Table of Contents

State/Territory Name: Texas

State Plan Amendment (SPA) #: 24-0008

This file contains the following documents in the order listed:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

April 18, 2024

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

RE: TX 24-0008 Adult Mental Health Benefit §1915(i) home and community-based services (HCBS) state plan amendment (SPA)

Dear Director Stephens:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's request to amend its 1915(i) state plan home and community-based services (HCBS) benefit, transmittal number TX 24-0008. The effective date for this amendment is January 1, 2024. With this amendment, the state is adding home health providers (under nursing services) to its electronic visit verification (EVV) requirement policy, in accordance with §1903(l) of the Social Security Act..

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

- Attachment 3.1-i, Pages 50, 52, 57 and 57a

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 change to the state's 1915(i) HCBS state plan benefit solely addresses the state's compliance with the applicable Medicaid authorities. CMS approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

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

Sincerely,

George P. Failla Jr -S

Digitally signed by George P. Failla Jr -S
Date: 2024.04.18 13:47:14 -04'00'

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

Enclosure

cc: Kathi Montalbano, TX HHSC
Steven Fox, TX HHSC
Cynthia Nanes, CMS DHCBSO
Wendy Hill Petras, CMS DHCBSO
Matthew Weaver, CMS DLTSS
Shante Shaw, CMS DHCBSO

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24-0008

2. STATE: TX

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
Section 1903(l) of the Social Security Act (42 U.S.C. §1396b(l))

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 0
b. FFY 2025 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-i
Page 50
Page 52
Page 57
Page 57a

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-i
Page 50 (TN 20-0003)
Page 52 (TN 20-0003)
Page 57 (TN 20-0003)
Page 57a (New Page)

9. SUBJECT OF AMENDMENT
The request proposes to amend existing language regarding Electronic Visit Verification (EVV) requirements. HHSC currently requires program providers to use EVV for certain personal care services. This amendment addresses the requirement in §1903(l) of the Social Security Act (U.S.C. Title 42, §1396b(l)) to also use EVV for home health care services. The personal care services for which the use of EVV is currently required are supported home living and in-home respite. The home health care service for which the use of EVV will be required effective January 1, 2024, is nursing services.

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
Emily Zalkovsky
Digitally signed by Emily Zalkovsky
Date: 2024.03.27 16:58:14 -05'00'

12. TYPED NAME
Emily Zalkovsky

13. TITLE
State Medicaid Director

14. DATE SUBMITTED
March 27, 2024

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
March 27, 2024

17. DATE APPROVED
April 18, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2024

19. SIGNATURE OF APPROVING OFFICIAL
George P. Failla Jr -S
Digitally signed by George P. Failla Jr -S
Date: 2024.04.18 13:47:35 -04'00'

20. TYPED NAME OF APPROVING OFFICIAL
George P. Failla Jr.

21. TITLE OF APPROVING OFFICIAL
Director Division of Home and Community Based Services Operations and Oversight

22. REMARKS

FORM CMS-179 (09/24)

Attachment to Block 6 of CMS Form 179

Transmittal Number 24-0008

	Total Fiscal Impact	Federal	State
FFY 2024	$0	$0	$0
FFY 2025	$0	$0	$0

The proposed amendment is estimated to have no fiscal impact, as it is not expected to have an effect on Medicaid utilization or cost.

Access to Care

Access to care will not be affected and communications with providers will be maintained to address any concerns, should they arise.

There were no across-the-board percentage decreases or increases.

1. How were providers, advocates and beneficiaries engaged in the discussion around rate modifications? What were their concerns and how did the State address those concerns? Was there any direct communication (bulletins, town hall meetings, etc.) between the State and providers regarding the modifications proposed via this amendment?

N/A

2. Did the State receive any feedback or complaints from the public regarding these rate modifications? If so, how were the complaints addressed and resolved?

N/A

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 serv ice. 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 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.

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 will review 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 will conduct biennial reviews of residential services in all settings, and will 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 will be 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):

✔ Categorically needy *(specify limits):*

Individuals receiving adult foster care or Department of Family and Protective Services foster care services may not also receive Supported Home Living services.

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.

This service may not be provided on the same day and at the same time as services that contain elements

			agency which includes HHSC-required training in the HCBS-AMH program. Before entering into a provider agreement with the provider agency, HHSC verifies the providers' compliance with these qualifications through a credentialing process. Contracted providers are obligated to verify on an ongoing basis that these qualifications are achieved, maintained, and documented in personnel files. HHSC will conduct annual review to verify these requirements continue to be met after the provider and HHSC enter into an agreement.

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

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

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:	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 will be 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 will be 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 afford an environment

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

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

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

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

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

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

☐	Participant-directed	✔	Provider managed

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

Service Title:	Nursing
Service Definition (Scope):	

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.

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 will be 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.

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.

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):*
	Nursing services are provided only after benefits available through Medic are, Medic aid, or other third party resources have been exhausted or are not applicable, including home health benefits.
☐	Medically needy *(specify limits):*
	N/A

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

Provider Type *(Specify):*	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
HCBS provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.	RN (or licensed vocational nurse under the supervision of a registered nurse), licensed to practice in the state.		HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or contracts with nursing providers. 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. 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.

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