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**State/Territory Name: Texas**

**State Plan Amendment (SPA) #: 25-0008**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Form CMS-179
- 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

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August 13, 2025

Emily Zalkovsky, Medicaid Director  
Texas Health & Human Services Commission  
PO Box 13247  
Austin, TX 78711

RE: Texas Adult Mental Health Benefit TN# 25-0008 §1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal

Dear Director Zalkovsky:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's 1915(i) state plan home and community-based services (HCBS) state plan amendment (SPA), transmittal number TX 25-0008. The purpose of this amendment is to renew Texas' 1915(i) state plan HCBS benefit. The effective date for this renewal is September 1, 2025. Enclosed is a copy of the approved SPA.

Since the state has elected to target the population who can receive §1915(i) state plan HCBS, CMS approves this SPA for a five-year period expiring August 31, 2030, in accordance with §1915(i)(7) of the Social Security Act. To renew the §1915(i) state plan HCBS benefit for an additional five-year period, the state must submit a renewal application to CMS at least 180 days prior to the end of the approval period. CMS approval of a renewal request is contingent upon state adherence to federal requirements and the state meeting its objectives with respect to quality improvement and beneficiary outcomes.

Per 42 CFR §441.745(a)(i), the state will annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in the §1915(i) state plan HCBS benefit in the previous year. Additionally, at least 21 months prior to the end of the five-year approval period, the state must submit evidence of the state's quality monitoring in accordance with the Quality Improvement Strategy in their approved SPA. The evidence must include data analysis, findings, remediation, and describe any system improvement for each of the §1915(i) requirements.

CMS reminds the state that the state must have an approved spending plan in order to use the money realized from section 9817 of the ARP. Approval of this action does not constitute approval of the state's spending plan.

It is important to note that CMS approval of this 1915(i) HCBS state plan benefit renewal 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](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](mailto:lynn.ward@cms.hhs.gov) or (214) 767-6327.

Sincerely,

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

Enclosure

cc:

Texas HHSC Medicaid mailbox  
Kathi Montalbano, TX HHSC  
Courtney Carothers, TX HHSC  
Matthew Weaver, CMS DLTSS  
Kathy Poisal, CMS DLTSS  
Deanna Clark, CMS DLTSS  
Cynthia Nanes, CMS DHCBSO  
Wendy Hill-Petras, CMS DHCBSO  
George Failla, CMS Director DHCBSO  
Shante Shaw, CMS DHCBSO

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

1. TRANSMITTAL NUMBER

2 5 0 0 0 8

2. STATE

T X

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL  
SECURITY ACTTO: CENTER DIRECTOR  
CENTERS FOR MEDICAID & CHIP SERVICES  
DEPARTMENT OF HEALTH AND HUMAN SERVICES4. PROPOSED EFFECTIVE DATE  
**September 1, 2025**

5. FEDERAL STATUTE/REGULATION CITATION

1915(i) of the Social Security Act and 42 CFR 441.700, Et seq.

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)

a. FFY 2025 \$ 14,984,318b. FFY 2026 \$ 15,555,965

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

**SEE ATTACHMENT TO BLOCKS 7 & 8**8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable)**SEE ATTACHMENT TO BLOCKS 7 & 8**

9. SUBJECT OF AMENDMENT

**The proposed amendment renews the §1915(i) Home and Community-Based Services—Adult Mental Health (HCBS-AMH) program.**

10. 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.

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME

**Emily Zalkovsky**

13. TITLE

**State Medicaid Director**

14. DATE SUBMITTED

**February 26, 2025**

15. RETURN TO

**Emily Zalkovsky  
State Medicaid Director  
Post Office Box 13247, MC: H-100  
Austin, Texas 78711****FOR CMS USE ONLY**

16. DATE RECEIVED

February 27, 2025

17. DATE APPROVED

August 13, 2025

**PLAN APPROVED - ONE COPY ATTACHED**

18. EFFECTIVE DATE OF APPROVED MATERIAL

September 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

George P. Failla, Jr.

21. TITLE OF APPROVING OFFICIAL

Director, Division of HCBS Operations and Oversight

22. REMARKS



**Attachment to Blocks 7 & 8 of CMS Form 179**

**Transmittal Number 25-0008**

<b><u>Number of the Plan Section or Attachment</u></b>	<b><u>Number of the Superseded Plan Section or Attachment</u></b>
3.1-i	3.1-i
P. 1-4	20-0003
p. 5	21-0053
p. 6-8	20-0003
p. 9-11	21-0053
p. 12-19	20-0003
p. 20-25	22-0026
p. 26	20-0003
p. 27	22-0026
p. 28	21-0053
p. 29	20-0003
p. 30	21-0053
p. 31	20-0003
p. 32	22-0026
p. 33	21-0053
p. 34	20-0003
p. 35-36	21-0053
p. 37-38	20-0003
p. 39-40	21-0053
p.41-43	20-0003
p. 44	21-0053
p. 45-47	20-0003
p. 48	21-0053
p. 49	24-0008
p. 50-53	20-0003
p. 54	20-0003
p. 55-60	21-0053
p. 61	24-0008
p. 62-68	21-0053
p. 69-72	20-0003
p. 73-75	24-0019
p. 76-82	21-0053
 <b><u>4.19-B</u></b>	 <b><u>4.19-B</u></b>
p. 83	20-0003
p. 84	23-0024
p.85-86	20-0003

## 1915(i) State plan Home and Community-Based Services

### Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

1. **Services.** (Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):

Transition Assistance Services (TAS);  
 HCBS Psychosocial Rehabilitation Services;  
 Adaptive Aids;  
 Employment Services;  
 Transportation;  
 Community Psychiatric Supports and Treatment (CPST);  
 Peer Support;  
 Host Home/Companion Care;  
 Supervised Living Services;  
 Assisted Living Services;  
 Supported Home Living;  
 Respite Care;  
 Home Delivered Meals;  
 Minor Home Modifications;  
 Nursing;  
 Substance Use Disorder (SUD) Services;  
 Home and Community-Based Services -Adult Mental Health (HCBS-AMH)- Recovery Management

2. **Concurrent Operation with Other Programs.** (Indicate whether this benefit will operate concurrently with another Medicaid authority):

Select one:

<input checked="" type="radio"/>	<b>Not applicable</b>
<input type="radio"/>	<b>Applicable</b>
Check the applicable authority or authorities:	
<input type="checkbox"/>	<b>Services furnished under the provisions of §1915(a)(1)(a) of the Act.</b> The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may <i>voluntarily</i> elect to receive <i>waiver</i> and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. <i>Specify:</i> (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the specific 1915(i) State plan HCBS furnished by these plans; (d) how payments are made to the health plans; and

	<i>(e) whether the 1915(a) contract has been submitted or previously approved.</i>	
<input type="checkbox"/>	<b>Waiver(s) authorized under §1915(b) of the Act.</b> <i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i>	
	Specify the §1915(b) authorities under which this program operates ( <i>check each that applies</i> ):	
<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)	<input type="checkbox"/> §1915(b)(3) (employ cost savings to furnish additional services)
<input type="checkbox"/>	§1915(b)(2) (central broker)	<input type="checkbox"/> §1915(b)(4) (selective contracting/limit number of providers)
<input type="checkbox"/>	<b>A program operated under §1932(a) of the Act.</b> <i>Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:</i>	
<input type="checkbox"/>	<b>A program authorized under §1115 of the Act.</b> <i>Specify the program:</i>	

**3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit.** (*Select one*):

<input checked="" type="radio"/>	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program ( <i>select one</i> ):	
<input type="radio"/>	The Medical Assistance Unit ( <i>name of unit</i> ):	
<input checked="" type="radio"/>	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
	<i>(name of division/unit)</i> <i>This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.</i>	Health and Human Services Commission Intellectual and Developmental Disability and Behavioral Health Services Department
<input type="radio"/>	The State plan HCBS benefit is operated by ( <i>name of agency</i> )	

	<p>a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.</p>
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**4. Distribution of State plan HCBS Operational and Administrative Functions.**

(By checking this box the state assures that): When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(Check all agencies and/or entities that perform each function):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2 Eligibility evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3 Review of participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4 Prior authorization of State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Execution of Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Establishment of a consistent rate methodology for each State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

1. Individual State plan HCBS enrollment: HCBS contracted providers are responsible for completing enrollment forms, including provider selection and consent. The determination of enrollment is made by HHSC staff.
2. Eligibility evaluation: The assessment is conducted by the Local Mental Health Authorities. Eligibility determinations are made by HHSC staff.
3. Review of participant service plans: Recovery Management Entities (RME) are responsible for developing participant service plans. HHSC reviews and approves all service plans.

(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. 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 biennially reviews 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 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: <https://demographics.texas.gov/Estimates/2022/#pageContent>



- 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 of staff 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 planning meetings.
- 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 the individual 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/or appeals.
- 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.

## Number Served

### 1. Projected Number of Unduplicated Individuals To Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	09/01/2025	08/31/2026	458
Year 2	09/01/2026	08/31/2027	464
Year 3	09/01/2027	08/31/2028	475
Year 4	09/01/2028	08/31/2029	486
Year 5	09/01/2029	08/31/2030	497

2. ☒ **Annual Reporting.** (By checking this box the state agrees to): annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

## Financial Eligibility

1. ☒ **Medicaid Eligible.** (By checking this box the state assures that): Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

### 2. Medically Needy (Select one):

☒ The State does not provide State plan HCBS to the medically needy.

☐ The State provides State plan HCBS to the medically needy. (Select one):



☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.

☐ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

## Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

<input checked="" type="radio"/>	Directly by the Medicaid agency
<input type="radio"/>	By Other ( <i>p</i> <i>ify</i> <i>S</i> <i>agency</i> <i>i</i> <i>y</i> <i>nder</i> <i>c</i> <i>i</i> <i>h</i> <i>the</i> <i>St</i> <i>M</i> <i>di</i> <i>id</i> <i>agen</i> <i>y</i> )

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. (*Specify qualifications*):

HHSC staff that perform the evaluations and reevaluations meet the following criteria: Bachelor's degree, masters preferred, from a U.S. accredited college or university with specialization in health services, business administration, human services, public policy, social work or related areas. Licensed Practitioner of the Healing Arts (LPHA) preferred, not required.

and

Has received HHSC-approved training in evaluating individuals for HCBS-AMH.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The evaluation / reevaluation is conducted using the Adult Needs and Strengths Assessment (ANSA) , medical records, and jail records to determine whether an individual meets the HCBS eligibility criteria and HHSC verifies the individual is Medicaid eligible. The assessment is conducted by the Local Mental Health Authorities. State Hospitals may conduct assessments as part of discharge planning. Eligibility determinations are made by HHSC staff.

4. ☒ **Reevaluation Schedule.** *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☒ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

The criteria takes into account the individual's support needs and risk factors. An individual is eligible for State Plan HCBS under the HCBS-AMH program if the individual requires HCBS-AMH level of service to maintain stability, improve functioning, prevent relapse, maintain residence in the community and who is assessed and found that, but for the provision of HCBS for stabilization and maintenance purposes, would decline to prior levels of need, i.e. subsequent medically necessary services and coordination of care for stabilization and maintenance is needed to prevent decline to previous needs-based functioning. This need is determined through evaluation and reevaluation of functional need using a standardized instrument (the Adult Needs and Strengths Assessment (ANSA)).

Any individual is eligible for State plan HCBS under the HCBS-AMH program if they meet all of the following:

- The individual has a functional need demonstrated by an ANSA score of 2 or higher, which indicates the need for hands-on assistance, in at least one of following 6 items in the Life Domain.
  - Physical/Medical
  - Family Functioning
  - Employment
  - Social Functioning
  - Living Skills
  - Residential Stability

In addition to meeting the above functional criterion, the individual must also meet one of the following risk factors:

- 1) 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).
- Or
- 2) In the three years prior to initial enrollment in HCBS-AMH two or more psychiatric crises (i.e., inpatient psychiatric hospitalizations and/or outpatient psychiatric crisis that meets inpatient psychiatric criteria) and four or more repeated arrests or discharges from correctional facilities.
- Or
- 3) In the three years prior to initial enrollment in HCBS-AMH two or more psychiatric crises (i.e., inpatient psychiatric hospitalizations and/or outpatient psychiatric crisis that meets inpatient psychiatric criteria) and fifteen or more total emergency department (ED) visits.

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)
<p>The individual must meet all the following:</p> <ul style="list-style-type: none"> <li>The individual has a functional need demonstrated by an ANSA score of 2 or higher, which indicates the need for hands-on assistance, in at least one of following 6 items in the Life Domain. <ul style="list-style-type: none"> <li>Physical/Medical</li> <li>Family Functioning</li> <li>Employment</li> <li>Social Functioning</li> <li>Living Skills</li> <li>Residential Stability</li> </ul> </li> <li>In addition to meeting the above functional criterion, the individual must also meet one of the following risk categories factors: 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);</li> </ul>	<p>The individual must:</p> <p>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)</p> <p>According to Texas rules (26 Tex. Admin. Code §554.2401), an individual must meet both of the following criteria for medical necessity:</p> <p>1. The individual must demonstrate a medical condition that:</p> <p>*is of sufficient seriousness that the individual's needs exceed the routine care which may be given by an untrained person; and</p> <p>*requires licensed nurses' supervision, assessment,</p>	<p>The individual must:</p> <p>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)</p> <p>1. Have a diagnosed developmental disability. The term "developmental disability" means a severe, chronic disability of an individual that:</p> <p>*is attributable to a mental or physical impairment or combination of mental and physical impairments;</p> <p>*is manifested before the individual attains age 22;</p>	<p>The individual must:</p> <p>1. Have a valid diagnosis as listed in the current version of the ICD as the principal admitting diagnosis and one of the following:</p> <p>a. Outpatient therapy or partial hospitalization has been attempted and failed.</p> <p>b. A psychiatrist has documented reasons why an inpatient level of care is required.</p> <p>AND</p> <p>2. The individual must meet at least one of the following criteria:</p> <p>a. The individual is presently a danger to self, demonstrated by at least one of the following:</p> <p>(i) Recent suicide attempt or active suicidal threats with a deadly plan, and there is</p>

<ul style="list-style-type: none"> <li>• Demonstrate in the three years prior to initial enrollment in HCBS-AMH two or more psychiatric crises (i.e., inpatient psychiatric hospitalizations and/or outpatient psychiatric crisis that meets inpatient psychiatric criteria) four or more repeated arrests or discharges from correctional facilities;</li> <li>• Demonstrate in the three years prior to initial enrollment in HCBS-AMH two or more psychiatric crises (i.e., inpatient psychiatric hospitalizations and/or outpatient psychiatric crisis that meets inpatient psychiatric criteria) and fifteen or more total emergency department (ED) visits.</li> </ul> <p>Note: Individuals in HCBS-AMH are not required to demonstrate the need for services that require 24-hour-a-day medical observation, supervision, and intervention.</p>	<p>planning, and intervention that is available only in an institution.</p> <p>AND</p> <p>2. The individual must require medical or nursing services that:</p> <ul style="list-style-type: none"> <li>*are ordered by a physician;</li> <li>*are dependent upon the individual's documented medical conditions;</li> <li>*require the skills of a registered or licensed vocational nurse;</li> <li>*are provided either directly by or under the supervision of a licensed nurse in an institutional setting; and</li> <li>*are required on a regular basis.</li> </ul> <p>Medical necessity and level of institutional need is determined by assessing the individual's functioning using the Minimum Data Set (MDS), version 3.0. for NFs.</p> <p>Medical necessity and level of care for STAR+PLUS</p>	<ul style="list-style-type: none"> <li>*is likely to continue indefinitely;</li> <li>*results in substantial functional limitations in 3 or more of the following areas of major life activity: <ul style="list-style-type: none"> <li>(i) Self-care.</li> <li>(ii) Receptive and expressive language.</li> <li>(iii) Learning.</li> <li>(iv) Mobility.</li> <li>(v) Self-direction.</li> <li>(vi) Capacity for independent living.</li> <li>(vii) Economic self-sufficiency;</li> </ul> </li> </ul> <p>and</p> <ul style="list-style-type: none"> <li>*reflects the individual's need for a combination and sequence of special, inter disciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.</li> </ul> <p>AND</p> <p>2. Require active treatment in an institutional setting specifically designed for treatment of intellectual and</p>	<p>an absence of appropriate supervision or structure to prevent suicide.</p> <p>(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).</p> <p>(iii) Active hallucinations or delusions directing or likely to lead to serious self-harm or debilitating psychomotor agitation or intellectual disability resulting in a significant inability to care for self.</p> <p>(iv) Significant inability to comply with prescribed medical health regimens due to concurrent psychiatric illness and such failure to comply is potentially hazardous to the</p>
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	HCBS (NF LOC waiver) uses the Medical Necessity/Level of Care (MN/LOC) document.	developmental disabilities.	<p>life of the individual.</p> <p>b. The individual is a danger to others. This behavior must be attributable to the individual's specific diagnosis that can be adequately treated only in a hospital setting. This danger is demonstrated by one of the following:</p> <p>(i) Recent life-threatening action or active homicidal threats of same with a deadly plan, and availability of means to accomplish the plan, with likelihood of acting on the threat.</p> <p>(ii) Recent serious assaultive or sadistic 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 assaultive behavior.</p> <p>(iii) Active hallucinations or delusions directing or likely to lead to serious harm of others.</p>
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			<p>c. The individual exhibits acute onset of psychosis or severe thought disorganization, or there is significant clinical deterioration in the condition of someone with a chronic psychosis, rendering the individual unmanageable and unable to cooperate in treatment, and the individual is in need of assessment and treatment in a safe and therapeutic setting.</p> <p>d. The individual has a severe eating or substance abuse disorder that requires 24- hour-a-day medical observation, supervision, and intervention.</p> <p>e. The individual exhibits severe disorientation of person, place, or time.</p> <p>f. The individual's evaluation and treatment cannot be carried out safely or effectively in other settings due to severely disruptive behaviors and other behaviors, which may also include physical, psychological,</p>
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			<p>or sexual abuse.</p> <p>g. The individual requires medication therapy or complex diagnostic evaluation where the individual's level of functioning precludes cooperation with the treatment regimen.</p> <p>h. The individual is involved in the legal system, manifests psychiatric symptoms, and is ordered by a court to undergo a comprehensive assessment in a hospital setting to clarify diagnosis and treatment needs.</p> <p>AND</p> <p>3. The proposed treatment or therapy requires 24-hour-a-day medical observation, supervision, and intervention and must include all of the following:</p> <p>a. Active supervision by a psychiatrist with the appropriate credentials, as determined by the Texas Medical Board (TMB) or other appropriate entity;</p>
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			<p>b. Implementation of an individualized treatment plan;</p> <p>c. Provision of services that can reasonably be expected to improve the client's condition or prevent further regression so that a lesser level of care can be implemented;</p> <p>d. Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a psychiatrist and is being provided in the least restrictive environment available, and ambulatory care resources available in the community do not meet the client's needs.</p> <p>e. A history of inpatient admission, repeated discharges from correctional facilities, psychiatric crisis, or ED visits is not sufficient to admit an individual to a psychiatric facility.</p>
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\*Long Term Care/Chronic Care Hospital

\*\*LOC= level of care

7. ☒ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

An adult over the age of 18 who meets the following criteria is eligible to receive State Plan HCBS:

**Serious mental illness (SMI)**--An illness, disease, disorder, or condition (other than a sole diagnosis of epilepsy, dementia, substance use disorder, or intellectual or developmental disability) that:

(A) substantially impairs an individual's thought, perception of reality, emotional process, development, or judgment; or

(B) grossly impairs an individual's behavior as demonstrated by recent disturbed behavior.

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

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

8. ☒ **Adjustment Authority.** The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).
9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	<b>Minimum number of services.</b> The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is: <div style="border: 1px solid black; padding: 2px; display: inline-block;">One</div>
ii.	<b>Frequency of services.</b> The state requires (select one):
	<input type="radio"/> <b>The provision of 1915(i) services at least monthly</b>
	<input checked="" type="radio"/> <b>Monthly monitoring of the individual when services are furnished on a less than monthly basis</b> If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

## Home and Community-Based Settings

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

1. ☒ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

Texas assures the settings included with this State Plan amendment (SPA) meet and will continue to meet the HCBS settings requirements. HHSC conducts biennial in-person HCBS settings checks and ad hoc in person HCBS settings checks as needed. This process ensures the settings meet and will continue to meet the HCBS settings requirements.

Individuals receive HCBS in the following settings.

- Host Home/Companion Care
- Community
- Own home/family home
- Assisted Living
- Supervised Living

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.
- The setting options are identified and documented in the person-centered service plan and are based on the individual's needs and preferences.
- 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.

Individuals in provider-owned and controlled residential settings have the following additional rights:

- The individual has a legally enforceable lease, residential agreement, or other form of written agreement that offers the same protections against eviction and appeals processes that tenants have under state landlord/tenant law.
- Each individual has privacy in their sleeping or living unit:
  - o Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
  - o Individuals sharing a unit have a choice of roommate.
  - o Individuals have the freedom to furnish and decorate their sleeping or living units.
  - o Individuals have the freedom and support to control their own schedules and activities.
  - o Individuals have access to food at any time.
  - o Individuals are able to have visitors of their choosing at any time.
  - o The setting is physically accessible to the individual.

Any modifications to these rights must be supported by a specific assessed need and justified in the person-centered service plan, consistent with requirements at 42 CFR 441.530 (a)(1)(vi)(F).

## Person-Centered Planning & Service Delivery

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

1. ☒ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.
2. ☒ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).
3. ☒ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.
4. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.**  
There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

(A) The agent performing the assessment is independent and qualified as defined in §441.730 and meets the provider qualifications defined by the State as listed:

1) Qualified Mental Health Professional -- a person who has demonstrated and documented competency in the work to be performed and:

(A) has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention (as determined by the LMHA or MCO in accordance with 26 TAC, Part 1, Chapter 301, Subchapter G §301.331 (relating to Competency and Credentialing));

(B) is a registered nurse; or

(C) completes an alternative credentialing process identified by HHSC.



Or

2) Licensed Practitioner of the Healing Arts:

- (A) a physician;
- (B) a licensed professional counselor;
- (C) a licensed clinical social worker;
- (D) a psychologist;
- (E) an advanced practice registered nurse recognized by the Texas Board of Nursing as a clinical nurse specialist in psychiatry/mental health or nurse practitioner in psychiatry/mental health; or
- (F) A licensed marriage and family therapist.

And

Has received HHSC-approved training in evaluating individuals for HCBS-AMH.

(B) The individual receives appropriate support during the assessment, including the use of any necessary on-site support-staff.

(C) The agent performing the assessment provides informed consent for this type of assessment.

**5. Responsibility for Development of Person-Centered Service Plan.** There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. (*Specify qualifications*):

Individual providers of recovery management who develop the person-centered service plan 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.

**6. Supporting the Participant in Development of Person-Centered Service Plan.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. (*Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process*):

The Recovery Manager, trained and competent in person-centered planning, will support the individual in all aspects of the individual's recovery process, including assisting the creation of the IRP, helping the individual gain access to needed services and other resources; making informed choices according to individual needs and preferences; resolving issues impeding recovery; and developing strategies/resources to promote recovery. The IRP addresses the individual's personal preferences, choices, and goals.

The person-centered planning is directed by the individual and involves the interdisciplinary team (IDT), which includes participants whom the individual has freely chosen including the individual, recovery manager, provider agency, legally authorized representative, and others, such as natural supports, advocates and service providers.

The IRP is based on information from the independent needs-based assessment, which is conducted by Local Mental Health Authorities and State Hospitals. The individual and team identify the individual's strengths, needs, preferences, and desired outcomes to determine the nature, amount, and scope of Medicaid and non-Medicaid services required. The resulting IRP incorporates the individual's goals and preferences, including those related to community participation in the most integrated setting, employment, income and savings, health care and wellness, education, and others. The IRP also takes into account the participant's social, treatment, and service history.

**7. Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

During the eligibility evaluation process, the contractor delegated to this task will inform the individual of the right to provider choice, inform the individual of available providers in the service area, and assist the individual in selecting a Recovery Management Entity and a Provider Agency. Provider choice must be attested by the individual using the Provider Selection Form.

Each individual will have an assigned Recovery Manager. The Recovery Manager will support the individual in all aspects of their recovery process including assisting the individual in gaining access to needed services and other resources, making informed choice of services and providers according to individual needs and preferences, resolving issues impeding recovery, and developing strategies/resources to promote recovery. The HCBS-AMH Recovery Manager will inform the individual and IDT of qualified provider options when IRPs are developed and revised.

While enrolled in HCBS-AMH, the individual has the right to select a new Recovery Management Entity and Provider Agency if desired. The Recovery Manager or a contractor delegated this task by HHSC will assist the individual in the provider selection process. Provider choice during program enrollment must be attested by the individual using the Provider Selection Update Form. All documentation regarding provider choice is included in the individual's record.

**8. Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency.** *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

The person-centered service plan (Individual Recovery Plan - IRP) will be developed by the individual's recovery manager, with full participation of the individual, HCBS-AMH provider agency, and significant others in a person-centered planning process that is based on the individual's preferences, needs, and personal goals. HHSC will review and authorize the IRPs. Individual plan data will include, at a minimum, the type, amount, and duration of services to be provided; effective dates of service; and individual goals. HHSC will collect and maintain individual recovery plan (IRP) data and provide aggregate reporting on utilization review findings. Services must be planned for and provided in home and community-based settings and provided in the least restrictive manner possible. Individuals are free to participate in services on their IRP or refuse these services.

HHSC uses an electronic data system to collect clinical information and authorize service plans/requests. The Recovery Management Entity and Provider Agency are responsible for ensuring service plans/requests are kept up to date. The HHSC Clinical Management for Behavioral Health Services (CMBHS) system provides a platform for HHSC employees and providers to electronically submit data. The CMBHS system interfaces with the MMIS to allow service authorization and claims payment. This system ensures that authorizations for services are in place ensuring correct claims payment to certified Medicaid providers. All claims will be subject to final review and approval by the single state Medicaid agency.

HHSC will perform first-level review of 100 percent of person-centered service plans, referred to as the Individual Recovery Plans (IRPs), consistent with operating procedures approved by HHSC. HHSC will collect and maintain aggregate performance data. In addition, HHSC will collect and maintain individual IRP data. Individual IRP data includes the IRPs, any supporting documentation, and claims/utilization records related to implementation of the IRPs. HHSC will retain final review and approval authority over the IRPs.

HHSC notifies individuals of his/her rights prior to enrollment into the HCBS-AMH Program. HHSC verifies notification of the individual of his/her rights through the individual or Legally Authorized Representative (LAR) signature on the Notification of Participant Rights Form as part of the enrollment process. The Notification of Participant Rights Form:

- Informs the individual of the contact information for the Department of Family and Protective Services (DFPS) and the Office of the Ombudsman;
- Informs the individual of his/her right to a Fair Hearing regarding the HCBS-AMH Program; and
- Informs the individual of the process for reporting allegations of abuse, neglect and exploitation (ANE) and the toll-free number for DFPS.

HCBS-AMH providers and recovery managers must also provide information to the individual and LAR regarding the participant's rights and how the participant or LAR can notify appropriate authorities or entities when the participant has experienced ANE. This information must be provided by recovery managers and providers when the individual and/or LAR request it, and when the provider or recovery manager identify a need to provide the information.

The use of seclusion is prohibited while delivering HCBS-AMH program services. If used, the provider is required to report use of seclusion as ANE. The use of restraints is prohibited except in a behavioral emergency. A behavioral emergency is a situation involving an individual who is behaving in a violent or self-destructive manner and in which preventive, de-escalative, or verbal techniques have been determined to be ineffective and it is immediately necessary to restrain the individual to prevent:

- imminent probable death or substantial bodily harm to the individual because the individual is attempting to commit suicide or inflict serious bodily harm; or
- imminent physical harm to others because of acts the individual is currently committing.

HCBS-AMH Recovery Management Entities, Provider Agencies, and their staff or subcontractors must adhere to the general requirements for use of restraint and seclusion as described in Chapter 415, Subchapter F of the Texas Administrative Code, Provider Clinical Responsibilities- Mental Health Services, Interventions in Mental Health Services.

The use of planned restrictive interventions is reflected on the individual's IRP, which is submitted to HHSC for approval. The use of restraints and seclusion must be documented as a critical incident by the HCBS-AMH provider and reported to HHSC. Unauthorized use of restrictive interventions will be detected by record review and through complaints.

The use of any restrictive intervention must be reported to HHSC as a critical incident by the provider. All critical incidents are reviewed by HHSC.

The recovery manager shall convene the individual's IDT and document alternative strategies for dealing with behaviors in each of the following circumstances and update the IRP and safety plan accordingly:

- In any case in which behaviors have necessitated the use of restrictive interventions for the same individual more than two times during any 30-day period; and
- When two or more separate episodes of restrictive interventions of any duration have occurred within the same 12-hour period.



HHSC is responsible for overseeing the reporting of and response to critical incidents that affect individuals enrolled in HCBS-AMH. Critical incidents are managed as part of the contract oversight process by HHSC. HHSC utilizes Critical Event or Incident Reporting and Management Processes that enable HHSC to collect information on sentinel events that occur. Critical incidents are situations that threaten the health and safety of the individual or the community or pose a significant change in the individual's status or environment. HCBS-AMH providers shall be responsible for implementing a procedure which ensures the reporting of all critical incidences. Incidences may include, but are not limited to, the following:

- Abuse, neglect, or exploitation of an HCBS-AMH participant;
- Hospital admission and discharge;
- Nursing borne home placement other than for the provision of respite;
- Incarceration;
- Restraint or seclusion of an HCBS-AMH participant;
- A slip or fall, medication error, or medical complication; or
- Incidents caused by the individual such as verbal and/or physical abuse of providers or other participants, destruction or damage of property, contraband, and member self-abuse;
- Eviction from primary residence;
- The individual poses an immediate health or safety risk to self or others; or
- Serious injury or death.

In the case of critical incidents, HCBS-AMH providers are expected to take immediate action to resolve, when feasible, and to report to the appropriate state and/or law enforcement entities. Providers shall submit to HHSC the Critical Incident Report Form within 72 hours of notification of outcome of the incident with any updated information.

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*):

<input checked="" type="checkbox"/>	Medicaid agency	<input type="checkbox"/>	Operating agency	<input checked="" type="checkbox"/>	Case manager
<input checked="" type="checkbox"/>	Other ( <i>specify</i> ):	Provider Agency			

## Services

1. **State plan HCBS.** (*Complete the following table for each service. Copy table as needed*):

<b>Service Specifications</b> ( <i>Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover</i> ):	
Service Title:	Transition Assistance Services (TAS)
Service Definition (Scope):	
TAS pays set-up expenses for individuals transitioning from institutions into community settings. Allowable expenses are those necessary to enable individuals to establish basic households and may include: security deposits for leases on apartments or homes; essential household furnishings and expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed and bath linens; set-up fees or deposits for utility or service access, including telephone, electricity, gas, and water; and services necessary for an individual's health and welfare, such as pest eradication and one-time cleaning prior to occupancy.	
TAS may also include services necessary for an individual's health and welfare, such as pest eradication and	



one- time cleaning prior to occupancy, and activities to assess need, arrange for, and procure needed resources (limited to up to 180 consecutive days prior to discharge).

Providers may only bill Medicaid for TAS on or after the date that the individual is enrolled in the State Plan benefit, on or after the date of discharge from the facility, and pursuant to the IRP. Room and board are not allowable TAS expenses. TAS are furnished only to the extent that the expense is reasonable and necessary, as determined through the individual recovery plan development process, and is clearly identified in the individual recovery plan. The IRP must document that individuals are unable to meet such expenses or the services cannot be obtained from other sources.

TAS does not include: monthly rental or mortgage expenses, food, regular utility charges, major household appliances, or items that are intended for purely recreational purposes. TAS excludes shared expenses, such as furniture and appliances, covered under provider owned or operated residential options.

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):

<input checked="" type="checkbox"/>	<b>Categorically needy (<i>specify limits</i>):</b>
	There is an individual lifetime limit of \$2,500 cost cap per participant for the transition event into his /her own home, including settings with supported home living and companion care arrangements. Individuals transitioning to their own home (not a provider-owned or operated setting) have a need to purchase and arrange for essential household furnishings and expenses required to occupy and use a community domicile.
	There is a one-time benefit of \$1,000 cost cap per participant for the transition event into a host home, supervised living, or assisted living arrangement. This cost cap reflects that, while the individual will need items to personalize their living space, other items such as furniture are provided by the residential setting.
<input type="checkbox"/>	<b>Medically needy (<i>specify limits</i>):</b>
	N/A

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

Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services.			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.
			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.
<b>Verification of Provider Qualifications</b> <i>(For each provider type listed above. Copy rows as needed):</i>			
<b>Provider Type</b> <i>(Specify):</i>	<b>Entity Responsible for Verification</b> <i>(Specify):</i>	<b>Frequency of Verification</b> <i>(Specify):</i>	
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with TAS providers.	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. HHSC will conduct biennial review to verify these requirements continue to be met after the provider and HHSC enter into an agreement	
<b>Service Delivery Method.</b> <i>(Check each that applies):</i>			
<input type="checkbox"/> Participant-directed		<input checked="" type="checkbox"/> Provider managed	

<b>Service Specifications</b> <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>	
<b>Service Title:</b>	HCBS Psychosocial Rehabilitation Services
<b>Service Definition (Scope):</b>	
<p>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. 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 in-person, audio-visual, or audio-only interventions with the individual present. Services may be provided individually or in a group setting. Audio-only is not allowed for group setting interventions. Audio-visual or audio-only option will not be available 100% of the time. All HCBS-AMH participants receive a least one in-person visit during each IRP period. This restriction supports utilization of telehealth delivery of services while supporting community integration. HIPPA compliance remains the responsibility of the provider delivering the service. In order to ensure the privacy of individuals is respected, HCBS-AMH providers are required to sign and submit an attestation form that was developed by HHSC to ensure services are in a private place. In addition, contracted providers must ensure each participant is in a private location where they feel safe to openly discuss their health. HHSC's HIPPA Compliance officer approved the telehealth methodology. Cameras may never be used for any reason in private spaces such as bedrooms, bathrooms, and areas for private phone calls or telehealth delivery services. Cameras are only allowed outside and in common areas, and with the use of consent from each person living in the home.</p> <p>Telehealth delivery of services enhances community integration by providing more flexibility for participation in community activities. Telehealth delivery services can connect participants to a broad range of services and community resources by removing barriers related to physical distance and expanding provider options thereby increasing participant choice. Telehealth delivery of services serves to promote independence and improve</p>	

patient/provider relationships as services can be provided in individualized preferred settings and provides participants ownership to their own treatment of care, thereby increasing opportunities for engagement on their own schedule. Allowing telehealth delivery of services supports community integration by increasing choice and access to multiple providers and community resources in the setting of participants choosing and affording participants equal opportunity to telehealth delivery of services as other individuals in the community. Whenever possible, HHSC encourages in person delivery of services. HCBS-AMH providers must document in the Individual Recovery Plan the reason(s) why telehealth delivery of services was delivered in place of in person delivery.

HHSC is responsible for monitoring the provision of telehealth delivery of services and enforces compliance of service delivery restrictions, participants privacy, and use of adaptive aids through biennial onsite or desk reviews. HCBS-AMH providers shall also establish internal escalation protocols that dictate when a participant receiving telehealth delivery of services should be transitioned to urgent in-person follow-up care, crisis care or intervention, or even receiving emergency services. HCBS-AMH providers must immediately report cases of suspected abuse neglect or exploitation (ANE) to the appropriate investigative authority.

The provider must incorporate research-based approaches pertinent to the needs of the target population. Approaches used must be approved by HHSC.

Rehabilitation services are provided by practitioners working under the direction of the HCBS-AMH Provider Agency and supervision of clinicians who are credentialed or qualified in the specific evidence-based practices.

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*):

HCBS-AMH rehabilitation services cannot be delivered at the same time as State Plan mental health rehabilitative services. Individuals will receive State Plan mental health rehabilitative services if the individual so desires and those services are appropriate for the individual.

Services are subject to prior approval by HHSC and may be subject to periodic reviews to ensure fidelity with evidence-based practice. Service plans for HCBS Psychosocial Rehabilitation must be developed with a practitioner credentialed in the evidence-based practices (EBP). The activities included under HCBS Psychosocial Rehabilitation services must be intended to achieve identified IRP goals or objectives and must be reviewed at least annually with the individual and significant others as part of the IRP process to determine whether the services are meeting related IRP goals and objectives, and may be adjusted as needed to reflect the individual's needs, preferences and progress.

As outlined in the IRP, services may be provided at an office of the provider, in the community, or in the individual's place of residence. Rehabilitative services are not intended to substitute for personal assistance 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-AMH provider enrolled			HCBS provider agency enrolled and contracted with HHSC to provide HCBS-

and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with psychosocial rehabilitation providers.			AMH services, which employs or has a contract with the HCBS Psychosocial Rehabilitation practitioner.  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.
<b>Verification of Provider Qualifications</b> <i>(For each provider type listed above. Copy rows as needed):</i>			
<b>Provider Type</b> <i>(Specify):</i>	<b>Entity Responsible for Verification</b> <i>(Specify):</i>		<b>Frequency of Verification</b> <i>(Specify):</i>
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with psychosocial rehabilitation providers.	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.
<b>Service Delivery Method.</b> <i>(Check each that applies):</i>			
<input type="checkbox"/> Participant-directed		<input checked="" type="checkbox"/> Provider managed	

<b>Service Specifications</b> <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>	
<b>Service Title:</b>	Adaptive Aids
<b>Service Definition (Scope):</b>	
HCBS-AMH allows the use of adaptive aid services to enhance all HCBS-AMH service delivery; telehealth delivery may require additional use of adaptive aids to ensure access for individuals requiring hands on assistance. This may include the purchase of specialized equipment to aid the access of telehealth delivery of services and promoting reasonable accommodations as needed. This may with prior approval from HHSC include communication aids, computers and appropriate accessories, appropriate software, computer evaluations, specifications and training, computer literacy training to educate individuals in use of adaptive	



software necessary to perform activities, webcam, screen readers, visual aids, headphones.

Specialized equipment and supplies including devices, controls and appliances that enable individuals to increase their abilities to perform activities of daily living; to perceive, control, or communicate with the environment in which they live; allow the individual to integrate more fully into the community; or to ensure the health, welfare and safety of the individual.

Adaptive aids include vehicle adaptations or modifications, environmental adaptations, and aids for daily living, such as reachers, adapted utensils, certain types of lifts, pill keepers, reminder devices, signs, calendars, planners, and storage devices.

Vehicle adaptations or modifications that are specified on the IRP may be made to a vehicle that is not owned by the provider and is the individual's primary means of transportation in order to accommodate the identified needs of the individual. Vehicle adaptations or modifications do not include the following: (1) adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual; (2) purchase or lease of a vehicle; and (3) regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modifications.

Adaptive aids also include service animals and items associated with equipping, training, and maintaining the health and safety of a service animal. (These items include veterinary care; travel benefits associated with obtaining and training an animal; and the provision, maintenance, and replacement of items and supplies required for the animal to perform the tasks necessary to assist individuals. The cost effectiveness of medical interventions outside of routine veterinary care is to be determined on an individual basis.) Other items may be included if specifically required to realize a goal specified in the IRP and prior approved by HHSC.

Items reimbursed are in addition to any supports furnished under the State Plan and do not include those items which are not of direct benefit to the individual. All items must meet applicable standards of manufacture, design, and installation.

Service animals must be provided in accordance with the IRP and documented as necessary for the individual to remain in the community.

This 1915(i) service is only provided to individuals age 21 and over. All medically necessary adaptive aid 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*):**

Individual items costing over \$500.00 must be recommended in writing by a licensed practitioner of the healing arts (Physician, Advanced Practice Registered Nurse, Psychologist, Licensed Professional Counselor, Licensed Clinical Social Worker or Licensed Marriage and Family Therapist qualified to assess the individual's need for the specific adaptive aid and be approved by HHSC. Any item costing over \$500.00 must also include comparable bids from three vendors.

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*):

<p>The annual cap is \$10,000 per individual, per year. Should an individual require adaptive aids after the cost limit has been reached, the recovery manager assists the individual/family to access any other resources or alternate funding sources.</p> <p>Adaptive aids are available only after benefits available through Medicare, other Medicaid benefits, or other third-party resources have been documented as exhausted. Adaptive aids are limited to those categories specified in the State Plan amendment.</p>			
<input type="checkbox"/> Medically needy ( <i>specify limits</i> ):			
N/A			
<b>Provider Qualifications</b> ( <i>For each type of provider. Copy rows as needed</i> ):			
Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services.			<p>HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or has contracts with adaptive aid providers.</p> <p>Adaptive aid providers and their employees must comply with all applicable laws and regulations for the provision of adaptive aids.</p>
<b>Verification of Provider Qualifications</b> ( <i>For each provider type listed above. Copy rows as needed</i> ):			
Provider Type ( <i>Specify</i> ):	Entity Responsible for Verification ( <i>Specify</i> ):		Frequency of Verification ( <i>Specify</i> ):
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with adaptive aid providers.	HHSC		<p>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.</p>
<b>Service Delivery Method.</b> ( <i>Check each that applies</i> ):			
<input type="checkbox"/> Participant-directed		<input checked="" type="checkbox"/> 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;
- include systematic job development based on individuals' interests, developing relationships with local employers by making systematic contacts; and
- provide time-unlimited and individualized support for as long the individual wants and needs support.

#### **Supported Employment**

Supported Employment provides individualized services to sustain individuals in paid jobs in regular work settings, who, because of disability, require support to become self-employed, work from home, or perform in a work setting at which individuals without disabilities are employed. Supported employment service options should be reviewed and considered as a component of an individual's person-centered services and supports plan no less than annually, more frequently as necessary or as requested by the individual. Service options are reviewed during the interdisciplinary team (IDT) meeting (which includes members of the individual's care team, HCBS providers, the individual, and the LAR, if applicable) prior to the development of the initial and updated Individual Recovery Plans (IRP). During the IDT, the participant is assessed for all needs, including Supported Employment, which is then documented in the goals and objectives sections of the IRP. Supported Employment includes adaptations, assistance, and training essential for individuals to sustain paid employment at or above the minimum wages and benefits provided to non-disabled workers performing similar jobs. Transporting an individual to support the individual to become self-employed, work from home, or perform in a community-based work setting is billable within the service. Components include:

- on-the-job training and skills development;
- assisting the individual with development of natural supports in the workplace;
- coordinating with employers or employees, coworkers and customers, as necessary. (Note: Coordinating with employers and other employees is done only if the individual prefers to have her or his mental illness disclosed and gives permission);
- providing work incentives planning prior to or during the process of job placement. Work incentives planning involves helping the person review her or his options for working (number of hours per week, etc.), given the hourly pay the person is being offered, or is likely to be offered, the person's current income needs, and the rules concerning how SSA benefits, medical benefits, medical subsidies, and other subsidies (housing, food stamps, etc.) change based on income from paid employment. Work incentives planning allows individuals to make informed decisions about how many hours per week to work, as well as their preferred timing in moving from part-time to full-time work. Individuals also are given information and assistance about reporting earnings to various sources of entitlements/benefits;
- assisting individuals in making informed decisions about whether to disclose their mental illness condition to employers and co-workers; and
- providing follow-along services for as long as the individual needs and desires them to help the individual maintain employment. Follow-along may include periodic reminders of effective workplace practices and reinforcement of skills.

**Employment Assistance**

Employment Assistance helps the individual locate and maintain paid employment in the community and may include activities on behalf of the individual to assist in maintaining employment. Components include:

- identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions;
- engaging the individual in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state's minimum wage. The outcome of this activity is documentation of the individual's stated career objective and a career plan used to guide individual employment assistance;
- providing support to establish or maintain home-based or self-employment, when identified as a goal by the individual;
- locating prospective employers offering employment compatible with the individual's identified preferences, skills, and requirements;
- contacting a prospective employer on behalf of an individual and negotiating the individual's job development/employment;
- developing customized employment options with the individual to meet the individual's needs and preferences; and transporting the individual to help the individual locate paid employment in the community.

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*):



<p>Services do not include payment for the supervisory activities rendered as a normal part of the business setting. Services do not include payment for supervision, training, support, and adaptations typically available to other non-disabled workers filling similar positions in the business. Services do not include adaptations, assistance, and training used to meet an employer's responsibility to fulfill requirements for reasonable accommodations under the Americans with Disabilities Act.</p> <p>Transportation to and from the work site may be a component of and the cost of this transportation may be included in the rate paid to providers, unless the individual can access public transportation or has other means of transportation available to them. If public transportation is available, then it should be utilized by the individual, if at all possible. Documentation must be maintained for each individual receiving this service that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973, relating to vocational rehabilitation services, or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), relating to special education.</p> <p>Services may not be for job placements paying below minimum wage. Services must be delivered in a manner that supports and respects the individual's communication needs including translation services, assistance with, and use of communication devices. Services may not be provided on the same day and at the same time as services that contain elements integral to the delivery of Employment Services (e.g., rehabilitation).</p> <p>Services must be provided in regular integrated settings and do not include sheltered work or other types of vocational services in specialized facilities, or incentive payments, subsidies, or unrelated vocational training expenses such as the following:</p> <ul style="list-style-type: none"> <li>• Incentive payments made to an employer to encourage hiring the individual;</li> <li>• Payments that are passed through to the individual;             <ul style="list-style-type: none"> <li>○ Payments for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business; or</li> <li>○ Payments used to defray the expenses associated with starting up or operating a business.</li> </ul> </li> </ul> <p>The documentation of employment services must be available to HHSC and to the Recovery Manager for monitoring at all times on an ongoing basis. The Recovery Manager will monitor on a quarterly basis to see if the objectives and outcomes are being met.</p>			
<input type="checkbox"/> Medically needy ( <i>specify limits</i> ):			
N/A			
<b>Provider Qualifications</b> ( <i>For each type of provider. Copy rows as needed</i> ):			
Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with a provider of employment services.			<p>HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or has agreements with employment practitioners with training/certification in evidence-based or evidence-informed employment services.</p> <p>The individual provider of employment services must be at least 18 years of age and meet one of the following qualifications:</p> <ul style="list-style-type: none"> <li>• 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</li> </ul>

			<p>people with disabilities;</p> <ul style="list-style-type: none"> <li>• 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</li> <li>• 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.</li> </ul> <p>The individual provider must complete training required by HHSC.</p>
<b>Verification of Provider Qualifications</b> <i>(For each provider type listed above. Copy rows as needed):</i>			
<b>Provider Type</b> <i>(Specify):</i>	<b>Entity Responsible for Verification</b> <i>(Specify):</i>	<b>Frequency of Verification</b> <i>(Specify):</i>	
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with employment service providers.	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.	
<b>Service Delivery Method.</b> <i>(Check each that applies):</i>			
<input type="checkbox"/> Participant-directed		<input checked="" type="checkbox"/> Provider managed	

<b>Service Specifications</b> <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>	
<b>Service Title:</b>	Transportation
<b>Service Definition (Scope):</b>	
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 CFR §431.53 and transportation services under the State Plan, defined at 42 CFR §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, neighbors, friends, or community agencies that can provide this service without charge will be utilized. This service does not duplicate transportation provided as part of other services or under the State Plan non-emergency medical transportation benefit.

HCBS-AMH Transportation Services are for non-medical transportation needs related to goals identified on the IRP and are mutually exclusive of State Plan medical transportation services. Contracted providers are required to provide and document service provision of HCBS-AMH in accordance with program policies and procedures and billing guidelines. HCBS-AMH documentation requirements for HCBS-AMH Transportation include date of contact; mileage log with start and stop time; printed name of service provider; location of origination and destination; and signature and credentials of service provider.

Documentation must support that claims for HCBS-AMH transportation are not duplicative or inclusive of transportation provided as part of another service, including other State Plan transportation benefits.

- System edits are in place to prevent duplicative billing.
- Medicaid transportation services are coordinated by the individual's recovery manager and through their managed care organization (MCO) if the individual is enrolled in managed care.
- The state Medicaid authority has final authority over approval of claims.
- HHSC performs periodic review of claims data to check for duplicative claims.
- Where duplicative claims are found, HHSC recoup claims payment.

HCBS-AMH Providers and direct service staff may not bill for Transportation Services when the transportation is related to or a part of another HCBS-AMH service such as Supported Home Living or Employment Services.

Transportation activities associated with Supported Home Living and Employment Services shall be billed in accordance with the requirements of those services, respectively.

This 1915(i) service is only provided to individuals age 21 and over. All medically necessary non-emergency medical transportation 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*):

There is a limit of \$2000 per individual per year for 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-AMH provider enrolled and contracted with HHSC to provide HCBS-			HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or contracts with transportation vendor s.

AMH services, which employs or contracts with transportation providers.			Individual transportation providers must be 18 years of age or older, pass a criminal background check, and have a valid driver's license and proof of insurance.  Clients may also use specialized transport, buses, or taxis
<b>Verification of Provider Qualifications</b> (For each provider type listed above. Copy rows as needed):			
<b>Provider Type</b> (Specify):	<b>Entity Responsible for Verification</b> (Specify):		<b>Frequency of Verification</b> (Specify):
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with transportation providers.	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. HHSC will conduct biennial review to verify these requirements continue to be met after the provider and HHSC enter into an agreement.
<b>Service Delivery Method.</b> (Check each that applies):			
<input type="checkbox"/> Participant-directed		<input checked="" type="checkbox"/> Provider managed	

<b>Service Specifications</b> (Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):	
<b>Service Title:</b>	Community Psychiatric Supports and Treatment (CPST)
<b>Service Definition (Scope):</b>	
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.

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.

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):*

<input checked="" type="checkbox"/>	<b>Categorically needy (<i>specify limits</i>):</b>
	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.
<input type="checkbox"/>	<b>Medically needy (<i>specify limits</i>):</b>
	N/A

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

Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with CPST providers.	Individual CPST providers: LPC, LMFT, LCSW, PhD psychologist, RN or MD  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):
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HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with CPST providers.	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. HHSC will conduct biennial review to verify these requirements continue to be met after the provider and HHSC enter into an agreement.
<b>Service Delivery Method.</b> <i>(Check each that applies):</i>		
<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed	

<b>Service Specifications</b> <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>	
Service Title:	Peer Support
Service Definition (Scope):	
<p>Peer support services are provided by self-identified consumers who are in recovery from mental illness and/or substance use disorders. Peer support specialists use their own experiences with mental illness, substance use disorder (SUD), and/or another co-occurring disorders (such as a chronic health condition), to help individuals reach their recovery goals. Peer support providers are supervised by mental health professionals or licensed SUD treatment providers, working under the direction of the HCBS provider agency, and are trained to deliver peer services. The services are coordinated within the context of a comprehensive, individual recovery plan that includes specific individualized goals and delineates activities intended to achieve the identified goals.</p> <p>Peer Support services promote coping skills, facilitate use of natural resources/supports, and enhance recovery-oriented attributes such as hope and self-efficacy. The activities provided by this service emphasize the opportunity for consumers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery.</p>	
Additional needs-based criteria for receiving the service, if applicable <i>(specify)</i> :	
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.	
<i>(Choose each that applies):</i>	
<input checked="" type="checkbox"/>	Categorically needy <i>(specify limits)</i> :

<p>Peer Support is available daily, limited to no more than four hours per day for an individual client. Progress notes document the individual's progress relative to goals identified in the IRP.</p> <p>Peer services are not a substitute for or adjunct to other HCBS services such as HCBS Psychosocial Rehabilitation or Community Psychiatric Supports and Treatment.</p>			
<input type="checkbox"/> Medically needy ( <i>specify limits</i> ):			
N/A			
<b>Provider Qualifications</b> ( <i>For each type of provider. Copy rows as needed</i> ):			
Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with peer support service providers		<p>Peer Specialists must be recognized under a HHSC-approved process for MH or SUD peers.</p> <p>Individual providers must maintain a HHSC-approved certification to be mental health or substance use disorder peer specialists.</p>	<p>HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or has agreements with recognized Peer Specialists.</p> <p>Individual providers must maintain a HHSC-approved certification to be mental health or substance use disorder peer specialists. At 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.</p>
<b>Verification of Provider Qualifications</b> ( <i>For each provider type listed above. Copy rows as needed</i> ):			
Provider Type (Specify):	Entity Responsible for Verification (Specify):		Frequency of Verification (Specify):
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with peer support service providers.	HHSC		<p>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.</p>
<b>Service Delivery Method.</b> ( <i>Check each that applies</i> ):			



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 a private residence meeting HCBS-AMH requirements by a host home or companion care service provider who lives in the residence. 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 CFR §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).

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 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. Host home/companion care is provided in a private residence meeting HCBS requirements by a host home or companion care provider who lives in the residence. In a host home arrangement, the host home provider owns or leases the residence. In a companion care arrangement, the residence may be owned or leased by the companion care provider or may be owned or leased by the individual. 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 HCBS-AMH provider agency is 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 ensures that the clinical boundary issues that would otherwise complicate rehabilitation services (if the same staff were also delivering personal care services) are mitigated.

The individual receiving Host Home/Companion Care 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 providers or landlords. Provider access to living units is documented in the IRP. The IRP is identified when persons other than the individual have access, what types of persons have access, and under what circumstances staff are 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.

Individuals have the freedom and support to control their own schedules and activities and have access to food and visitors of their choosing at any time, and have the freedom to furnish and decorate units. Settings facilitate individual choice regarding services and supports and who provides them.

Each living unit is separate and distinct from each other. The individual retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. 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.

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.

Host Home/Companion Care services are available to individuals as they are determined necessary, based upon a quarterly assessment documented in the IRP and approved by HHSC.

HHSC reviews the authorized residential service on an ongoing basis to ensure that it is community-based, inclusive, and meets federal and state HCBS setting requirements. HHSC staff conduct biennial reviews of residential services in all settings and conduct unannounced site visits to provider owned or operated settings. If the monitoring suggests that a change in service is needed, an independent re-assessment is conducted by HHSC or its designee to re-evaluate the participant to determine the appropriateness of the service in accordance with HHSC requirements.

The HCBS-AMH provider agency must implement and maintain a plan for initial and periodic training of staff members and service providers that ensures staff members and service providers are qualified to deliver services as required by the current needs and characteristics of the individuals to whom they deliver services and are knowledgeable of acts that constitute abuse, neglect, or exploitation of an individual and methods to prevent the occurrence of abuse, neglect, and exploitation.

Periodic training is delivered by the HCBS-AMH provider agency, as needed, to ensure service providers are qualified to provide HCBS-AMH services in accordance with state and federal laws and regulations); and to ensure the individual's safety and security.

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):*

<input checked="" type="checkbox"/>	<p><b>Categorically needy (<i>specify limits</i>):</b></p> <p>Payments for Host-home/Companion Care are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. An individual may receive only one type of residential assistance (Host-home/Companion Care, Assisted Living, Supervised Living, or Supported Home Living) at a time.</p> <p>Separate payments will not be made for respite, personal assistance, home-delivered meals, minor home modifications, or non-medical transportation services for individuals who receive Host-Home/Companion Care in provider owned or operated settings.</p> <p>Individuals receiving adult foster care or Department of Family and Protective Services foster care services may not also receive Host Home/Companion Care services.</p> <p>Texas ensures duplication of services does not occur by prohibiting payment for services without authorization. Two entities may not be paid for providing the same service to the same individual during the same time period.</p> <p>Individuals are responsible for their room and board costs.</p> <p>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.</p> <p>Services that are provided by third parties must be coordinated with the Host Home/Companion Care provider and through the recovery manager, including community-based rehabilitative services provided outside of the residence.</p> <p>Host Home/Companion Care services should be provided only in settings within Texas, which meet home and community-based characteristic requirements for the type of residential support provided. Residential services cannot be provided in or on the grounds of the following settings:</p> <ul style="list-style-type: none"> <li>• Nursing facilities;</li> <li>• Institutions for mental disease;</li> <li>• Intermediate care facilities for individuals with Intellectual or Developmental Disabilities;</li> <li>• Inpatient hospitals; or</li> <li>• Any other location that has qualities of an institutional setting.</li> </ul>
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☐ **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-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with Host Home/Companion Care providers.			<p>HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or has agreements with Host Home/Companion Care Providers. Residential settings must meet relevant state and local requirements.</p> <p>Individual direct service providers must be at least 18 years of age. The employee provider must have a high school diploma</p>



			<p>or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency 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.</p> <p>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.</p> <p>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.</p>
<b>Verification of Provider Qualifications</b> <i>(For each provider type listed above. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>	
HCBS-AMH providers enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with Host Home/Companion Care providers.	HHSC	<p>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.</p>	

**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 HHSC. 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 CFR §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).

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 access to living units are documented in the IRP. The IRP identifies when staff members have access, what types of staff have access, and under what circumstances staff 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.

Individuals have the freedom and support to control their own schedules and activities and have access to food and visitors of their choosing at any time and have the freedom to furnish and decorate units. Settings facilitate individual choice regarding services and supports and who provides them. Each living unit is separate and distinct from each other. The individual retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. 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 documents any planned intervention which could potentially impinge on individual autonomy. Documentation includes 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 HCBS AMH provider agency is 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 ensures 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.

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

HHSC reviews the authorized residential service on an ongoing basis to ensure that it is community- based, inclusive, and meets federal and state HCBS setting requirements. HHSC staff conduct biennial reviews of residential services in all settings. HHSC staff also conduct unannounced site visits to provider owned or operated settings. HHSC conducts biennial on-site reviews of community-based settings to ensure that settings do not have the qualities of an institutional setting, meet HCB setting requirements, and promote choice and community inclusion. If the monitoring suggests that a change in service is needed, an independent re-assessment will be conducted by HHSC or its designee to re-evaluate the participant to determine the appropriateness of the service in accordance with HHSC requirements.

The HCBS-AMH provider agency must implement and maintain a plan for initial and periodic training of staff members and service providers that ensures staff members and service providers are qualified to deliver services as required by the current needs and characteristics of the individuals to whom they deliver services and are knowledgeable of acts that constitute abuse, neglect, or exploitation of an individual and methods to prevent the occurrence of abuse, neglect, and exploitation.

Periodic training is delivered by the HCBS-AMH provider agency, as needed, to ensure service providers are qualified to provide HCBS-AMH services in accordance with state and federal laws and regulations); and to ensure the individual ' s safety and security.

**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):

<input checked="" type="checkbox"/>	<b>Categorically needy (<i>specify limits</i>):</b>		
	<p>Supervised living services can only be provided in settings approved by HHSC or in licensed assisted living facilities with no more than 4 beds. HHSC approved settings with more than four beds must maintain a staffing ratio of 4:1.</p> <p>Payments for Supervised Living are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. An individual may receive only one type of residential assistance (Host-home/Companion Care, Assisted Living, Supervised Living, or Supported Home Living) at a time.</p> <p>Separate payments will not be made for respite, personal assistance, home-delivered meals, minor home modifications, or non-medical transportation services for individuals who receive Supervised Living in provider owned or operated settings.</p> <p>Individuals receiving adult foster care or Department of Family and Protective Services foster care services may not also receive Supervised Living Services.</p> <p>Texas ensures duplication of services does not occur by prohibiting payment for services without authorization. Two entities may not be paid for providing the same service to the same individual during the same time period.</p> <p>Individuals are responsible for their room and board costs.</p> <p>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.</p> <p>Services that are provided by third parties must be coordinated with the Supervised Living Services provider and through the recovery manager, including community-based rehabilitative services provided outside of the residence.</p> <p>Supervised Living Services should be provided only in settings within Texas, which meet home and community-based characteristic requirements for the type of residential support provided. Supervised Living Services cannot be provided in or on the grounds of the following settings:</p> <ul style="list-style-type: none"> <li>• Nursing facilities;</li> <li>• Institutions for mental disease;</li> <li>• Intermediate care facilities for individuals with Intellectual or Developmental Disabilities;</li> <li>• Inpatient hospitals; or</li> <li>• Any other location that has qualities of an institutional setting.</li> </ul>		
<input type="checkbox"/>	<b>Medically needy (<i>specify limits</i>):</b>		
	N/A		
<b>Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):</b>			
<b>Provider Type</b> <i>(Specify):</i> HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with supervised living providers.	<b>License</b> <i>(Specify):</i>	<b>Certification</b> <i>(Specify):</i>	<b>Other Standard</b> <i>(Specify):</i> HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or has agreements with Supervised Living Services Providers.  Residential settings must meet relevant state and local requirements.  Individual direct service providers must be at least 18 years of age. The employee



		<p>provider must have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency 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.</p> <p>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.</p> <p>Assisting with tasks delegated by an RN must be in accordance with state law.</p> <p>Individual providers of Supervised Living Services must complete initial and periodic training provided by HCBS provider agency which includes HHSC-required training in the HCBS-AMH program.</p>
<b>Verification of Provider Qualifications</b> <i>(For each provider type listed above. Copy rows as needed):</i>		
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with supervised.	HHSC	<p>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 annual review to verify these requirements continue to be met after the provider and HHSC enter into an agreement.</p>



**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:** 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 HHSC. 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 CFR §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).

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 onsite 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 is 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. The individual receiving Assisted 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 access to living units will be documented in the IRP. The IRP identifies when staff members have access, what types of staff have access, and under what circumstances staff 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. Settings facilitate individual choice regarding services and supports and who provides them.

Each living unit is separate and distinct from each other. The individual retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. 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.

HHSC reviews the authorized residential service on an ongoing basis to ensure that it is community-based, inclusive, and meets federal and state HCBS setting requirements. HHSC staff conduct biennial reviews of residential services in all settings and conduct unannounced site visits to provider owned or operated settings. HHSC conducts biennial on-site reviews of community-based settings to ensure that settings do not have the qualities of an institutional setting, meet HCBS setting requirements, and promote choice and community inclusion. If the monitoring suggests that a change in service is needed, an independent re-assessment will be conducted by HHSC or its designee to re-evaluate the participant to determine the appropriateness of the service in accordance with HHSC requirements.

The HCBS-AMH provider agency must implement and maintain a plan for initial and periodic training of staff members and service providers that ensures staff members and service providers are qualified to deliver services as required by the current needs and characteristics of the individuals to whom they deliver services and are knowledgeable of acts that constitute abuse, neglect, or exploitation of an individual and methods to prevent the occurrence of abuse, neglect, and exploitation.

Periodic training is delivered by the HCBS-AMH provider agency, as needed, to ensure service providers are qualified to provide HCBS-AMH services in accordance with state and federal laws and regulations); and to ensure the individual's safety and security.

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*):

	<p>Payments for Assisted Living are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. An individual may receive only one type of residential assistance (Host-home/Companion Care, Assisted Living, Supervised Living, or Supported Home Living) at a time.</p> <p>Separate payments will not be made for respite, personal assistance, home-delivered meals, minor home modifications, non-medical transportation, or transition assistance services for individuals who receive Assisted Living.</p> <p>Individuals receiving adult foster care or Department of Family and Protective Services foster care services may not also receive Assisted Living Services.</p> <p>Nursing and skilled therapy services (except periodic nursing evaluations) are incidental, rather than integral to providing assisted living services. Payment will not be made for 24-hour skilled care.</p> <p>HHSC ensures duplication of services does not occur by prohibiting payment for services without authorization. Two entities may not be paid for providing the same service to the same individual during the same time period.</p> <p>Individuals are responsible for their room and board costs.</p> <p>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.</p> <p>Services that are provided by third parties must be coordinated with the Assisted Living Services provider and through the recovery manager, including community-based rehabilitative services provided outside of the residence.</p> <p>Assisted Living Services should be provided only in settings within Texas, which meet home and community-based characteristic requirements for the type of residential support provided. Assisted Living Services cannot be provided in or on the grounds of the following settings:</p> <ul style="list-style-type: none"> <li>• Nursing facilities;</li> <li>• Institutions for mental disease;</li> <li>• Intermediate care facilities for individuals with Intellectual or Developmental Disabilities;</li> <li>• Inpatient hospitals; or</li> <li>• Any other location that has qualities of an institutional setting.</li> </ul>		
<input type="checkbox"/>	Medically needy ( <i>specify limits</i> ):		
	N/A		
<b>Provider Qualifications</b> ( <i>For each type of provider. Copy rows as needed</i> ):			
<b>Provider Type</b> ( <i>Specify</i> ):	<b>License</b> ( <i>Specify</i> ):	<b>Certification</b> ( <i>Specify</i> ):	<b>Other Standard</b> ( <i>Specify</i> ):
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with assisted living providers.			<p>HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or has agreements with Assisted Living Services Providers.</p> <p>Residential settings must meet relevant state and local requirements.</p> <p>Individual direct service providers must be at least 18 years of age. The provider must have a high school diploma or Certificate of</p>

			<p>High School Equivalency (GED credentials) or documentation of a proficiency 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.</p> <p>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.</p> <p>Assisting with tasks delegated by an RN must be in accordance with state law. Individual providers of Assisted Living Services must complete initial and periodic training provided by HCBS provider agency which includes HHSC-required training in the HCBS-AMH program.</p>
<b>Verification of Provider Qualifications</b> <i>(For each provider type listed above. Copy rows as needed):</i>			
<b>Provider Type</b> <i>(Specify):</i>	<b>Entity Responsible for Verification</b> <i>(Specify):</i>		<b>Frequency of Verification</b> <i>(Specify):</i>
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with assisted living providers.	HHSC		<p>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.</p>
<b>Service Delivery Method.</b> <i>(Check each that applies):</i>			



☐ 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: Supported Home Living

Service Definition (Scope):

Supported Home Living services are supportive and health-related residential services provided to individuals in their own home or family home or in a private residence meeting HCBS-AMH requirements by a supported home living service provider who lives in the residence. 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 CFR §441.710. (Refer to Section 9 "Home and Community-Based Settings " for HCBS-AMH settings requirements.) Supported Home 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. Services also include social and recreational programming and medication assistance (to the extent permitted under state law).

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 includes 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 identifies 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 residence. When supported home living, is provided to individuals residing with their family members, it is designed to support rather than supplant the family and natural supports. Individuals residing in their own homes receive supported home living as necessary, based on the individual's IRP, to support them in their independent residence.

Transportation provided to individuals in accordance with HHSC guidelines is a billable supported home living service. Transportation costs which are not billable, but which are incurred to provide the supported home living service, are included in the indirect portion of the rate.

This service is 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.

Supported home living services are available to individuals as they are determined necessary, based upon a quarterly assessment documented in the IRP and approved by HHSC. HHSC reviews the authorized residential service on an ongoing basis to ensure that it is community-based, inclusive, and meets federal and state HCBS setting requirements. HHSC staff conduct biennial reviews of residential services in all settings and conduct unannounced site visits to provider owned or operated settings. HHSC conducts biennial on-site reviews of community-based settings to ensure that settings do not have the qualities of an institutional setting, meet HCB setting requirements, and promote choice and community inclusion. If the monitoring suggests that a change in service is needed, an independent re-assessment will be conducted by HHSC or its designee to re-evaluate the participant to determine the appropriateness of the service in accordance with HHSC requirements.

The HCBS-AMH provider agency must implement and maintain a plan for initial and periodic training of staff members and service providers that ensures staff members and service providers are qualified to deliver services as required by the current needs and characteristics of the individuals to whom they deliver services and are knowledgeable of acts that constitute abuse, neglect, or exploitation of an individual and methods to prevent the occurrence of abuse, neglect, and exploitation.

Periodic training is delivered by the HCBS-AMH provider agency, as needed, to ensure service providers are qualified to provide HCBS-AMH services in accordance with state and federal laws and regulations); and to ensure the individual's safety and security.

To comply with §1903(l) of the Social Security Act, as added by the 21st Century Cures Act, HHSC requires program providers to use electronic visit verification (EVV) for the services described in Title 1 of the Texas Administrative Code, Part 15, Chapter 354, Subchapter O.

The use of EVV is enforced through a matching process which compares an accepted EVV visit transaction to a program provider's service claim before the payment of the claim. If critical data elements on the visit transaction and claim do not match, the claim will be denied.

**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):

<input checked="" type="checkbox"/>	<b>Categorically needy (<i>specify limits</i>):</b>		
	<p>Individuals receiving adult foster care or Department of Family and Protective Services foster care services may not also receive Supported Home Living services.</p> <p>Texas ensures duplication of services does not occur by prohibiting payment for services without authorization. Two entities may not be paid for providing the same service to the same individual during the same time period.</p> <p>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.</p> <p>Services that are provided by third parties must be coordinated with the Supported Home Living provider and through the recovery manager, including community-based rehabilitative services provided outside of the residence.</p> <p>Supported Home Living services should be provided only in settings within Texas, which meet home and community-based characteristic requirements for the type of residential support provided. Supported Home Living services cannot be provided in or on the grounds of the following settings:</p> <ul style="list-style-type: none"> <li>• Nursing facilities;</li> <li>• Institutions for mental disease;</li> <li>• Intermediate care facilities for individuals with Intellectual or Developmental Disabilities;</li> <li>• Inpatient hospitals; or</li> <li>• Any other location that has qualities of an institutional setting.</li> </ul>		
<input type="checkbox"/>	<b>Medically needy (<i>specify limits</i>):</b>		
	N/A		
<b>Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):</b>			
<b>Provider Type (<i>Specify</i>):</b>	<b>License (<i>Specify</i>):</b>	<b>Certification (<i>Specify</i>):</b>	<b>Other Standard (<i>Specify</i>):</b>
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with Supported Home Living providers.			<p>HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or has agreements with Supported Home Living Providers.</p> <p>Residential settings must meet relevant state and local requirements.</p> <p>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 a proficiency 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</p>

			<p>the individual(s) to be served.</p> <p>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.</p> <p>Assisting with tasks delegated by an RN must be in accordance with state law.</p> <p>Individual providers of Supported Home Living services must complete initial and periodic training provided by HCBS provider agency which includes HHSC-required training in the HCBS-AMH program.</p>
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**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-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with Supported Home Living providers.	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.

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

<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed
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**Service Specifications** *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Respite Care
Service Definition (Scope):	Respite is a service that provides temporary relief from care giving to the primary caregiver of an individual during times when the individual's primary caregiver would normally provide care.

In-home respite is provided in the individual's home or place of residence, or in the home of a family member or friend.

To comply with §1903(l) of the Social Security Act, as added by the 21st Century Cures Act, HHSC requires program providers to use electronic visit verification (EVV) for the services described in Title 1 of the Texas Administrative Code, Part 15, Chapter 354, Subchapter O.

The use of EVV is enforced through a matching process which compares an accepted EVV visit transaction to a program provider's service claim before the payment of the claim. If critical data elements on the visit transaction and claim do not match, the claim will be denied.

Respite is provided for the planned or emergency short-term relief for natural, unpaid caregivers. Respite is provided intermittently when the natural caregiver is temporarily unavailable to provide supports. This service provides an individual 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 rehabilitation or specialized therapies; assisting an individual with administration of certain medications or with supervision of self-medication in accordance with the Texas Board of Nursing rules as defined the Texas Administrative Code; and supervision as needed to ensure the individual's health and safety.

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. Respite is provided in the residence of the individual or in other locations, including residences in which supervised living or residential support is provided or in a respite facility that meets HHSC requirements and affords an environment that ensures the health, safety, comfort, and welfare of the individual. The provider of respite must ensure that respite is provided in accordance with the individual's recovery plan.

Transportation costs associated with the respite service are included in the respite rate. Transportation to and from the respite service site is not a billable service for the respite service but is included in the billable service for supported home living.

Out-of-home respite can be provided in the following locations:

- Adult foster care home;
- 24-hour residential habilitation home;
- Licensed assisted living facilities;
- Licensed Nursing Facilities.

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*):



<p>Reimbursement for respite is limited to 30 days annually of any combination of in-home or out-of-home respite.</p> <p>Other services indicated on the individual's recovery plan may be provided during the period of respite, if they are not duplicative of or integral to services which can be reimbursable as respite.</p> <p>Respite is not a reimbursable service for individuals receiving community-based residential supports in provider owned or operated settings, including host home /companion care, supervised living or assisted living; to relieve paid caregivers and providers or to supplant natural supports Payment of the cost of room and board is the responsibility of the individual except when the individual is receiving out-of-home respite services under HCBS-AMH. Room and board is included in the rate for out-of-home respite services.</p>			
<input type="checkbox"/> Medically needy ( <i>specify limits</i> ):			
N/A			
<b>Provider Qualifications</b> ( <i>For each type of provider. Copy rows as needed</i> ):			
Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with a respite care provider.			<p>HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or contracts with individual respite workers.</p> <p>Respite settings must meet appropriate state and local licensure or certification requirements.</p> <p>Individual direct service workers must be 18 years of age or older; trained in CPR/first-aid; pass criminal history checks; not be on list of Employee Misconduct Registry or Nurse Aide Registry; maintain current Texas driver's license and proof of automobile insurance if transporting individuals; and be familiar with client-specific competencies.</p>
<b>Verification of Provider Qualifications</b> ( <i>For each provider type listed above. Copy rows as needed</i> ):			
Provider Type (Specify):	Entity Responsible for Verification (Specify):		Frequency of Verification (Specify):
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with a respite care provider.	HHSC		<p>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</p>



		to verify these requirements continue to be met after the provider and HHSC enter into an agreement.
<b>Service Delivery Method.</b> <i>(Check each that applies):</i>		
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/> Provider managed

<b>Service Specifications</b> <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>			
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 <i>(specify)</i> :			
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.			
<i>(Choose each that applies):</i>			
<input checked="" type="checkbox"/>	Categorically needy <i>(specify limits)</i> :		
	The provision of home delivered meals does not provide a full nutritional regimen (i.e., 3 meals a day).		
<input type="checkbox"/>	Medically needy <i>(specify limits)</i> :		
	N/A		
<b>Provider Qualifications</b> <i>(For each type of provider. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	License <i>(Specify):</i>	Certification <i>(Specify):</i>	Other Standard <i>(Specify):</i>
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with home delivered meal providers.			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.
<b>Verification of Provider Qualifications</b> <i>(For each provider type listed above. Copy rows as needed):</i>			

Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with home delivered meal providers.	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

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

<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed
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**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):	
<p>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 that add 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.</p>	
Additional needs-based criteria for receiving the service, if applicable (specify):	
<p>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.</p>	
(Choose each that applies):	
<input checked="" type="checkbox"/>	Categorically needy (specify limits):

<p>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.</p>			
<input type="checkbox"/> Medically needy ( <i>specify limits</i> ):			
N/A			
<b>Provider Qualifications</b> ( <i>For each type of provider. Copy rows as needed</i> ):			
Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with minor home modification providers.			<p>HCBS provider agency enrolled and contracted with HHSC to provide HCBS services.</p> <p>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.</p> <p>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.</p> <p>Qualified building contractors provide minor home modifications in accordance with state and local building codes and other applicable regulations.</p>
<b>Verification of Provider Qualifications</b> ( <i>For each provider type listed above. Copy rows as needed</i> ):			
Provider Type ( <i>Specify</i> ):	Entity Responsible for Verification ( <i>Specify</i> ):		Frequency of Verification ( <i>Specify</i> ):
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services providers.	HHSC		<p>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.</p>

		HHSC will conduct biennial review to verify these requirements continue to be met after the provider and HHSC enter into an agreement.
<b>Service Delivery Method.</b> <i>(Check each that applies):</i>		
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/> Provider managed

<b>Service Specifications</b> <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>	
Service Title:	Nursing
Service Definition (Scope):	
<p>Nursing services are those services that are within the scope of the Texas Nurse Practice Act and are provided by an RN (or licensed vocational nurse under the supervision of an RN), licensed to practice in the state. Services cover ongoing chronic conditions such as wound care, medication administration (including training, monitoring, and evaluation of side effects), and supervising delegated tasks. This broadens the scope of these services beyond State Plan services. Nursing services provide treatment and monitoring of health care procedures prescribed by a physician/medical practitioner, or as required by standards of professional practice or state law to be performed by licensed nursing personnel.</p> <p>To comply with §1903(l) of the Social Security Act, as added by the 21st Century Cures Act, HHSC requires program providers to use electronic visit verification (EVV) for the services described in Title 1 of the Texas Administrative Code, Part 15, Chapter 354, Subchapter O.</p> <p>The use of EVV is enforced through a matching process which compares an accepted EVV visit transaction to a program provider's service claim before the payment of the claim. If critical data elements on the visit transaction and claim do not match, the claim will be denied.</p> <p>This 1915(i) service is only provided to individuals age 21 and over. All medically necessary nursing services for children under age 21 are covered in the State Plan pursuant to the EPSDT benefit.</p>	
Additional needs-based criteria for receiving the service, if applicable <i>(specify)</i> :	
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.	
<i>(Choose each that applies):</i>	
<input checked="" type="checkbox"/>	Categorically needy <i>(specify limits)</i> :
	Nursing services are provided only after benefits available through Medicare, Medicaid, or other third-party resources have been exhausted or are not applicable, including home health benefits.
<input type="checkbox"/>	Medically needy <i>(specify limits)</i> :
	N/A
<b>Provider Qualifications</b> <i>(For each type of provider. Copy rows as needed):</i>	



Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with nursing providers.	Individual service provider: RN (or licensed vocational nurse under the supervision of a registered nurse), licensed to practice in Texas		<p>HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or contracts with nursing providers.</p> <p>An individual service provider must be an RN (or licensed vocational nurse under the supervision of a registered nurse), licensed to practice in the state or otherwise authorized to practice in Texas under the Nurse Licensure Compact.</p> <p>Nurses providing this service must comply with the requirements for delivery of nursing services, which include requirements such as compliance with the Texas Nurse Practice Act and delegation of nursing tasks.</p>
<b>Verification of Provider Qualifications</b> (For each provider type listed above. Copy rows as needed):			
Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):	
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with nursing providers.	HHSC	<p>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.</p>	
<b>Service Delivery Method.</b> (Check each that applies):			
<input type="checkbox"/> Participant-directed		<input checked="" type="checkbox"/> 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

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. Therapeutic modalities may include motivational interviewing; individual, group, and family counseling; psychoeducation; 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 ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with SUD service providers.	Individual counselors providing the SUD service must be Qualified Credentialed Counselors (QCCs) as defined by HHSC.  SUD treatment programs must be licensed by the Texas Department of State Health		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 act within the scope of their licensure and/or credentialing.

	Services as Chemical Dependency Treatment Programs.		
<b>Verification of Provider Qualifications</b> <i>(For each provider type listed above. Copy rows as needed):</i>			
<b>Provider Type</b> <i>(Specify):</i>	<b>Entity Responsible for Verification</b> <i>(Specify):</i>		<b>Frequency of Verification</b> <i>(Specify):</i>
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with SUD service providers.	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. HHSC will conduct biennial review to verify these requirements continue to be met after the provider and HHSC enter into an agreement
<b>Service Delivery Method.</b> <i>(Check each that applies):</i>			
<input type="checkbox"/> Participant-directed		<input checked="" type="checkbox"/> Provider managed	

<b>Service Specifications</b> <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>	
<b>Service Title:</b>	Home and Community-Based Services -Adult Mental Health (HCBS-AMH)- Recovery Management
<b>Service Definition (Scope):</b>	
<p>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.</p> <p>The recovery manager:</p> <ul style="list-style-type: none"> <li>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;</li> <li>Provides supporting documentation to be considered by HHSC in the independent evaluation and reevaluations;</li> <li>Identifies services / providers, brokers to obtain and integrate services, facilitates, and advocates to resolve issues that impede access to needed services;</li> <li>Develops / pursues resources to support the individual's recovery goals including non-HCBS Medicaid, Medicare, and/or private insurance or other community resources;</li> <li>Assists the individual in identifying and developing natural supports (family, friends, and</li> </ul>	

- 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 and Provider Agency) 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.
  - Assists the individual in obtaining and maintaining an acceptable form of Medicaid to maintain program eligibility.

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*):

	<p>The following activities are excluded from recovery management as a billable HCBS-AMH service:</p> <ul style="list-style-type: none"> <li>• Travel time incurred by the recovery manager may not be billed as a discrete unit of service;</li> <li>• 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</li> <li>• Representative payee functions.</li> </ul> <p>Recovery management may only be provided by agencies and individuals employed by agencies who are not:</p> <ul style="list-style-type: none"> <li>• Related by blood or marriage to the consumer;</li> <li>• Financially or legally responsible for the consumer;</li> <li>• Empowered to make financial or health-related decisions on behalf of the consumer; or</li> <li>• 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)</li> </ul> <p>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. HHSC periodically reviews claims data in search of duplicative claims and adjust system edits accordingly.</p> <p>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.</p> <p>Recovery management functions necessary to facilitate community transition may not be billed under TAS.</p>		
<input type="checkbox"/>	<p>Medically needy (<i>specify limits</i>):</p> <p>N/A</p>		
<p><b>Provider Qualifications</b> (<i>For each type of provider. Copy rows as needed</i>):</p>			
<p><b>Provider Type</b> (<i>Specify</i>):</p> <p>HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH Recovery Management services, which employs individual recovery management providers.</p>	<p><b>License</b> (<i>Specify</i>):</p>	<p><b>Certification</b> (<i>Specify</i>):</p>	<p><b>Other Standard</b> (<i>Specify</i>):</p> <p>Individual providers of recovery management must:</p> <ul style="list-style-type: none"> <li>• Have at least 2 years of experience working with people with severe mental illness;</li> <li>• 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);</li> <li>• Demonstrate knowledge of issues affecting people with severe mental illness and community-based interventions/resources for this population; and</li> <li>• Complete HHSC-required training in the HCBS-AMH program</li> </ul>



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

Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
HCBS-AMH provider enrolled and contracted with HHSC to provide HCBS-AMH Recovery Management services, which employs individual recovery management providers.	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. HHSC will conduct biennial review to verify these requirements continue to be met after the provider and HHSC enter into an agreement.

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

<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed
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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):*

HHSC 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.

## Participant-Direction of Services

*Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).*

**1. Election of Participant-Direction.** (Select one):

<input checked="" type="radio"/>	The state does not offer opportunity for participant-direction of State plan HCBS.
<input type="radio"/>	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input type="radio"/>	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. (Specify criteria):

**2. Description of Participant-Direction.** (Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):

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**3. Limited Implementation of Participant-Direction.** (Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewide requirements. Select one):

<input type="radio"/>	Participant direction is available in all geographic areas in which State plan HCBS are available.
<input type="radio"/>	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (Specify the areas of the state affected by this option):

**4. Participant-Directed Services.** (Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):

Participant-Directed Service	Employer Authority	Budget Authority
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

**5. Financial Management.** (Select one) :

<input type="radio"/>	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
<input type="radio"/>	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

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):*

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8. **Opportunities for Participant-Direction**

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

<input checked="" type="radio"/>	The state does not offer opportunity for participant-employer authority.
<input type="radio"/>	Participants may elect participant-employer Authority <i>(Check each that applies):</i>
<input type="checkbox"/>	<b>Participant/Co-Employer.</b> 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.
<input type="checkbox"/>	<b>Participant/Common Law Employer.</b> 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):*

<input checked="" type="radio"/>	The state does not offer opportunity for participants to direct a budget.
<input type="radio"/>	Participants may elect Participant–Budget Authority.
	<b>Participant-Directed Budget.</b> <i>(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.):</i>
	<b>Expenditure Safeguards.</b> <i>(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.)</i>

## Quality Improvement Strategy

### Quality Measures

*(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):*

1. Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c) document choice of services and providers.
2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
3. Providers meet required qualifications.
4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).
5. The SMA retains authority and responsibility for program operations and oversight.
6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

*(Table repeats for each measure for each requirement and lettered sub-requirement above.)*

Requirement	Service Plans a) address assessed needs of 1915(i) participants; b) are updated annually; and c) document choice of services and providers.
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	<p>Sub-requirement 1-a: The state must demonstrate that service plans address assessed needs of 1915(i) participants.</p> <p>1.a.1 – Number and percent of participants with IRPs that address all members' assessed needs (including health and safety risk factors) and personal goals, either by the provision of HCBS services or through other means.</p> <p><b>Numerator:</b> Number of participants with IRPs that address all members assessed needs.  <b>Denominator:</b> Number of participants with an IRP.</p> <p>1.a.2 – Number and percent of participants with IRPs which document providers and</p>

	<p>individual goals consistent with their individual assessments.</p> <p><b>Numerator:</b> Number of participants with IRPs which document providers and individual goals consistent with their individual assessments.</p> <p><b>Denominator:</b> Number of participants with an IRP.</p> <p><b>Sub-requirement 1-b: Service plans are updated annually.</b></p> <p><b>1.b</b> – Number and percent of participants with current individual recovery plans (IRPs) updated annually.</p> <p><b>Numerator:</b> Number of participants whose IRP was updated annually.</p> <p><b>Denominator:</b> Number of participants with an IRP.</p> <p><b>Sub-requirement 1-c: Service plans document the 1915(i) participants' choice of services and providers.</b></p> <p><b>1.c</b> – Number and percent of participants with IRPs which document the individual's choice among and between HCBS-AMH services and providers.</p> <p><b>Numerator:</b> Number of participants with IRPs that document choice among HCBS-AMH services and providers.</p> <p><b>Denominator:</b> Number of participants with an IRP.</p>
<b>Discovery Activity</b> <i>(Source of Data &amp; sample size)</i>	Record review, desk or onsite; Representative sample with a confidence level of 95 percent.
<b>Monitoring Responsibilities</b> <i>(Agency or entity that conducts discovery activities)</i>	HHSC collects, generates, aggregates, and analyzes.
<b>Frequency</b>	Biennially
<b>Remediation</b>	
<b>Remediation Responsibilities</b> <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	HHSC
<b>Frequency</b> <i>(of Analysis and Aggregation)</i>	Annually

<b>Requirement</b>	Eligibility Requirements – a) an evaluation for 1915(i) State Plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; b) the processes and instruments described in the approved State Plan for determining 1915(i) eligibility are applied appropriately; and c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or, if more frequent, as specified in the State Plan for 1915(i) HCBS.
<b>Discovery</b>	
<b>Discovery Evidence</b> <i>(Performance Measure)</i>	<p><b>Sub-requirement 2-a: An evaluation for 1915(i) State Plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future.</b></p> <p>2.1 – The number and percent of individuals that were determined to meet needs- based criteria requirements prior to receiving 1915(i) services.</p> <p><i>Numerator:</i> Number of individuals that were determined to meet needs-based criteria requirements prior to receiving 1915(i) services.  <i>Denominator:</i> Total number of new individuals enrolled.</p> <p><b>Sub-requirement 2-b: The processes and instruments described in the approved State Plan for determining 1915(i) eligibility are applied appropriately.</b></p> <p>2.2 – The number and percent of individuals' initial needs-based criteria determination forms/instruments that were completed, as required in the approved SPA.</p> <p><i>Numerator:</i> Number of individuals' initial needs-based criteria determination forms/instruments that were completed, as required in the approved SPA.  <i>Denominator:</i> Total number of new individuals assessed for 1915(i)_eligibility.</p> <p><b>Sub-requirement 2-c: The 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or, if more frequent, as specified in the approved State Plan for 1915(i) HCBS.</b></p> <p>2.3 – The number and percent of individuals' initial determinations, where level of need criteria was applied correctly.</p> <p><i>Numerator:</i> Number of individuals' initial determinations, where level of need criteria was applied.  <i>Denominator:</i> Total number of new individuals with level of need determinations.</p> <p>2.4 – The number and percent of enrolled 1915(i) participants who received a re-evaluation prior to expiration of their previous evaluation.</p> <p><i>Numerator:</i> Number of enrolled 1915(i) participants who received a re-evaluation prior to expiration of their previous evaluation.  <i>Denominator:</i> Total number of enrolled participants.</p>
<b>Discovery Activity</b> <i>(Source of Data &amp; sample size)</i>	Record review, desk or onsite; Representative sample with a confidence level of 95 percent.
<b>Monitoring Responsibilities</b>	HHSC collects, generates, aggregates, and analyzes.



(Agency or entity that conducts discovery activities)	
<b>Frequency</b>	Biennially
<b>Remediation</b>	
<b>Remediation Responsibilities</b> (Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	HHSC
<b>Frequency</b> (of Analysis and Aggregation)	Annually

<b>Requirement</b>	Qualified Providers – Providers meet required qualifications.
<b>Discovery</b>	
<b>Discovery Evidence</b> (Performance Measure)	<p><b>3.1</b> – Number and percent of HCBS service providers who require licensure and certification requirements prior to furnishing HCBS services.</p> <p><i>Numerator:</i> Number of HCBS service providers who require licensure and certification requirements prior to furnishing HCBS services.  <i>Denominator:</i> Number of licensed and certified HCBS providers.</p> <p><b>3.2</b> – Number and percent of HCBS service providers that require (or meet) licensure and certification requirements while furnishing services.</p> <p><i>Numerator:</i> Number of HCBS service providers that require (or meet) licensure and certification requirements while furnishing services.  <i>Denominator:</i> Number of licensed and certified HCBS providers.</p> <p><b>3.3</b> – Number and percent of HCBS-AMH provider agencies with an active agreement with HHSC.</p> <p><i>Numerator:</i> Number of HCBS-AMH provider agencies with an active agreement with HHSC.  <i>Denominator:</i> Number of HCBS-AMH provider agencies.</p> <p><b>3.4</b> – Number and percent of service providers who completed required trainings.  <i>Numerator:</i> Number of service providers who completed required trainings.  <i>Denominator:</i> Number of service providers.</p>
<b>Discovery Activity</b>	Representative sample, with a confidence level of 95 percent, of provider agencies, open enrollment applications, provider agreements, state licensure authorities, and provider personnel records.

	<i>(Source of Data &amp; sample size)</i>	
	<b>Monitoring Responsibilities</b> <i>(Agency or entity that conducts discovery activities)</i>	HHSC collects, generates, aggregates, and analyzes.
	<b>Frequency</b>	Biennially
<b>Remediation</b>		
	<b>Remediation Responsibilities</b> <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	HHSC
	<b>Frequency</b> <i>(of Analysis and Aggregation)</i>	Annually

<b>Requirement</b>		Home and Community Based Settings Requirement - Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).
<b>Discovery</b>		
<b>Discovery Evidence</b> <i>(Performance Measure)</i>	4.1 – Number and percent of HCBS settings meeting federal requirements  <i>Numerator:</i> Number of HCBS settings meeting federal requirements. <i>Denominator:</i> Number of HCBS provider settings.	
<b>Discovery Activity</b> <i>(Source of Data &amp; sample size)</i>	Representative sample, with a confidence level of 95 percent, of provider agencies, desk or on-site reviews, and report of recovery managers.	
<b>Monitoring Responsibilities</b> <i>(Agency or entity that conducts discovery activities)</i>	HHSC collects, generates, aggregates, and analyzes the data	
<b>Frequency</b>	Biennially	
<b>Remediation</b>		
<b>Remediation Responsibilities</b>	HHSC	

<i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	
<b>Frequency</b> <i>(of Analysis and Aggregation)</i>	Annually

<b>Requirement</b>	Administrative Authority - The SMA retains authority and responsibility for program operations and oversight.
<b>Discovery</b>	
<b>Discovery Evidence</b> <i>(Performance Measure)</i>	<p><b>5.1</b> – 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 requirements.</p> <p><b>Numerator:</b> Number 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 requirements.</p> <p><b>Denominator:</b> Number of performance measure reports generated and reviewed by the State Medicaid Agency.</p> <p><b>5.2</b> – Number and percent of State Plan amendments, renewals, and financial reports approved by HHSC prior to implementation by HHSC.</p> <p><b>Numerator:</b> Number of SPAs, renewals, and financial reports approved by HHSC prior to implementation by HHSC.</p> <p><b>Denominator:</b> Number of 1915(i) SPAs, renewals, and financial reports implemented.</p>
<b>Discovery Activity</b> <i>(Source of Data &amp; sample size)</i>	Reports to HHSC on delegated administrative functions; 100 percent sample size
<b>Monitoring Responsibilities</b> <i>(Agency or entity that conducts discovery activities)</i>	HHSC collects, generates, aggregates, and analyzes the data.
<b>Frequency</b>	Biennially
<b>Remediation</b>	

<b>Remediation Responsibilities</b> <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	HHSC
<b>Frequency</b> <i>(of Analysis and Aggregation)</i>	Annually

<b>Requirement</b>	Financial Accountability –HHSC maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
<b>Discovery</b>	
<b>Discovery Evidence</b> <i>(Performance Measure)</i>	<p><b>6.1</b> – Number and percent of paid claims that reflect only the services listed in accordance with the participant’s IRP.</p> <p><b>Numerator:</b> Number of paid claims that reflect only the services listed in accordance with the participant’s IRP.  <b>Denominator:</b> Number of paid claims</p> <p><b>6.2</b> – Number and percent of payment rates which remain consistent with the approved rate methodology throughout the five-year SPA cycle.</p> <p><b>Numerator:</b> Number of payment rates which remain consistent with the approved rate methodology throughout the five-year SPA cycle.  <b>Denominator:</b> Number of payment rates.</p>
<b>Discovery Activity</b> <i>(Source of Data &amp; sample size)</i>	Routine claims verification audits; Representative sample, with confidence level of 95 percent of case managers. Annual review of rate setting methodology.
<b>Monitoring Responsibilities</b> <i>(Agency or entity that conducts discovery activities)</i>	HHSC collects, generates, aggregates, and analyzes the data.
<b>Frequency</b>	Biennially
<b>Remediation</b>	
<b>Remediation Responsibilities</b> <i>(Who corrects, analyzes, and</i>	HHSC



<i>aggregates remediation activities; required timeframes for remediation)</i>	
<b>Frequency</b> <i>(of Analysis and Aggregation)</i>	Annually

<b>Requirement</b>	Incidents of Abuse, Neglect, and exploitation - The State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation (ANE), including the use of restraints.
<b>Discovery</b>	
<b>Discovery Evidence</b> <i>(Performance Measure)</i>	<p><b>7.1(a)</b> – Number and percent of abuse, neglect, exploitation, (ANE) and unexplained death reports where a provider investigation was initiated and completed by HHSC Provider Investigations (PI) according to required timeframes.</p> <p><b>Numerator:</b> Number of ANE and unexplained death reports where a provider investigation was initiated and completed by HHSC PI according to required timeframes.  <b>Denominator:</b> Number of ANE and unexplained death reports received.</p> <p><b>7.1(b)</b> – Number and percent of abuse, neglect, exploitation (ANE) and unexplained death reports where a non-provider investigation was initiated and completed according to Department of Family and Protective Services (DFPS) policies and procedures.</p> <p><b>Numerator:</b> Number of ANE and unexplained death reports where a non-provider investigation was initiated and completed according to DFPS policies and procedures.  <b>Denominator:</b> Number of ANE and unexplained death reports received.</p> <p><b>7.2</b> – Number and percent of enrolled participants who received information on how to report suspected abuse, neglect, or exploitation of adults.</p> <p><b>Numerator:</b> Number of enrolled participants who received information on how to report suspected abuse, neglect, exploitation of adults.  <b>Denominator:</b> Number of enrolled participants.</p> <p><b>7.3</b> – Number and percent of enrolled participants who received information regarding their rights to a state fair hearing via the official state form.</p> <p><b>Numerator:</b> Number of enrolled participants who received information regarding their rights to a state fair hearing via the official state form.  <b>Denominator:</b> Number of enrolled participants.</p> <p><b>7.4</b> – Number and percent of grievances filed by participants that were resolved according to federal requirements.</p> <p><b>Numerator:</b> Number of grievances filed by participants that were resolved according to federal requirements.  <b>Denominator:</b> Number of grievances filed by participants.</p>

	<p>7.5 – 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.</p> <p><b>Numerator:</b> Number of allegations of abuse, neglect, or exploitation investigated that were later substantiated, where recommended actions to protect health and welfare were implemented.</p> <p><b>Denominator:</b> Number of allegations of substantiated ANE.</p> <p>7.6 – 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.</p> <p><b>Numerator:</b> Number of participants’ critical incidents related to ANE that were reported, initiated, reviewed, and completed within the required timeframes as specified in the approved SPA.</p> <p><b>Denominator:</b> Number of critical incidents reported related to ANE.</p> <p>7.7 – Number and percent of unauthorized uses of restrictive interventions that were appropriately reported.</p> <p><b>Numerator:</b> Number of unauthorized uses of restrictive interventions that were appropriately reported.</p> <p><b>Denominator:</b> Number of unauthorized restrictive interventions reported.</p> <p>7.8 – Number and percent of HCBS participants records reviewed who had an annual comprehensive nursing assessment.</p> <p><b>Numerator:</b> Number of HCBS participants records reviewed who had an annual comprehensive nursing assessment consistent with state requirements.</p> <p><b>Denominator:</b> Number of HCBS participants.</p>
<b>Discovery Activity</b> (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.
<b>Monitoring Responsibilities</b> (Agency or entity that conducts discovery activities)	HHSC collects, generates, aggregates, and analyzes the data.
<b>Frequency</b>	Biennially
<b>Remediation</b>	
<b>Remediation Responsibilities</b> (Who corrects, analyzes, and aggregates remediation activities; required)	HHSC

timeframes for remediation)	
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
- Provider monthly meetings
- Assess system changes
- Focus on reporting requirements and refining reports
- Quality Management (QM) reviews
- Documentation review
- Interviews
- Corrective action plans (CAP)

### 2. Roles and Responsibilities

HHSC collects, collates, reviews, and posts. HHSC reviews the data and has final direction over corrective action plans. HHSC collects, analyzes, and reports HHSC provides oversight and direction.

HHSC coordinates and conducts QM reviews and reports findings to providers through exit interviews and implements corrective action plans (CAP) as needed. The QM reviews may be conducted onsite or as a desk review. HHSC provides oversight and direction. Biennially, HHSC [reviews] clinical operations (utilization management, quality management, care management, compliance with HCBS 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 CAP to the satisfaction of HHSC. The CAP is monitored by HHSC, which has final direction over the CAP. Verification of the CAP implementation is reviewed at the next scheduled QM review.

### 3. Frequency

- Program performance data – Updated monthly and reported quarterly
- Providers monthly meetings –Monthly meetings
- Quality Management reviews- Biennially
- Corrective Action Plans (CAP) – Biennially QM Reviews

**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, makes corrective action plans regarding quality improvement (QI).
  - HHSC reviews QI recommendations as needed at the monthly provider meetings and build upon those improvements through continuous quality improvement.
- Provider monthly meetings
  - Monitoring contract and HCBS compliance for service delivery
  - Review of clinical assessment client outcome measures
- Quality Management (QM) reviews
  - Review of clinical operations (utilization management, quality management, care management, compliance with HCBS settings requirements)
  - Compliance issues will require the submission of a corrective action plan to HHSC for approval and ongoing monitoring.
- Corrective action plans (CAP) -
  - Review of supporting documentation as evidence of CAP implementation.

## Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates):*

<input type="checkbox"/>	HCBS Case Management
<input type="checkbox"/>	HCBS Homemaker
<input type="checkbox"/>	HCBS Home Health Aide
<input type="checkbox"/>	HCBS Personal Care
<input type="checkbox"/>	HCBS Adult Day Health
<input type="checkbox"/>	HCBS Habilitation
<input checked="" type="checkbox"/>	HCBS Respite Care <ul style="list-style-type: none"> <li>The In-Home Respite rate is based on the Community Based Alternatives (CBA - terminated 9/1/2014) Medicaid Waiver program and the Community Living Assistance and Support Services (CLASS) Medicaid Waiver program rate. This rate is set using cost report data from both programs combined into a single array. Please see below for details on setting rates using cost report data and the rate setting process in general.</li> <li>Out-of-Home Respite in a Nursing Facility rates are the State Plan Nursing Facility rates. These rates are set using cost report data. Please see below for details on setting rates using cost report data and the rate setting process in general.</li> <li>The Out-of-Home Respite in a Licensed Assisted Living Facility rates are the CBA Assisted Living rates. These rates are set using cost report data. Please see below for details on setting rates using cost report data and the rate setting process in general.</li> <li>The Out-of-Home Respite in a 24-hour Residential Habilitation Home rate is based on a weighted average of the Home and Community-based Services (HCS) Medicaid Waiver program Supervised Living Services rates. These rates are set using cost report data. Please see below for details on setting rates using cost report data and the rate setting process in general.</li> <li>The Out-of-Home Respite in an Adult Foster Care home rates are the CBA Out-of-Home Respite in an Adult Foster Care home rates. These rates are determined by modeling the estimated amount of one-on-one time the adult foster care provider would provide to the individual multiplied by a reimbursement amount appropriate for the skill level of the caregiver providing the assistance. These rates are updated periodically for inflation. Please see below for information on the rate setting process in general.</li> </ul>
For Individuals with Chronic Mental Illness, the following services:	
<input type="checkbox"/>	HCBS Day Treatment or Other Partial Hospitalization Services
<input checked="" type="checkbox"/>	HCBS Psychosocial Rehabilitation



	The rates for psychosocial rehabilitative services are based on the established State Plan Medicaid fee schedule.
<input type="checkbox"/>	HCBS Clinic Services (whether or not furnished in a facility for CMI)
<input checked="" type="checkbox"/>	Other Services (specify below)
	<p><u>General Rate Setting</u> The rates for all services in the HCBS-AMH program are available on the agency website, as outlined in Attachment 4.19-B, Page 1. Unless otherwise specified, all rates are effective as of September 1, 2023.</p> <p>HHSC determines payment rates every two years for each service. The rates for services are prospective and uniform statewide. HHSC determines payment rates after analysis of financial and statistical information and the effect of the payment rates on the achievement of program objectives, including economic conditions and budgetary considerations. Payment rates are developed as described below.</p> <p><u>Cost Reports</u> The rates for certain services are set using cost report data from providers of similar services in the Home and Community-Based Services Waiver (HCS) and Texas Home Living (TxHmL) waiver programs. Providers of these services are required to submit cost reports to HHSC every other year. Providers are responsible for eliminating all unallowable expenses from the cost report prior to submission of the cost report. HHSC reviews all cost reports, and a sample of cost reports are reviewed on-site. HHSC removes any unallowable costs and corrects any errors detected on the cost report during the review or on-site audit. Audited cost reports are used in the determination of statewide prospective rates. Cost principles follow 2 CFR § 200.</p> <p>The recommended unit of service rates for each service are determined as follows: (1) total allowable costs for each provider are determined from the audited cost report; (2) each provider's total allowable costs are projected from the historical cost reporting period to the prospective reimbursement period using the appropriate inflationary factors outlined below; (3) payroll taxes and benefits are allocated to each salary item; (4) total projected allowable costs are divided by the number of units of service to determine the projected cost per unit of service; (5) the allowable costs per unit of service for each contracted provider are arrayed and weighted by the number of units of service and the median cost per unit of service is calculated; and (6) the median cost per unit of service for each service is multiplied by 1.044.</p> <p>For general inflation adjustments, HHSC uses the Personal Consumption Expenditures (PCE) chain-type price index published by the Bureau of Economic Analysis of the U.S. Department of Commerce. HHSC uses a PCE forecast published by IHS Markit or its successor. HHSC uses specific indices in place of the general inflation index when appropriate item- or program-specific inflation indices are available from cost reports or other surveys, other Texas state agencies, nationally recognized public agencies, or independent private firms or sources, and HHSC has determined that these specific inflation indices are derived from information that adequately represents the program(s) or cost(s) to which the specific index is to be applied.</p> <p>For inflation adjustments of costs pertaining to wages and salaries of licensed vocational nurses and nurse aides, HHSC uses an employment cost index of wages and salaries for private industry workers in nursing and residential care facilities published by the U.S. Bureau of Labor Statistics. HHSC uses a forecast of this inflation index published by IHS Markit or its successor. Periodic reviews of the chosen inflation index will be performed based on cumulative cost report data on nursing wages and salaries.</p> <p>HHSC includes Federal Insurance Contributions Act (FICA) payroll tax rates, such as for Social Security taxes and Medicare taxes, and federal and state unemployment tax rates in its projected costs of non-contracted staff salaries and wages. When a FICA tax rate or unemployment tax rate is amended per federal or state statute, HHSC adjusts its cost projections in accordance with the amended tax rate.</p>

	<p>The Supported Employment and Employment Assistance rates are based on the CLASS, Deaf Blind with Multiple Disabilities (DBMD) Medicaid Waiver program, HCS, and Texas Home Living (TxHmL) Medicaid Waiver program rates. These rates are set using cost report data from these programs combined into a single array. Please see below for details on setting rates using cost report data and the rate setting process in general.</p> <p>The Nursing Services rates are based on the CBA, CLASS, DBMD, HCS, Medically Dependent Children Program (MDCP), and TxHmL rates. These rates are set using cost report data from these programs combined into a single array. Please see below for details on setting rates using cost report data and the rate setting process in general.</p> <p>The Community Psychiatric Supports and Treatment rate is based on the Behavioral Support Services rate in the CLASS, DBMD, HCS, and TxHmL programs. This rate is set using cost report data from these programs combined into a single array. Please see below for details on setting rates using cost report data and the rate setting process in general.</p>
	<p><u>Modeled Rates</u></p> <p>If payment rates are not available from other programs that provide similar services, or when historical costs are unavailable, such as in the case of a new program, payment rates are determined using a pro-forma analysis in accordance with Title 1 of the Texas Administrative Code (TAC)§ 355.10S(h) (relating to General Reporting and Documentation Requirements, Methods, and Procedures).</p> <p>A pro-forma analysis is defined as an item-by-item, or classes-of-items, calculation of the reasonable and necessary expenses for a provider to operate. The analysis may involve assumptions about the salary of an administrator or program director, staff salaries, employee benefits and payroll taxes, building depreciation, mortgage interest, contracted client care expenses, and other building or administration expenses. To determine the cost per unit of service, HHSC adds all the pro-forma expenses and divides the total by the estimated number of units of service that a fully operational provider is likely to provide. The pro-forma analysis is based on available information that is determined to be sufficient, accurate, and reliable by HHSC, including valid cost report data and survey data. Pro-forma rate setting involves using historical costs of delivering similar services, where appropriate data are available, and estimating the basic types and costs of products and services necessary to deliver services meeting federal and state requirements. The pro-forma analysis is conducted in a way that ensures that the resultant reimbursements are sufficient to support the requirements of the contracted program. When HHSC staff determine that sufficient and reliable cost report data have become available, the pro-forma reimbursement determination may be replaced with a process based on cost reports.</p> <p>The following rates are modeled using a pro-forma analysis:</p> <p>The rate for Transition Assistance Services is a lifetime cap of \$2500 per participant for the procurement of items and services the participant needs to move from an institution into community settings. The rate is determined by modeling the estimated salary for a person with the necessary skills and training, the estimated time spent with the participant, and the procurement of the necessary goods and services. The salary and time estimates were based upon the experience of providers delivering similar services under a different program. This rate is updated periodically for inflation.</p> <p>Non-Medical Transportation is paid at the rate set by the Texas Comptroller of Public Accounts. The Texas Comptroller adopts the maximum mileage rate established by the IRS for personal income tax purposes.</p> <p>The home delivered meals rate is a cost limit, established at the 80th percentile of provider costs using cost report data submitted by providers of service.</p>
	<p>Peer support rates are modeled based on the estimated salary for a person with the necessary skills and training to provide peer support.</p>

	Adaptive Aids, Vehicular Modification, and Minor Home Modifications rates are at cost. The rates for Substance Abuse Disorder services and HCBS - Adult Mental Health Recovery Management are based on the established State Plan Medicaid fee schedule.