE ATTACHMENT**
a. **FFY 2021 $0**
b. **FFY 2022 $0**
c. **FFY 2023 $0**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
SEE ATTACHMENT TO BLOCKS 8 & 9

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SEE ATTACHMENT TO BLOCKS 8 & 9

10. SUBJECT OF AMENDMENT:

The proposed amendment is to modify the Quality Improvement Strategy; proposes to remove some quality measures; to replace current quality measures with new measures; and modification to timeframes for monitoring reviews

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: **Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.**

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Stephanie Stephens

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
December 30, 2021

16. RETURN TO:

Stephanie Stephens
State Medicaid Director
Post Office Box 13247, MC: H-100
Austin, Texas 78711

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 30, 2021

18. DATE APPROVED: 3/7/2022

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2021

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: George P. Failla, Jr.

22. TITLE: Director, DHCBSO

23. REMARKS:

FORM CMS – 179 (07-92)

Attachment to Blocks 8 & 9 of CMS Form 179

Transmittal Number 21-0053

Number of the **Plan Section or Attachment**	**Number of the Superseded** **Plan Section or Attachment**
Attachment 3.1-i	**Attachment 3.1-i**
Page 5-6	Pages 5-6 (TN 20-0003)
Page 10	Page 10 (TN 16-0001)
Page 23	Page 23 (TN 20-0003)
Page 25	Page 25 (TN 20-0003)
Page 27	Page 27 (TN 20-0003)
Page 29	Page 29 (TN 20-0003)
Page 32	Page 32 (TN 20-0003)
Page 34-35	Page 34-35 (TN 20-0003)
Page 37	Page 37 (TN 20-0003)
Page 40-41	Page 40-41 (TN 20-0003)
Page 45	Page 45 (TN 20-0003)
Page 49	Page 49 (TN 20-0003)
Page 54	Page 54 (TN 20-0003)
Page 55	Page 55 (TN 20-0003)
Page 56	Page 56 (TN 20-0003)
Page 58-63	Page 58-63 (TN 20-0003)
Page 65	Page 65 (TN 20-0003)
Page 66	Page 66 (TN 20-0003)
Page 70-74	Page 70-74 (TN 20-0003)

(By checking the following boxes the State assures that):

5. ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
   - related by blood or marriage to the individual, or any paid caregiver of the individual
   - financially responsible for the individual
   - empowered to make financial or health-related decisions on behalf of the individual
   - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

HHSC ensures that conflicts of interest do not occur. The individuals performing the independent assessments, reassessments, and Person Centered Service Plans (AKA Individual Recovery Plans) (IRP)s cannot also be providers of HCBS-AMH on the IRP or under the administrative control of a provider of HCBS-AMH on the IRP unless the provider is the only willing and qualified entity in a geographic area who can be responsible for assessments and person-centered service plan development.

The individuals performing the assessments and IRPs are HHSC employees or contractors who are delegated this responsibility. Contractors must have the requisite experience and skill to perform assessments and/or IRPs. For assessments and person-centered service plan development, the contractors may be public or private sector entities, but may not be HCBS–AMH providers, unless they are the only willing and qualified entity in a geographic area who can be responsible for assessments and person-centered service plan development. The needs-based assessments are reviewed by HHSC staff pursuant to the 1915(i) Quality Improvement Strategy (QIS) requirements listed later in this state plan. HHSC will biennially review contractors who complete assessments and IRPs to ensure that they do not have an interest in or are under the control of a provider on the IRP. Contractors delegated the responsibility to perform assessments who are an HCBS-AMH provider of last resort will have a higher level of scrutiny.

IRPs will be completed by recovery managers. Recovery management may only be provided by agencies and individuals employed by agencies who are not providers of other HCBS-AMH services for the individual, or those who have interest in or are employed by a provider of HCBS-AMH on the IRP. On occasion the State anticipates exceptions may be necessary in which the recovery management provider for the individual is employed by a provider of other HCBS-AMH services on the IRP as the provider of last resort. Recovery management may only be provided by the provider of last resort when they are the only willing and qualified entity in a geographic area who can be responsible for the development of the person-centered service plan. Recovery management will only be provided by the provider of last resort when there is no other willing and qualified non-provider entity to perform these functions.

Texas anticipates that some service areas may not have separate Provider Agencies and Recovery Management Entities, who develop the person-centered service plans that meet requirements of the program and provider agreement. HHSC will enroll HCBS-AMH Provider Agencies and Recovery Management entities through separate Open Enrollments and will actively recruit both types of entities with consideration for counties where Recovery Management Providers are serving as the recovery management provider of last resort. The state anticipates the provision of recovery management by recovery management provider of last resort and instances in which contractors delegated the responsibility to perform assessments are an HCBS-AMH provider of last resort will occur in health manpower shortage areas, combined with rural and frontier counties.

- Health manpower shortage area designations can be found at: http://hpsafind.hrsa.gov/
- Rural county designations can be found at: http://www.dshs.texas.gov/chs/hprc/counties.shtm
- Frontier and Remote Area Codes as identified by the Economic Research Service of the United States Department of Agriculture can be found at: https://www.ers.usda.gov/data-products/frontier-and-remote-area-codes/

In lieu of denying an individual residence in his/her community of choice due to lack of available Provider Agencies and Recovery Management Entities, the State foresees that in this circumstance an HCBS provider of last resort may also provide recovery management services with certain conflict of interest protections in place.

When an HCBS provider of last resort also provides recovery management services, HHSC will require a clear separation of provider and recovery management functions. The distinct individual staff providing recovery management must be administratively separate from other HCBS-AMH provider functions and any related utilization review units and functions. Recovery Managers who work for provider agencies that are providing other HCBS-AMH services as the provider of last resort will not be providers of any other HCBS-AMH service on the IRP. HHSC reviews the administrative structure of the HCBS-AMH agency to ensure that there is a clear administrative separation of recovery management and HCBS-AMH provider staff/functions before approving a provider to serve as a recovery manager, and periodically reviews (including unannounced site-reviews) the individuals performing recovery management to ensure that they are not providers of HCBS-AMH and not under the administrative control of units providing HCBS-AMH services. HHSC will also review resulting IRPs to ensure that there is no conflict of interest.

The following conflict mitigation strategies are utilized by HHSC:

- Individual staff performing the assessments shall not be under the same administrative authority ofstaff providing HCBS-AMH or developing the IRP.
- Restricting the entity that develops the person-centered service plan from providing services without the direct approval of the state.
- Requiring the recovery management entity that develops the IRP to be administratively separate the plan development function from the direct service provider functions.
- Assuring that individuals can advocate for themselves or have an advocate present in planningmeetings.
- Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of HCBS-AMH services, not just the services furnished by the recovery management entity that is responsible for development of the IRP.
- Having clear, well-known, and easily accessible means for individuals to make grievances and/or appeals to the State for assistance regarding concerns about choice, quality, and outcomes. This includes a consumer bill of rights for mental health; published rules on consumer rights; a toll-free line staffed by dedicated Consumer Rights representatives who can answer questions about rights and assist theindividual in resolving issues with mental health HCBS services or with filing a complaint regarding services. HHSC's client ombudsman office is also available via toll-free line to assist consumers in resolving issues with Medicaid providers or services. Information on these rights and grievance/appeal processes will be provided in writing to each individual enrolled in the HCBS program.
- Documenting the number and types of appeals and the decisions regarding grievances and/orappeals.
- Conducting biennial on-site reviews, desk reviews, and analysis of aggregate and individual data.
- Documenting consumer experiences with measures that capture the quality of IRP development

6. ☑ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

6. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	**NF (& NF LOC** waivers)**	**ICF/IID (& ICF/IID LOC waivers)**	**Applicable Hospital* (& Hospital LOC waivers)**
The individual must: 1. Require HCBS-AMH services to improve or maintain functioning, prevent relapse to a lower level of functioning, and maintain residence in the community; demonstrated by a level of functional need (ANSA score of 2 or higher) that indicates a need for intervention provided by HCBS-AMH services that is identified in one of the following domains assessed by the ANSA: behavioral health, life domain functioning (including ADLs and IADLs), or functional needs and strengths; And 2. Meet one of the following risk categories: a. Demonstrate a history of extended or repeated stay(s) in an inpatient psychiatric hospital (i.e., three years or more of consecutive or cumulative inpatient psychiatric hospitalization during the five years prior to initial enrollment in HCBS-AMH); b. Demonstrate in the three years prior to initial enrollment in HCBS-AMH two or more psychiatric crises (i.e., inpatient psychiatric	The individual must: Live in a Medicaid-certified NF for 30 consecutive days or live in the community (for NF LOC waivers) and meet medical necessity requirements (see below) According to Texas rules (40 Tex. Admin. Code §19.2401), an individual must meet both of the following criteria for medical necessity: 1. The individual must demonstrate a medical condition that: * is of sufficient seriousness that the individual's needs exceed the routine care which may be given by an untrained person; and * requires licensed nurses' supervision, assessment, planning, and intervention that is available only in an institution. AND 2. The individual must require medical or nursing services that: *are ordered by a physician; *are dependent upon the individual's documented medical conditions;	The individual must: Live in a Medicaid-certified Intermediate Care Facility for Individuals with Intellectual or Developmental Disabilities (ICF-IID) for 30 consecutive days or live in the community (for ICF/IID waivers) and meet medical necessity requirements (see below) 1. Have a diagnosed developmental disability. The term "developmental disability" means a severe, chronic disability of an individual that: * is attributable to a mental or physical impairment or combination of mental and physical impairments; * is manifested before the individual attains age 22; * is likely to continue indefinitely; * results in substantial functional limitations in 3 or more of the following areas of major life activity: (i) Self-care. (ii) Receptive and expressive language. (iii) Learning. (iv) Mobility. (v) Self-direction. (vi) Capacity for independent living. (vii) Economic self-sufficiency; and	The individual must: 1. Have a valid diagnosis as listed in the current version of the ICD as the principal admitting diagnosis and one of the following: a. Outpatient therapy or partial hospitalization has been attempted and failed b. A psychiatrist has documented reasons why an inpatient level of care is required. AND 2. The individual must meet at least one of the following criteria: a. The individual is presently a danger to self, demonstrated by at least one of the following: (i) Recent suicide attempt or active suicidal threats with a deadly plan, and there is an absence of appropriate supervision or structure to prevent suicide. (ii) Recent self-mutilative behavior or active threats of same with likelihood of acting on the threat, and there is an absence of appropriate supervision or structure to prevent self- mutilation (i.e., intentionally cutting/burning self). (iii) Active hallucinations or delusions directing or likely to lead to serious self-harm or debilitating psychomotor agitation or

- The HCBS-AMH provider must administer the medication according to the label directions or as amended by a physician.
- The HCBS-AMH provider must administer the medication only to the individual for whom it is intended.
- The HCBS-AMH provider must not administer the medication after its expiration date.
- If applicable, the HCBS-AMH provider may provide non-prescription medications if the HCBS-AMH provider obtains LAR consent prior to administration of the medication. Consent may be given over the phone and documented as such by the HCBS-AMH provider.
- At least quarterly, or more frequently if indicated by the individual's condition, medication regimen or changes to the regimen, HCBS-AMH providers shall review medication administration records to ensure that medications are correctly administered.

HHSC includes medication management review as part of its biennial review of contracted HCBS-AMH providers. HHSC is responsible for monitoring the performance of providers administering medications to the individual. HHSC enforces requirements through biennial review and review of critical incidents.

9. **Maintenance of Person-Centered Service Plan Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

☒	Medicaid agency	☐	Operating agency	☒	Case manager
☐	Other *(specify):*				

HCBS Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.			HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or contracts with a provider of TAS services. The TAS provider must comply with the requirements for delivery of transition assistance services, which include requirements such as allowable purchases, cost limits, and time frames for delivery. TAS providers must demonstrate knowledge of, and history in, successfully serving individuals who require home and community-based services. Before entering into a provider agreement with the provider agency, HHSC verifies the providers' compliance with these qualifications through a credentialing process. Contracted providers are obligated to verify on an ongoing basis that these qualifications are achieved, maintained, and documented. HHSC will conduct biennial review to verify these requirements continue to be met after the provider and HHSC enter into an agreement. Individual providers of TAS must be 18 years of age or older, pass criminal background check, demonstrate knowledge and/or experience in managing transitions to home and community-based settings.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
HCBS Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.	HHSC	Biennial

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	✔	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:

Service Title:	HCBS Psychosocial Rehabilitation Services

Service Definition (Scope)*:*

HCBS Psychosocial Rehabilitation services are evidence-based or evidence-informed interventions which support the individual's recovery by helping the individual develop, refine, and/or maintain the skills needed to function successfully in the community to the fullest extent possible. Skills include but are not limited to: illness/recovery management, self-care, activities of daily living, and instrumental activities of daily living. The modality(ies) used must be approved by HHSC. A variety of evidence-based practices may be used as appropriate to individual needs, interests and goals. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's IRP. Rehabilitative services are face-to-face interventions with the individualpresent. Services may be provided individually or in a group setting.

The provider must incorporate research-based approaches pertinent to the needs of the target population.

HCBS Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.			HCBS provider agency enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or has a contract with the HCBS Psychosocial Rehabilitation practitioner. Before entering into a provider agreement with the provider agency, HHSC verifies the providers' compliance with these qualifications through a credentialing process. Contracted providers are obligated to verify on an ongoing basis that these qualifications are achieved, maintained, and documented in personnel files. HHSC will conduct biennial review to verify these requirements continue to be met after the provider and HHSC enter into an agreement. Individual providers must be qualified and demonstrate competency and fidelity to the evidence-based practices (EBPs) used. Individual providers must have the level of education and experience required by the evidence-based modality employed. An individual provider must, at a minimum, have a bachelor's degree in psychology or a related field, HHSC-approved training and/or certification in the evidence-based practice(s) employed and must be supervised by a licensed clinician trained and competent in the EBP.

Verification of Provider Qualifications *(For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
HCBS Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.	HHSC	Biennial

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	✔	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:

Service Title:	Adaptive aids
Service Definition (Scope):	

HCBS Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.			HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or has contracts with adaptive aid providers. Before entering into a provider agreement with the provider agency, HHSC verifies the providers' compliance with these qualifications through a credentialing process. Contracted providers are obligated to verify on an ongoing basis that these qualifications are achieved, maintained, and documented in personnel files. HHSC will conduct biennial review to verify these requirements continue to be met after the provider and HHSC enter into an agreement. Adaptive aid providers and their employees must comply with all applicable laws and regulations for the provision of adaptive aids.

Verification of Provider Qualifications *(For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
HCBS Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.	HHSC	Biennial

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	✔	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:

Service Title:	Employment Services

Service Definition (Scope)*:*

Employment services help people with severe mental illness work at regular jobs of their choosing and to achieve goals meaningful to them, such as increasing their economic security. Services must follow evidence- based or evidence-informed practices approved by HHSC. Employment services:

- focus on the individual's strengths and preferences;
- promote recovery and wellness by enabling individuals to engage in work which is meaningful to them and compensated at a level equal to or greater than individuals without severe mental illness or other disabilities (competitive employment);
- collaborate with and do not supplant existing resources, such as state vocational rehabilitation programs available to the individual;
- use a multidisciplinary team approach;
- are individualized and extended as needed to assist the individual attain and maintain meaningful work;
- are provided based on individual preference and choice without exclusions based on readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, level of disability, or legal system involvement;
- are coordinated with mental health services provided to the individual, such as rehabilitation;
- help individuals obtain personalized, understandable, and accurate information about their Social Security, Medicaid, and other government entitlements in relation to work;

			services must be at least 18 years of age and meet one of the following qualifications: • have a bachelor's degree in rehabilitation, business, marketing, or a related human services field, and one year's paid or unpaid experience providing employment services to people with disabilities; • have an associate degree in rehabilitation, business, marketing, or a related human services field, and two years paid or unpaid experience providing employment services to people with disabilities; or • have a high school diploma or Certificate of High School Equivalency (GED credentials), and three years paid or unpaid experience providing employment services to people with disabilities. The individual provider must complete training required by HHSC. Before entering into a provider agreement with the provider agency, HHSC verifies the providers' compliance with these qualifications through a credentialing process. Contracted providers are obligated to verify on an ongoing basis that these qualifications are achieved, maintained, and documented in personnel files. HHSC will conduct biennial review to verify these requirements continue to be met after the provider and HHSC enter into an agreement.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
HCBS Provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.	HHSC	Biennial

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	✔	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:

Service Title:	Transportation

Service Definition (Scope):

Transportation is offered in order to enable individuals served to gain access to services, activities, and resources, as specified in the IRP. This service is offered in addition to medical transportation required under 42 C.F.R.§ 431.53 and transportation services under the State Plan, defined at 42 C.F.R. § 440.170(a) (if applicable), and will not replace them.

Transportation services are offered in accordance with the individual's recovery plan. Whenever possible, family,

			buses, or taxis.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type (*Specify*):	Entity Responsible for Verification (*Specify*):	Frequency of Verification (*Specify*):
Transportation	HHSC	Biennial

Service Delivery Method. (*Check each that applies*):

☐	Participant-directed	✔	Provider managed

Service Specifications (*Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Community Psychiatric Supports and Treatment (CPST)

Service Definition (Scope):

CPST are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the individual's IRP. CPST is a face-to-face intervention with the individual present; however, family or other persons significant to the individual may also be involved. This service may include the following components:

Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual's mental illness and/or substance use disorder, with the goal of minimizing the negative effects of symptoms, emotional disturbances, or associated environmental stressors which interfere with the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.

Provide individual supportive counseling, solution-focused interventions, emotional and behavioral management support, and behavioral analysis with the individual, with the goal of assisting the individual with developing and implementing social, interpersonal, self-care, daily living, and independent living skills to restore stability, support functional gains, and adapt to community living.

Facilitate participation in and utilization of strengths based planning and treatments which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports, and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their mental illness and/or substance use disorder.

Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan, and/or seeking other supports to restore stability and functioning, as appropriate.

CPST addresses specific individual needs with evidence-based and evidence-informed psychotherapeutic practices designed specifically to meet those needs. Examples include, but are not limited to:

Cognitive Behavioral Therapy (CBT): CBT is an empirically supported treatment that focuses on maladaptive patterns of thinking and the beliefs that underlie such thinking. This includes variations of CBT specific to the needs of an individual, such as Cognitive Processing Therapy.

Dialectical Behavior Therapy (DBT): DBT is a form of CBT directed at individuals with borderline personality disorder or other disorders with chronic suicidal ideation and unstable relationships. It is a manual treatment program that provides support in managing chronic crisis and stress to keep individuals in outpatient treatment settings. It requires specialized training by the original developer or other entity approved by original developer (Marsha Linehan). The treatment program includes individual and group therapy sessions and requires homework by the individual. These therapies are provided by licensed therapists working under the direction of the HCBS provider agency.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies)*:	
✔	Categorically needy *(specify limits)*:
	Community Psychiatric Support and Treatment (CPST) services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid eligible adults with significant functional impairments meeting the need levels in the 1915(i). Medical necessity for these treatment services must be determined by a licensed behavioral health practitioner (LBHP) or physician who is acting within the scope of his/her professional license and applicable state law and furnished by or under the direction of a licensed practitioner to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level. The LBHP or physician may conduct an assessment consistent with state law, regulation, and policy. A unit of service is defined according to the HCPCS approved code set unless otherwise specified. If the determination of medical necessity for CPST requires additional assessment, this assessment may be conducted as part of the service up to one unit of the service. This service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service.
☐	Medically needy *(specify limits)*:
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
HCBS Provider agency	LPC, LMFT, LCSW, PhD psychologist, RN or MD (for individual therapists). Licensure candidates may provide services as part of a graduate education program under the direct supervision of an appropriately licensed professional.		HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or contracts with licensed practitioners with demonstrated competence in specialized mental health therapies. Direct-care therapists must be trained, credentialed, and demonstrate competence in the specialized psychotherapy practice used. Individual service providers must be determined to be a clinician under State regulations, meaning a person with a doctoral or master's degree in psychology, counseling, social work, nursing, rehabilitation, or related field from an accredited college or university (or a registered nurse with a certificate in mental health nursing from the American Nurses Association).

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
HCBS Provider agency that meets	HHSC	Biennial

			minimum, individuals must also be 18 years of age or older and have common life experiences with the individual, such as having a mental health or substance use condition, using services or supports for mental health and substance use conditions and being in a recovery process.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type (*Specify*):	Entity Responsible for Verification (*Specify*):	Frequency of Verification (*Specify*):
HCBS Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.	HHSC	Biennial

Service Delivery Method. (*Check each that applies)*:

☐	Participant-directed	✔	Provider managed

Service Specifications (*Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:

Service Title:	Host Home/Companion Care

Service Definition (Scope):

Host Home/Companion Care services are supportive and health-related residential services provided to individuals in the individual's own home or in settings licensed or approved by the State of Texas. Host Home/Companion Care services are necessary, as specified in the individual's person-directed IRP, to enable the individual to remain integrated in the community and ensure the health, welfare, and safety of the individual in accordance with 42 C.F.R. § 441.710. (Refer to Section 9 "Home and Community-Based Settings" for HCBS-AMH settings requirements.) Community-based residential services include personal care and supportive services (homemaker, chores, attendant services, and meal preparation) that are furnished to individuals who reside in homelike, non-institutional, integrated settings. In addition, they include 24-hour onsite response capability to meet scheduled and unscheduled or unpredictable resident needs and to provide supervision and safety. Services also include social and recreational programming and medication assistance (to the extent permitted under state law).

Home and Community-Based Settings must:
Be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
Be selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting.
Ensure rights of privacy, dignity and respect, and freedom from coercion and restraint.
Optimize, but not regiment, individual initiative, autonomy, and independence in making life choices, daily activities, physical environment, and with whom to interact.
Facilitate individual choice regarding services and supports, and who provides them

Host home/companion care services promote recovery by supporting individual recovery goals, using natural supports and typical community services available to all people, enabling social interaction and participation in leisure activities, and helping the individual develop daily living and functional living skills. This service also fosters the individual's recovery and independence by providing personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of specialized rehabilitative, habilitative, or psychosocial therapies/activities; assistance with medications based upon the results of an RN assessment and the performance of tasks delegated by a RN in

the minimum eligibility and standards for HCBS-AMH provider enrollment.			services, which employs or has agreements with Host Home/Companion Care Providers. Residential settings must meet relevant state and local requirements. Individual direct service providers must be at least 18 years of age. The employee provider must have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of aproficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served as demonstrated through a written competency-based assessment. The individual provider must pass a criminal background check and also have at least three personal references from persons not related within three degrees of consanguinity that evidence the ability to provide a safe and healthy environment for the individual(s) to be served. Transportation of individuals must be provided in accordance with applicable state laws. Individuals transporting individuals must be 18 years of age or older; pass a criminal background check; and must have a valid driver's license and proof of insurance. Assisting with tasks delegated by an RN must be in accordance with state law. Individual providers of Host Home/Companion Care must complete initial and periodic training provided by HCBS provider agency which includes HHSC-required training in the HCBS-AMH program. Before entering into a provider agreement with the provider agency, HHSC verifies the providers' compliance with these qualifications through a credentialing process. Contracted providers are obligated to verify on an ongoing basis that these qualifications are achieved, maintained, and documented in personnel files. HHSC will conduct biennial review to verify these requirements continue to be met after the provider and HHSC enter into an agreement.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
HCBS Provider Agency that meets	HHSC	Biennial

the minimum eligibility and standards for HCBS-AMH provider enrollment.		

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	✔	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:

Service Title:	Supervised Living Services

Service Definition (Scope):

Supervised Living Services are supportive and health-related residential services provided to individuals in settings licensed or approved by the State of Texas. Residential services are necessary, as specified in the individual's person-directed IRP, to enable the individual to remain integrated in the community and ensure the health, welfare, and safety of the individual in accordance with 42 C.F.R. § 441.710. (Refer to Section 9 "Home and Community-Based Settings" for HCBS-AMH settings requirements.) Supervised Living Services include personal care and supportive services (homemaker, chores, attendant services, and meal preparation) that are furnished to individuals who reside in homelike, non-institutional, integrated settings. In addition, they include 24-hour onsite response capability to meet scheduled and unscheduled or unpredictable resident needs and to provide supervision and safety. Services also include social and recreational programming and medication assistance (to the extent permitted under state law).

Home and Community-Based Settings must:
Be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
Be selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting.
Ensure rights of privacy, dignity and respect, and freedom from coercion and restraint.
Optimize, but not regiment, individual initiative, autonomy, and independence in making life choices, daily activities, physical environment, and with whom to interact.
Facilitate individual choice regarding services and supports, and who provides them

Supervised Living Services promote recovery by supporting individual recovery goals, using natural supports and typical community services available to all people, enabling social interaction and participation in leisure activities, and helping the individual develop daily living and functional living skills. Supervised living also fosters recovery and independence by providing individuals with personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of specialized rehabilitative, habilitative or psychosocial therapies; assistance with medications based upon the results of an RN assessment; the performance of tasks delegated by a RN in accordance with the Texas Board of Nursing rules as defined by Title 22 of the Texas Administrative Code, Part 11, Chapter 225; and supervision of the individual's safety and security. Transportation costs included in the rate for the supervised living service are for providing transportation to the participant and not provider staff. Supervised living provides residential assistance as needed by individuals who live in residences in which the HCBS provider holds a property interest and that meet program certification standards. This service may be provided to individuals in one of two modalities:
By providers who are not awake during normal sleep hours but are present in the residence and able to respond to the needs of individuals during normal sleeping hours; or
By providers assigned on a shift schedule that includes at least one complete change of staff each day.
Transportation costs are included in the rate. Type and frequency of supervision is determined on an individual basis based on the level of need for each individual.

The individual receiving supervised living services has a right to privacy. Sleeping and individual living units may be locked at the discretion of the individual, with keys available only to appropriate staff or landlords. Staff

☐	Participant-directed	✔	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Assisted Living Services

Service Definition (Scope)*:*

Assisted Living Services are supportive and health-related residential services provided to individuals in settings licensed or approved by the State of Texas. Residential services are necessary, as specified in the individual's person-directed IRP, to enable the individual to remain integrated in the community and ensure the health, welfare, and safety of the individual in accordance with 42 C.F.R. § 441.710. (Refer to Section 9 "Home and Community-Based Settings" for HCBS-AMH settings requirements.) Assisted Living Services include personal care and supportive services (homemaker, chores, attendant services, and meal preparation) that are furnished to individuals who reside in homelike, non-institutional, integrated settings. In addition, they include 24-hour onsite response capability to meet scheduled and unscheduled or unpredictable resident needs and to provide supervision and safety. Services also include social and recreational programming and medication assistance (to the extent permitted under state law).

Home and Community-Based Settings must:
Be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
Be selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting.
Ensure rights of privacy, dignity and respect, and freedom from coercion and restraint.
Optimize, but not regiment, individual initiative, autonomy, and independence in making life choices, daily activities, physical environment, and with whom to interact.
Facilitate individual choice regarding services and supports, and who provides them

Assisted Living Services are personal care, homemaker, and chore services; medication oversight; and therapeutic, social, and recreational programming provided in a home-like environment in a licensed community setting in conjunction with residing in the assisted living setting. This service includes 24-hour on- site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security. Other individuals or agencies may also furnish care directly or under arrangement with the community setting, but the services provided by these other entities supplement that provided by the community setting and do not supplant it. Assisted living is furnished to individuals who reside in their own living units/ bedrooms, which may include dually-occupied units when both occupants consent to the arrangement, that contain toilet facilities, and may or may not include kitchenette and/or living rooms. The assisted living setting must have a central dining room; living room or parlor; and/or common activity center(s) (which may also serve as living rooms or dining rooms). Individuals have the freedom and support to control their own schedules and activities, have access to food and visitors of their choosing at any time, have access at any time to the common/shared areas (including kitchens, living rooms, and activity centers), and have the freedom to furnish and decorate units. Individuals in assisted living settings, where units do not have a private kitchen/kitchenette and/or living room or parlor, have full access to a shared kitchen with cooking facilities and comfortable seating in the shared areas for private visits with family and friends.

The HCBS AMH provider agency will be encouraged to hire providers to deliver personal care services separate from those who provide rehabilitation services, if there is more than one provider on-site at the residence during normal hours who can provide personal care services. This will ensure that the clinical boundary issues that would otherwise complicate rehabilitation services (if the same staff were also delivering personal care services) will be mitigated.

This service will be provided to meet the individual's needs as determined by an individualized assessment performed in accordance HHSC requirements and as outlined in the individual 's IRP.

Assisted Living Services are available to individuals as they are determined necessary, based upon a quarterly assessment documented in the IRP and approved by HHSC.

furnished to individuals who reside in homelike, non- institutional, integrated settings. Services also include social and recreational programming and medication assistance (to the extent permitted under state law).

Home and Community-Based Settings must:
Be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
Be selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting.
Ensure rights of privacy, dignity and respect, and freedom from coercion and restraint.
Optimize, but not regiment, individual initiative, autonomy, and independence in making life choices, daily activities, physical environment, and with whom to interact.
Facilitate individual choice regarding services and supports, and who provides them

Supported Home Living services assist individuals living in community-based residences. Supported home living promotes individual recovery and community inclusion by providing individuals with direct personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement specialized rehabilitative, habilitative, or psychosocial mental health therapies/activities; assistance with medications and the performance of tasks delegated by a registered nurse in accordance with the Texas Board of Nursing rules as defined by Title 22 of the Texas Administrative Code, Part 11, Chapter 225; and supervision as needed to ensure the individual's health and safety; and supervision of the individual's safety and security. This service includes activities that facilitate the individual's inclusion in community activities, use of natural supports and typical community services available to all people, social interaction, and participation in leisure activities, and development of socially valued behaviors and daily living and functional living skills.

Services must be furnished in a way that fosters the independence of each individual to facilitate recovery. Routines of service delivery must be individual-driven to the maximum extent possible and each individual must be treated with dignity and respect. The IRP will document any planned intervention which could potentially impinge on individual autonomy. Documentation will include informed consent of the individual to the intervention; the specific need for the intervention in supporting the individual to achieve his/her goals; assurance that the intervention is the most inclusive and person-centered option; time limits for the intervention, periodic reviews of the intervention to determine if it is still needed, and assurance that the intervention will cause no harm to the individual.

The individual receiving supported home living has a right to privacy. Sleeping and individual living units may be locked at the discretion of the individual, with keys available only to landlords or appropriate service providers. Service providers with access to living units will be documented in the IRP. The IRP will identify when service providers have access, what types of service providers have access, and under what circumstances service providers will be allowed to access an individual's unit. In order to justify a modification of person- centered residence requirements, the IRP must document: a specific and individualized assessed need; the positive interventions and supports used prior to any modifications; less intrusive methods of meeting the need that have been tried but did not work; a clear description of the condition that is directly proportionate to the specific assessed need; regular collection and review of data to measure the ongoing effectiveness of the modification; established time limits for periodic reviews to determine if the modification is still necessary or can be terminated; informed consent of the individual; and assurance that interventions and supports will cause no harm to the individual.

Supported Home Living services can be provided to individuals residing in their own or family

			with the provider agency, HHSC verifies the providers' compliance with these qualifications through a credentialing process. Contracted providers are obligated to verify on an ongoing basis that these qualifications are achieved, maintained, and documented in personnel files. HHSC will conduct biennial review to verify these requirements continue to be met after the provider and HHSC enter into an agreement.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
HCBS Provider Agency	HHSC	Biennial

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	✔	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:

Service Title:	Home Delivered Meals

Service Definition (Scope):

Home delivered meals services provide a nutritionally sound meal to individuals. Each meal provides a minimum of one-third of the current recommended dietary allowance (RDA) for the individual as adopted by the United States Department of Agriculture. The meal is delivered to the participant's home. Home delivered meals do not constitute a full nutritional regimen.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.
(Choose each that applies):

✔	Categorically needy *(specify limits)*:
	The provision of home delivered meals does not provide a full nutritional regimen (i.e., 3 meals a day).
☐	Medically needy *(specify limits)*:
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
HCBS Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.			HCBS-AMH provider agency enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with home-delivered meal providers. An individual home delivered meals provider must follow procedures and maintain facilities that comply with all applicable state and local laws and regulations related to fire,

			health, sanitation, and safety; and food preparation, handling, and service activities. Before entering into a provider agreement with the provider agency, HHSC verifies the providers' compliance with these qualifications through a credentialing process. Contracted providers are obligated to verify on an ongoing basis that these qualifications are achieved, maintained, and documented in personnel files. HHSC will conduct biennial review to verify these requirements continue to be met after the provider and HHSC enter into an agreement.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
HCBS Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.	HHSC	Biennial

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	✔	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:

Service Title:	Minor Home Modifications

Service Definition (Scope):

Minor home modifications are those physical adaptations to an individual's home that are necessary to ensure the individual's health, welfare, and safety, or that enable the individual to function with greater independence in the home. In order to receive minor home modifications under this program, the individual would require institutionalization without these adaptations. Adaptations may include widening of doorways, modification of bathroom facilities, installation of ramps, or other minor modifications which are necessary to achieve a specific rehabilitative goal defined in the IRP and prior approved by HHSC. Adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. are excluded from minor home modifications. Adaptations thatadd to the total square footage of the home are excluded from this benefit. Minor home modifications are not made to residential settings that are leased, owned, or controlled by service providers. All minor home modifications are provided in accordance with applicable state or local building codes.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

The minor home modifications must be necessary to address specific functional limitations documented in the individual's recovery plan and must be approved by HHSC.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

✔	Categorically needy *(specify limits)*:
	There is an individual limit of $7,500.00 per lifetime for minor home modifications. Once that maximum

	is reached, $300 per service plan year per individual will be allowed for repair, replacement, or updating of existing modifications. The agency is responsible for obtaining cost-effective modifications authorized on the individual's plan. Should an individual require environmental modifications after the cost cap has been reached, the service planning team will assist the individual/family to access any other resources or alternate funding sources. Requests for exceptions will be evaluated on a case-by-case basis, including evaluation of need and exhaustion of all other means of obtaining the necessary minor home modification.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
HCBS provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.			HCBS provider agency enrolled and contracted with HHSC to provide HCBS services. The agency must comply with the requirements for delivery of minor home modifications, which include requirements as to type of allowed modifications, time frames for completion, specifications for the modification, inspections of modifications, and follow-up on the completion of the modification. Individual providers must meet applicable laws and regulations for the provision of the approved minor home modification and provide modifications in accordance with applicable state and local building codes. Qualified building contractors provide minor home modifications in accordance with state and local building codes and other applicable regulations.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
HCBS provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.	HHSC	Biennial

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	✔	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:

Service Title:	Nursing
Service Definition (Scope)*:*	

enrollment.		
Nurse	HCBS Provider agency	Biennial

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	✔	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:

Service Title:	Substance Use Disorder (SUD) Services (abuse and dependence)

Service Definition (Scope):

Substance Use Disorder (SUD) services are assessment and ambulatory group and individual counseling for substance use disorders. Services are specialized to meet the needs of individuals who have experienced extended institutional placement. Providers must follow evidence-based or evidence-informed treatment modalities approved by HHSC. Services may be provided in the individual's home or other community-based setting. Individuals must exhaust other state plan SUD benefits before choosing the HCBS SUD benefit unless other state plan benefits are not appropriate to meet the individual's needs, limitations, and recovery goals as determined by the independent evaluation (e.g. severe cognitive or social functioning limitations, or a mental disability). Services are designed to assist the individual in achieving specific recovery goals identified in the IRP and in preventing relapse. Services are also designed to respect the individual's culture, while addressing attitudinal and behavioral challenges that may impede the individual from realizing their desired recovery goals. Therapeutic modalities may include motivational interviewing; individual, group, and family counseling; psycho-education; medication management; harm reduction; and relapse-prevention. SUD treatment plans will be developed with active participation of the individual to specifically address and accommodate the individual's needs, goals, and preferences and will support the overall HCBS recovery goals. Services will be provided using a team approach which integrates other HCBS services, such as peer support as appropriate to the individual's needs and preferences.

This 1915(i) service is only provided to individuals age 21 and over. All medically necessary SUD services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

✔	Categorically needy *(specify limits)*:
	This service may not be provided on the same day and at the same time as state plan SUD services.
☐	Medically needy *(specify limits)*:
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
HCBS provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment, which employs or contracts	Individual counselors providing the SUD service must be Qualified Credentialed Counselors		If the HCBS provider contracts with SUD treatment programs, these programs must be licensed by the Texas Department of State Health Services as Chemical Dependency Treatment Programs. Individual providers must be licensed and/or appropriately credentialed to provide services

and directly supervises Licensed Chemical Dependency Treatment providers	(QCCs) as defined by HHSC. SUD treatment programs must be licensed by the Texas Department of State Health Services as Chemical Dependency Treatment Programs.		and act within the scope of their licensure and/or credentialing. Before entering into a provider agreement with the provider agency, HHSC verifies the providers' compliance with these qualifications through a credentialing process. Contracted providers are obligated to verify on an ongoing basis that these qualifications are achieved, maintained, and documented in personnel files. HHSC will conduct biennial review to verify these requirements continue to be met after the provider and HHSC enter into an agreement.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
HCBS provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.	HHSC	Biennial

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	✔	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:

Service Title:	HCBS – AMH Recovery Management

Service Definition (Scope)*:*

Service Definition (Scope):

Recovery Management includes services assisting beneficiaries in gaining access to needed Medicaid State Plan and HCBS services, as well as medical, social, educational, and other resources, regardless of funding source. Recovery Managers are responsible for monitoring the provision of services included in the IRP to ensure that the individual's needs, preferences, health, and welfare are promoted. The recovery manager:

- Coordinates / leads development of the IRP using a person-centered planning approach which supports the individual in directing and making informed choices according to the individual's needs and preferences;
- Provides supporting documentation to be considered by HHSC in the independent evaluation and reevaluations;
- Identifies services / providers, brokers to obtain and integrate services, facilitates, and advocates to resolve issues that impede access to needed services;
- Develops / pursues resources to support the individual's recovery goals including non-HCBS Medicaid, Medicare, and/or private insurance or other community resources;
- Assists the individual in identifying and developing natural supports (family, friends, and other community members) and resources to promote the individual's recovery;
- Informs consumers of fair hearing rights;
- Assists HCBS-AMH consumers with fair hearing requests when needed and upon request;
- Educates and informs individuals about services, the individual recovery planning process, recovery resources, rights, and responsibilities;
- Actively coordinates with other individuals and/or entities essential to physical and/or behavioral services for the individual (including the individual's MCO) to ensure that other services are integrated and support the individual's recovery goals, health, and welfare;

- Monitors health, welfare, and safety through regular contacts (visits with the individual, paid and unpaid supports, and natural supports) at a minimum frequency required by HHSC;
- Responds to and assesses emergency situations and incidents and assures that appropriate actions are taken to protect the health, welfare, and safety of individuals;
- Reviews provider service documentation and monitors the individual's progress;
- Initiates recovery plan team discussions or meetings when services are not achieving desired outcomes. Outcomes include housing status, employment status, involvement in the criminal justice system, response to treatment and other services, and satisfaction with services; and
- Through the recovery plan monitoring process, solicits input from consumer and/or family, as appropriate, related to satisfaction with services.

In the performance of the monitoring function, the recovery manager will:

- Arrange for modifications in services and service delivery, as necessary;
- Advocate for continuity of services, system flexibility and integration, proper utilization of facilities and resources, accessibility, and beneficiary rights; and
- Participate in any HHSC-identified activities related to quality oversight and provide reporting as required by HHSC.

Recovery management includes functions necessary to facilitate community transition for beneficiaries who receive Medicaid-funded institutional services (e.g., Institutions for Mental Disease). Recovery management activities for individuals leaving institutions must be coordinated with, and must not duplicate, institutional discharge planning. This service may be provided up to 180 days in advance of anticipated movement to the community.

The maximum caseload for a recovery manager providing services through HCBS-AMH is set by HHSC and includes individuals in other waiver or state plan programs and other funding sources, unless the requirement is waived by HHSC.

Services must be delivered in a manner that supports the consumer's communication needs, including age-appropriate communication and translation services for beneficiaries that are of limited-English proficiency or who have other communication needs requiring translation assistance.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.
(Choose each that applies):

✔ Categorically needy *(specify limits):*

The following activities are excluded from recovery management as a billable HCBS-AMH service:

- Travel time incurred by the recovery manager may not be billed as a discrete unit of service;
- Services that constitute the administration of another program such as child welfare or child protective services, parole and probation functions, legal services, public guardianship, special education, and foster care; and
- Representative payee functions.

Recovery management may only be provided by agencies and individuals employed by agencies who are not:

- Related by blood or marriage to the consumer;
- Financially or legally responsible for the consumer;
- Empowered to make financial or health-related decisions on behalf of the consumer; or
- Providers of HCBS-AMH for the individual, or those who have interest in or are employed by a provider of HCBS-AMH on the IRP, except when the provider is the only willing and qualified entity in a geographic area whom the individual consumer chooses to provide the service (provider of last resort)

The Recovery Manager is responsible for coordination of services, including coordinating HCBS-AMH services, coordinating with the MCO that is providing other Medicaid services, and coordinating services provided by third parties. Recovery management providers will coordinate with the individual's MCO to assure that other case management services are not being provided to the individual. The State will periodically review claims data in search of duplicative claims and adjust system edits accordingly, and when claims processing is automated through MMIS, system edits will prevent processing of duplicative claims.

HHSC will enroll HCBS-AMH Provider Agencies and Recovery Management entities through separate Open Enrollments and will actively recruit both types of entities. Due to enormous geographic area of Texas and mental health professional shortages in the state (especially rural and frontier areas), Texas anticipates that some service areas may not have separate Provider Agencies and Recovery Management Entities that meet requirements of the program and provider agreement. In lieu of denying an individual life in his/her community of choice due to lack of available Provider Agencies and Recovery Management Entities, the State foresees that in this circumstance an HCBS provider of last resort may also provide recovery management services with certain conflict of interest protections in place.

When an HCBS provider of last resort also provides recovery management services, HHSC will require a clear separation of provider and recovery management functions. The distinct individual staff providing recovery management must be administratively separate from other HCBS-AMH provider functions and any related utilization review units and functions. Recovery Managers who work for provider agencies that are providing other HCBS-AMH services as the provider of last resort will not be providers of any other HCBS-AMH service on the IRP. HHSC reviews the administrative structure of the HCBS-AMH agency to ensure that there is a clear administrative separation of recovery management and HCBS-AMH provider staff/functions before approving a provider to serve as a recovery manager, and periodically reviews (including unannounced site-reviews) the individuals performing recovery management to ensure that they are not providers of HCBS-AMH and not under the administrative control of units providing HCBS-AMH services. HHSC will also review resulting IRPs to ensure that there is no conflict of interest.

This service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service.

Recovery management functions necessary to facilitate community transition may not be billed under TAS.

☐	Medically needy *(specify limits)*:
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Recovery management provider enrolled and contracted with HHSC to provide recovery management services, or a recovery management entity which employs or contracts with individual recovery management providers			Individual providers of recovery management must: • Have at least 2 years of experience working with people with severe mental illness; • Have a master's degree in human services or a related field (the requirement to have a master's degree may be waived by HHSC if HHSC determines that waiver is necessary to provide access to care to Medicaid recipients); • Demonstrate knowledge of issues affecting people with severe mental illness and community-based interventions/resources for this population; and • Complete HHSC-required training in the HCBS-AMH program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
HCBS provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.	HHSC	Biennial

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	✔	Provider managed

2. ▣ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

The State permits HCBS agencies to make payment to legally responsible individuals, legal guardians, and relatives for furnishing State Plan HCBS, only for Host Home services.
A) relative other than a spouse; court appointed guardian; legally authorized representative
B) Host Home/Companion Care
C) Host Home/Companion Services are provided to meet the person's needs as determined by an individualized assessment performed in accordance with HHSC. The services are coordinated within the context of the IRP which delineates how Host Home/Companion Care Services are intended to achieve the identified goals.
D) HHSC reviews the authorized host home/companion setting on an ongoing basis to ensure that it is community-based, inclusive and meets federal and state HCBS setting requirements. HHSC staff conduct periodic reviews of residential services in all settings to include unannounced site visits to provider-owned or operated settings. If the monitoring suggests that a change in service is needed, an independent reassessment is conducted by HHSC, or its designee, to re-evaluate the participant to determine the appropriateness of the service in accordance with HHSC requirements.
E) HCBS-AMH Provider must have written documentation to support a service claim for Host Home/Companion Care as outlined in the HCBS-AMH billing guidelines. HHSC shall monitor performance of program activities and conduct regular data verification via onsite and/or desk reviews. The process includes comparing the scope, frequency, duration, and amount of authorized services reported on the IRP with services reported on the provider invoice. Billable services are subject to prior approval by HHSC and may be subject to periodic reviews to ensure fidelity with evidence-based practice.

6. **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and: Specifies the State plan HCBS that the individual will be responsible for directing; Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget; Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual; Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and Specifies the financial management supports to be provided.

7. **Voluntary and Involuntary Termination of Participant-Direction.** *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

8. **Opportunities for Participant-Direction**

a. **Participant–Employer Authority** *(individual can select, manage, and dismiss State plan HCBS providers). (Select one):*

(●)	The state does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. **Participant–Budget Authority** *(individual directs a budget that does not result in payment for medical assistance to the individual). (Select one):*

(●)	The state does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*

	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

	AMH services
Frequency	Biennially
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HHSC
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	Settings meet the home and community-based setting requirements as specified in this SPA.
Discovery	
Discovery Evidence *(Performance Measure)*	1. Number and percent of HCBS settings meeting appropriate licensure or certification and Federal HCBS requirements.
Discovery Activity *(Source of Data & sample size)*	Representative sample, with a confidence level of 95 percent, of provider agencies, desk or on- site reviews, and report of recovery managers
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	HHSC collects, generates, aggregates, and analyzes a representative sample, with a confidence level of 95 percent, of provider agencies, onsite reviews, and report of recovery managers of the number and percent of HCBS settings meeting appropriate licensure or certification and Federal HCBS requirements
Requirement	Settings meet the home and community-based setting requirements as specified in this SPA.
Frequency	Biennial monitoring reviews
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HHSC
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	The SMA retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence *(Performance Measure)*	1. Number and percent of aggregated performance measure reports generated and reviewed by the State Medicaid Agency that contain discovery, remediation, and system improvements for ongoing compliance of the assurances. 2. Number and percent of state plan amendments, renewals, and financial reports approved by HHSC prior to implementation by HHSC. 3. Number and percent of SPA concepts and policies requiring MMIS programming approved by HHSC prior to the development of a formal implementation plan by HHSC.
Discovery Activity *(Source of Data & sample size)*	Reports to HHSC on delegated administrative functions; 100 percent sample size
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	HHSC collects, generates, aggregates, analyzes
Requirement	The SMA retains authority and responsibility for program operations and oversight.
Frequency	Biennially
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HHSC
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	HHSC maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of paid claims that reflect only the services listed in accordance with the participant's IRP. 2. Number and/or percentage of rates which remain consistent with the approved rate methodology throughout the five-year SPA cycle.
Discovery Activity *(Source of Data & sample size)*	Routine claims verification audits; Representative sample, with confidence level of 95 percent of case managers. Annual review of rate setting methodology

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	HHSC collects, generates, aggregates, and analyzes
Requirement	HHSC maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
Frequency	Biennially
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HHSC
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	The State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation (ANE), including the use of restraints.
Discovery	
Discovery Evidence *(Performance Measure)*	1. Number and/or percent of reports related to the abuse, neglect, exploitation, and unexplained deaths of participants where an investigation was completed within time frames established by State law. 2. Number and percent of participants who received information on how to report the suspected abuse, neglect, or exploitation of adults. 3. Number and percent of participants who received information regarding their rights to a state fair hearing via the official state form. 4. Number and percent of grievances filed by participants that were resolved within 14 calendar days according to approved SPA guidelines. 5. Number and percent of allegations of abuse, neglect, or exploitation investigated that were later substantiated, where recommended actions to protect health and welfare were implemented. 6. Number and percent of participants' critical incidents related to ANE that were reported, initiated, reviewed, and completed within required timeframes as specified in the approved SPA. 7. Number and percent of unauthorized uses of restrictive interventions that were appropriately reported. 8. Number and percent of HCBS participants reviewed who had an annual comprehensive nursing assessment.
Discovery Activity *(Source of Data & sample size)*	100 percent sample, HHSC performance monitoring of reports related to abuse, neglect, exploitation, or unexplained deaths; critical incidents; reports of restrictive intervention application; and; reports of ANE by primary care or physical health providers.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	HHSC collects, generates, aggregates, and analyzes.

Requirement	The State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation (ANE), including the use of restraints.
Frequency	Biennially
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HHSC
Frequency *(of Analysis and Aggregation)*	Annually

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. **Methods for Analyzing Data and Prioritizing Need for System Improvement**

Program performance data
- Track and trend system performance
- Analyze discovery

Quality management meetings
- Assess system
- changes
- Focus on reporting
- requirements and
- refining reports

Onsite and/or desk reviews
- Documentation review
- Interviews

Corrective action plans (CAP)

2. **Roles and Responsibilities**

HHSC will collect, collate, review, and post. HHSC will review the data and have final direction over corrective action plans. HHSC will collect, analyze, and report. HHSC provides oversight and direction.

HHSC coordinates and conducts onsite and/or desk reviews. HHSC provides oversight and direction. Biennially, HHSC [reviews] clinical operations (utilization management, quality management, care management, compliance with HCB settings requirements). Compliance issues will require the submission of a corrective action plan to HHSC for approval and ongoing monitoring.

The provider shall be actively engaged in the development of the corrective action plan (CAP) to the satisfaction of the State. The CAP is monitored by HHSC-, which has final direction over the CAP. Areas for improvement will be monitored as per CAP and presented quarterly during Quality Management meetings and includes analysis of performance data and onsite review findings of program non-compliance follow-up.

3. **Frequency**

- Program performance data - Updated monthly and reported quarterly
- Quality management meetings – Quarterly meetings
- Onsite and/or desk reviews – Biennially
- Corrective action plans (CAP) - Areas for improvement will be monitored as per CAP and presented quarterly during Quality Management meetings

4. Method for Evaluating Effectiveness of System Changes

- Program performance data
  - Set performance benchmarks
  - Review of service trends
  - Review program implementation
  - Track and trend system performance
  - Analyze the discovery; synthesize the data;
  - HHSC, with HHSC, will make corrective action plans regarding quality improvement (QI).
  - HHSC will review QI recommendations quarterly and build upon those improvements through continuous quality improvement.
- Quality management meetings
  - Monitoring contract and HCBS compliance for service delivery
  - Review of clinical assessment client outcome measures
- Onsite and/or desk reviews
  - Review of clinical operations (utilization management, quality management, care management, compliance with HCB settings requirements)
  - Compliance issues will require the submission of a corrective action plan to HHSC for approval and ongoing monitoring.
- Corrective action plans (CAP) - Areas for improvement will be monitored as per CAP and presented quarterly during Quality Management meetings
  - Analysis of performance data
  - Onsite and/or desk review findings of program non- compliance follow-up