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State/Territory Name: Texas

State Plan Amendment (SPA) #: 14-0014

This file contains the following documents in the order listed:

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- 2) CMS 179 Form
- 3) Superseding Page Listing
- 4) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, Texas 75202



DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

October 13, 2015

Our Reference: SPA TX 14-014

Ms. Kay Ghahremani
State Medicaid/CHIP Director
Health and Human Services Commission
Post Office Box 13247
Mail Code H100
Austin, Texas 78711

Dear Ms. Ghahremani:

We have reviewed the State's proposed amendment to the Texas State Plan submitted under Transmittal Number 14-014, dated July 22, 2014. This state plan amendment establishes the Home and Community-based Services Adult Mental Health (HCBS-AMH) benefit under section 1915(i) of the Social Security Act. With this benefit, the state will provide HCBS-AMH services to individuals over the age of 18 with serious mental illness.

Since the state has elected to target the population who can receive these Section 1915(i) state plan services, CMS approves this SPA for a five-year period in accordance with Section 1915(i)(7) of the Social Security Act (the Act) and 42 CFR 441.745(a)(2)(vi)(A). Texas will be able to renew this SPA for an additional five-year period if CMS determines, prior to the beginning of the renewal period, that the state met Federal requirements and that the state's monitoring is in accordance with the quality improvement strategy specified in Texas's approved SPA. To renew State plan HCBS for an additional 5-year period, the state must provide a written request for renewal to CMS at least 180 days prior to the end of the approval period.

As an initial 1915(i) State plan HCBS benefit, we note that any settings used must meet the settings requirements specified in 42 CFR Section 441.710. There is not a transition plan option for settings in this newly approved State plan HCBS benefit. We further note the state's description of the settings in this SPA and the state's process for assuring the home and community-based requirements of these settings initially and on an on-going basis were satisfactory.

Based on the information submitted, we have approved the amendment for incorporation into the official Texas State Plan with an effective date change of September 1, 2015. A copy of the CMS-179 and approved plan pages are enclosed with this letter.

If you have questions, please contact Cheryl Rupley at (214) 767-6278.

Sincerely,



Bill Brooks
Associate Regional Administrator

cc: Becky Brownlee, Policy Development Support

Attachment to Blocks 8 & 9 of CMS Form 179

Transmittal Number 14-014

**Number of the Plan
Section or Attachment**

**Number of the Superseded
Plan Section or Attachment**

Attachment 2.2-A

Page 23i

Page 23j

Page 23k

Attachment 2.2-A

N/A - new page

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Attachment 3.1-i

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Attachment to Blocks 8 & 9 of CMS Form 179

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**Number of the Plan
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Attachment 3.1-I

Attachment 3.1-I

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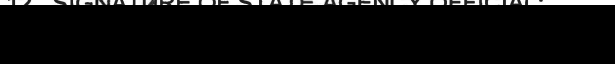

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Attachment 4.19-B

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TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		1. TRANSMITTAL NUMBER: 14-014	2. STATE: TEXAS
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE: September 1, 2015	
5. TYPE OF PLAN MATERIAL (Circle One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1915(i) of the Social Security Act 42 C.F.R. § 440.180(d)(2) 42 C.F.R. § 440.182(c)(8)		7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT a. FFY 2015 \$ 0 b. FFY 2016 \$ 650,783 c. FFY 2017 \$ 2,561,383	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: SEE ATTACHMENT TO BLOCKS 8 & 9		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): SEE ATTACHMENT TO BLOCKS 8 & 9	
10. SUBJECT OF AMENDMENT: The proposed amendment establishes the Home and Community-based Services - Adult Mental Health (HCBS-AMH) program under the authority of Section 1915(i) of the Social Security Act.			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt. <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Kay Ghahremani State Medicaid Director Post Office Box 13247, MC: H-100 Austin, Texas 78711	
13. TYPED NAME: Kay Ghahremani			
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED: July 22, 2014			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 22 July, 2014		18. DATE APPROVED: 13 October, 2015	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 September, 2015		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Bill Brooks		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health	
23. REMARKS:			

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

<input 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 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>
<input checked="" type="radio"/>	The State Plan HCBS benefit is operated by (<i>name of agency</i>) Texas Department of State Health Services (DSHS) 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.

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3. 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 checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Eligibility evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Review of participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Prior authorization of State Plan HCBS	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7 Execution of Medicaid provider agreement	<input checked="" type="checkbox"/>	<input checked="" 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 checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

In 2004, the Texas Legislature consolidated 10 health and human service agencies into four agencies (including DSHS) to operate under the authority and oversight of the Health and Human Services Commission (HHSC). In accordance with Title 42 of the Code of Federal Regulations, Section 431.10, HHSC is designated as the single State Medicaid Agency and, therefore, has administrative authority over the state plan and waivers. The Texas Legislature gave HHSC plenary authority to supervise and operate the Medicaid program, including monitoring and ensuring the effective use of all federal funds received by the State’s health and human services agencies.

Texas Government Code, Section 531.0055 (b), states in part that HHSC “shall supervise the administration and operation of the Medicaid program.”

Section 531.0055 (b) also gives HHSC full authority over federal funds received by the agencies under its control by requiring HHSC to “monitor and ensure the effective use of all federal funds received by a health and human services agency in accordance with Section 531.028 and the General Appropriations Act.”

Further, Texas Government Code, Section 531.021 states, in part, that HHSC “is the state agency designated to administer federal medical assistance funds” and requires HHSC to “plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program.”

HHSC designates DSHS as the operating agency for the 1915(i) program, known as Home and Community Based – Adult Mental Health (HCBS-AMH). HHSC delegates authority for administering this 1915(i) program under an interagency agreement which specifies responsibility for each administrative function. DSHS also administers the

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state's health system, including the state's mental health system. DSHS contracts for community-based treatment through public and private providers throughout Texas. The State's mental health system is administered at the local level by Local Mental Health Authorities (LMHAs). LMHAs are designated responsibility related to planning, oversight, policy development, coordination, resource allocation, and resource development for mental health services.

DSHS is assisting HHSC with the following functions related to the operation of the 1915(i) state plan option:

1. DSHS is responsible for disseminating information for potential enrollees under the oversight of HHSC.
2. There are no enrollment limits under the HCBS-AMH state plan option. Enrollment is tracked by DSHS and the State Medicaid Office at HHSC.
3. Eligibility determinations for Medicaid are performed as described under the Texas Medicaid State Plan. HHSC makes the final determination of eligibility for the 1915(i) state plan option. In accordance with the Social Security Act §1902(a)(5), the determination of eligibility for medical assistance under the plan shall be made by HHSC or, for individuals qualifying for Supplemental Security Income (SSI), by the agency or agencies administering the SSI program. Targeting and needs-based criteria evaluations / assessments will be applied by DSHS pursuant to policies and procedures set up and approved in advance. The individuals performing the evaluations and assessments are not providers of the HCBS-AMH treatment plan. DSHS designates staff or contractors to perform initial and on-going independent evaluations / assessments and to develop plans of care. Review of participants' individual plans of care, which are known as Individual Recovery Plans (IRPs) in the HCBS – AMH program, are conducted by DSHS under standards subject to the approval of HHSC.
4. Prior authorizations for the HCBS-AMH state plan option are conducted by DSHS in accordance with policies and procedures subject to the approval of HHSC.
5. Utilization management is conducted by DSHS pursuant to policies and procedures set up and subject to the approval of HHSC.
6. Qualified provider enrollment and recruitment is conducted by DSHS pursuant to policies and procedures set up and subject to the approval of HHSC.
7. DSHS executes contracts with HCBS providers with oversight by HHSC, and administers and evaluates the HCBS – AMH program. HCBS provider agencies execute a provider agreement with HHSC in order to obtain reimbursement through the Medicaid Management Information System (MMIS). Individuals enrolled in the HCBS-AMH program receive other Medicaid services through the Medicaid system extant in their area. Typically, this system is a capitated model known as STAR+PLUS. HHSC requires that Medicaid MCOs coordinate services with the DSHS and HCBS-AMH provider agencies.
8. HHSC establishes a consistent rate methodology for the HCBS-AMH state plan option.
9. Rules, policies, procedures, and information development governing the HCBS-AMH state plan option benefit are promulgated by DSHS under the delegated authority and oversight of HHSC as specified in the executive directive. DSHS develops provider manuals and billing guidelines. HHSC ensures that federal funding via an Advance Planning Document (APD) enables HCBS claims to be paid through the MMIS. Once modifications are complete, the State will use an electronic data system to collect clinical information and authorize service requests. The DSHS Clinical Management for Behavioral Health Services (CMBHS) system provides a platform for providers to electronically submit these data to the state. The CMBHS system interfaces with the MMIS to allow service authorizations and claims payment through MMIS. Until the MMIS is modified, DSHS will authorize individual recovery plans and pay claims manually. All claims are subject to final review and approval by HHSC.
10. Quality assurance and quality improvement activities are conducted by DSHS pursuant to policies and procedures subject to the approval of HHSC and pursuant to the State's Quality Improvement Strategy.

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

4. **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):*

DSHS, under executive directive and subject to oversight of HHSC, approves assessment and functional eligibility determinations, provides prior authorization of all individual plans of care (AKA individual recovery plans -IRPs), and ensures that conflicts of interest do not occur. The individuals performing the independent assessments, reassessments, evaluations, and IRPs cannot also be providers of HCBS-AMH on the IRP or under the administrative control of a provider of HCBS-AMH on the IRP.

The individuals performing the evaluations, reevaluations, assessments, and IRPs are DSHS employees or contractors who are delegated this responsibility. Contractors must have the requisite experience and skill to perform evaluations, reevaluations, assessments, and/or IRPs; the contractors may be public or private sector entities, but may not be HCBS-AMH providers. The needs-based assessments are reviewed by DSHS staff pursuant to the 1915(i) Quality Improvement Strategy (QIS) requirements listed later in this state plan. DSHS will annually review contractors who complete evaluations, reevaluations, assessments, and IRPs to ensure that they do not have an interest in or are under the control of a provider on the IRP.

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 the recovery management provider is the only willing and qualified entity in a geographic area that the individual chooses to receive the service. 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 that meet requirements of the program and provider agreement. DSHS 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 is more likely to occur in health manpower shortage areas, combined with rural and frontier counties.

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, DSHS 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. DSHS 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

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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. DSHS will also review resulting IRPs to ensure that there is no conflict of interest. The following conflict mitigation strategies are utilized by DSHS:

- Assuring that individuals can advocate for themselves or have an advocate present in planning meetings.
- 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 annual on-site reviews, desk reviews, and analysis of aggregate and individual data.
- Documenting consumer experiences with measures that capture the quality of IRP development

5. **Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.
6. **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.
7. **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 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.

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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	9/01/2015	08/31/2016	50
Year 2	9/01/2016	08/31/2017	100
Year 3	9/01/2017	08/31/2018	100
Year 4	9/01/2018	08/31/2019	100
Year 5	9/01/2019	08/31/2020	100

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.)

2. Income Limits.

In addition to providing State Plan HCBS to individuals described in item 1 above, the State is **also** covering the optional categorically needy eligibility group of individuals under 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the federal poverty level, or who are eligible for HCBS under a waiver approved for the State under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate (as described in Attachment 2.2A, Page 11 of the State Plan). Choose one:

The State covers all individuals described in items 2(a) and 2(b) as described in Attachment 2.2-A of the State Plan.

or

The State covers only the following group individuals described below as specified in Attachment 2.2-A of the State Plan. Choose (a) or (b):

(a) Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services.

or

(b) Individuals who would meet the criteria for a 1915(c) or 1115 waiver and whose income does not exceed 300% of the supplemental security income benefit rate. Complete (i) and/or (ii).

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i. Specify the 1915(c) Waiver/Waivers CMS Base Control Number/Numbers for which the individual would be eligible: _____

and/or

ii. Specify the name(s) or number(s) of the 1115 waiver(s) for which the individual would be eligible:

3. **Medically Needy** (*Select one*):

<input checked="" type="checkbox"/> The State does not provide State plan HCBS to the medically needy.
<input type="checkbox"/> The State provides State plan HCBS to the medically needy. (<i>Select one</i>):
<input type="checkbox"/> 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, medically needy individuals receive only 1915(i) services.
<input type="checkbox"/> The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

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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 type="radio"/>	Directly by the Medicaid agency
<input checked="" type="radio"/>	By Other (<i>specify State agency or entity under contract with the State Medicaid agency</i>):
	DSHS staff or contractors who are not providers of HCBS-AMH services will conduct the independent evaluations and reevaluations. DSHS is not and will not become an HCBS provider. In addition, DSHS will annually review contractors completing evaluations/reevaluations to ensure that they do not have a conflict of interest and are not administratively under the control/direction of a provider who is on the beneficiary's IRP.

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*):

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 25 Tex. Admin. Code § 412.316(d) (relating to Competency and Credentialing));

(B) is a registered nurse; or

(C) completes an alternative credentialing process identified by the Texas Department of State Health Services.

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 DSHS-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) to identify functional needs and determine whether an individual meets the needs-based HCBS eligibility criteria. Criteria evaluated using the ANSA include behavioral health needs, life domain functioning (including assessment of ADLs and IADLs), and functional needs / strengths. Evaluations and reevaluations of eligibility for HCBS will be conducted by DSHS staff or contractors who are not providers of HCBS-AMH services.

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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.

(Specify the needs-based criteria): The criteria take into account the individual's support needs, and may include other risk factors: An individual is eligible for State Plan HCBS under the HCBS-AMH program if the individual requires HCBS-AMH services to improve or maintain functioning, prevent relapse to a lower level of functioning, and maintain residence in the community. This need is determined through evaluation and reevaluation of functional need using a standardized instrument (the Adult Needs and Strengths Assessment (ANSA)).

Each domain on the ANSA assesses functional needs and strengths. Each item within a domain has four levels, with anchored definitions. The assessor uses these definitions to determine a score which is translated into the following action levels (separate for needs and strengths):

For needs:

0= No evidence

1= Watchful waiting/prevention

2= Action

3= Immediate/Intensive Action

For strengths:

0= Centerpiece strength

1= Strength that you can use in planning

2= Strength has been identified-must be built

3= No strength identified

Individuals must have a level of functional need (ANSA score of 2 or higher) that indicates a need for intervention provided by HCBS-AMH services that is identified by items in one of the following domains assessed by the ANSA: behavioral health, life domain functioning (including ADLs and IADLs), or functional needs and strengths.

Need is also evidenced by 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). Institutional criteria—which require that the individual be acutely ill and in need of 24 hour observation, stabilization and intervention, including active supervision by a psychiatrist—are more stringent than HCBS needs-based criteria. However, individuals meeting an institutional level of care are not excluded from HCBS-AMH eligibility on that basis.

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):*

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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:</p> <p>Require HCBS-AMH services to improve or maintain functioning, prevent relapse to a lower level of functioning, and maintain residence in the community; demonstrated by a level of functional need (ANSA score of 2 or higher) that indicates a need for intervention provided by HCBS-AMH services that is identified in one of the following domains assessed by the ANSA: behavioral health, life domain functioning (including ADLs and IADLs), or functional needs and strengths; and</p> <p>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).</p>	<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 (40 Tex. Admin. Code §19.2401), an individual must meet both of the following criteria for medical necessity:</p> <p>1.The individual must demonstrate a medical condition that:</p> <ul style="list-style-type: none"> * is of sufficient seriousness that the individual's needs exceed the routine care which may be given by an untrained person; and * requires licensed nurses' supervision, assessment, planning, and intervention that is available only in an institution. <p>AND</p> <p>2.The individual must require medical or nursing services that:</p> <ul style="list-style-type: none"> *are ordered by a physician; *are dependent upon the individual's documented medical conditions; * require the skills of a registered or licensed 	<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> <ul style="list-style-type: none"> * is attributable to a mental or physical impairment or combination of mental and physical impairments; * is manifested before the individual attains age 22; * is likely to continue indefinitely; * results in substantial functional limitations in 3 or more of the following areas of major life activity: <ul style="list-style-type: none"> (i) Self-care. (ii) Receptive and expressive language. (iii) Learning. (iv) Mobility. (v) Self-direction. (vi) Capacity for independent living. (vii) Economic self-sufficiency; <p>and</p> <ul style="list-style-type: none"> * reflects the 	<p>The individual must:</p> <p>Have a valid diagnosis as listed in the current version of the ICD as the principal admitting diagnosis and one of the following:</p> <ul style="list-style-type: none"> * Outpatient therapy or partial hospitalization has been attempted and failed * A psychiatrist has documented reasons why an inpatient level of care is required. * The client must meet at least one of the following criteria: * The client is presently a danger to self, demonstrated by at least one of the following: <ul style="list-style-type: none"> (i) Recent suicide attempt or active suicidal threats with a deadly plan, and there is an absence of appropriate supervision or structure to prevent suicide. (ii) Recent self-mutilative behavior or active threats of same with likelihood of acting on the threat, and there is an absence of appropriate supervision or structure to prevent self-mutilation (i.e., intentionally cutting/burning self). (iii) Active hallucinations or delusions directing likely to lead to serious self-harm or debilitating psychomotor agitation or retardation resulting in a significant inability to care for self. (iv) Significant inability

	<p>vocational nurse;</p> <p>*are provided either directly by or under the supervision of a licensed nurse in an institutional setting; and</p> <p>*are required on a regular basis.</p> <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.</p>	<p>individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.</p> <p>AND</p> <p>2. Require active treatment in an institutional setting specifically designed for treatment of intellectual and developmental disabilities.</p>	<p>to comply with prescribed medical health regimens due to concurrent psychiatric illness and such failure to comply is potentially hazardous to the life of the client.</p> <p>* The client is a danger to others. This behavior must be attributable to the client's specific diagnosis that can be adequately treated only in a hospital setting. This danger is demonstrated by one of the following:</p> <ul style="list-style-type: none"> (i) Recent life-threatening action or active homicidal threats of same with a deadly plan, availability of means to accomplish the plan, and with likelihood of acting on the threat. (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. (iii) Active hallucinations or delusions directing or likely to lead to serious harm of others. <p>* The client 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 client unmanageable and unable to cooperate in treatment, and the client is in need of</p>
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			<p>assessment and treatment in a safe and therapeutic setting.</p> <p>* The client has a severe eating or substance abuse disorder that requires 24-hour-a-day medical observation, supervision, and intervention.</p> <p>* The client exhibits severe disorientation of person, place, or time.</p> <p>* The client'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, or sexual abuse.</p> <p>* The client requires medication therapy or complex diagnostic evaluation where the client's level of functioning precludes cooperation with the treatment regimen.</p> <p>* The client 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>The proposed treatment or therapy requires 24-hour-a-day medical observation, supervision, and intervention and must include all of the following:</p>
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			<p>* Active supervision by a psychiatrist with the appropriate credentials, as determined by the Texas Medical Board (TMB) or other appropriate entity;</p> <p>* Implementation of an individualized treatment plan;</p> <p>* 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>* 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>A history of inpatient admission 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). (*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.

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

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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. **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 HCB Settings requirements at 42 CFR 441.710(a)-(b) and associated CMS guidance. Include:*

1) Description of the settings and how they meet federal HCB 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 HCB Setting requirements, at the time of this submission and ongoing.)

The State Plan HCBS benefit established under Chapter 25 Texas Administrative Code, Sections 416.51-416.58 will be furnished to individuals who reside in their own home, family home, or in a community residential setting. HCBS-AMH standards and processes require that individuals in all community-based settings under the state plan amendment optimize participant independence and community integration, promote initiative and choice in settings, daily living, and facilitate full access to community services. DSHS assures that the individual recovery plan addresses issues of choice and independence which includes that the individual will be able to select from choice of settings including non-disability specific options and an options for a private unit in a residential setting.

Residential settings are fully integrated into the community and support full access for individuals receiving HCBS-AMH services to the greater community in accordance with the requirements of 42 CFR §441.710. Individuals in residential settings live in environments which respect privacy and choice which ensure the individual has a right to privacy, dignity and respect, and freedom from coercion and restraint. Living units meet all HCBS criteria. Units will have lockable doors which may be locked at the discretion of the individual, with only appropriate staff having keys to the doors. Staff access to living units will be documented in the IRP. The plan will identify 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. Each unit is separate and distinct from the others. Individuals who share a unit have a choice of roommate. 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, and have the freedom to furnish and decorate units. Settings facilitate individual choice regarding services and supports and who provide them.

Individuals may not reside in any of the following settings and receive HCBS-AMH services:

- Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;
- Any setting that is located in a building on the grounds of, or immediately adjacent to, a public institution; or
- Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

If the individual is renting the residence then that individual will have a legally enforceable agreement and will enjoy the same, protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, Texas will ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS-AMH participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

Settings for both residential and non-residential services must be physically accessible to the individual. Services must be furnished in integrated settings and in a way that fosters the independence of each individual and the realization of the benefits of community living. Routines of service delivery must be person-driven to the maximum extent possible, treat each individual with dignity and respect, promote individuals' inclusion in community activities, use natural supports and typical community services, promote social interaction and participation in leisure activities, and improve/maintain daily living and functional living skills. Setting are integrated in and support full access of individuals receiving Medicaid HCBS 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.

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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.

All settings for HCBS-AMH services will be compliant with HCB settings requirements prior to provider enrollment, prior to enrollment of the individual (for settings where the individual resides), and on an ongoing basis. For provider owned or operated settings, DSHS staff reviews provider credentials and conducts an on-site review before executing an agreement with the provider to ensure that the setting will afford individuals independence and community integration. DSHS staff members also review IRPs in relation to practice and conduct biennial on-site reviews of community-based settings to ensure that settings do not have the qualities of an institutional setting, meet home and community-based setting requirements, and promote choice and community inclusion. Additionally, residential homes must meet state licensure or program certification requirements which pertain to each setting.

All non-residential services must be provided in settings that comply with HCB settings requirements. Prior to enrollment of providers, DSHS reviews provider credentials, assurances and attestations that non-residential settings will be compliant with HCB settings requirements. DSHS approves the IRPs. DSHS reviews ongoing compliance with settings requirements for HCSB-AMH services through the quality improvement process to ensure that non-residential HCBS-AMH settings do not have the qualities of an institutional setting, but do meet home and community-based setting requirements, and promote choice and community inclusion.

The residential assistance (Host-home/Companion Care, Assisted Living, Supervised Living, and Supported Home Living) providers 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 individual needs, goals and characteristics of the individuals to whom they deliver services, and that they are knowledgeable of acts that constitute abuse, neglect, or exploitation of an individual and of methods to prevent the occurrence of abuse, neglect, and exploitation. Providers of residential assistance (Host-home/Companion Care, Assisted Living, Supervised Living, and Supported Home Living) must complete initial and periodic training as required by DSHS.

Individuals are supported in their recovery process to transition from more structured community-based residential options to their own home or apartment as the individual's preferences and needs indicate.

Residential settings include homes or apartments owned by the individual consumer or their family; homes or apartments leased by the individual from non-HCBS provider sources; homes owned or leased by an HCBS-AMH provider and approved by the State (one to three beds); or assisted living facilities licensed by the State under Title 40, Social Services and Assistance, Part 1, Department of Aging and Disability Services, Chapter 92, Licensing Standards for Assisted Living Facilities.

Assisted living may include dually-occupied units in which the individuals have a choice of roommates. The units contain bedrooms and toilet facilities and may or may not include kitchenette and/or living rooms. The facility 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 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.

Settings do not include those that do not have the community characteristics or qualities of home and community-based settings (e.g. nursing facility, institution for mental diseases, or an intermediate care facility for individuals with intellectual disabilities.)

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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*):

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, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention;
- (B) is a registered nurse; or
- (C) completes an alternative credentialing process identified by the Texas Department of State Health Services.

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 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 DSHS-approved training in assessing individuals for HCBS.

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*):

Individualized, person-centered plans of care, referred to as the Individual Recovery Plans (IRPs), are developed by individuals with Qualified Mental Health Professional (QMHP) credentials at a minimum. Individuals developing the plans of care must also receive DSHS required training and demonstrate competence in person-centered, individualized planning.

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- 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:*)

Individuals will be afforded the services of an independent Recovery Manager, trained and competent in person-centered planning who will support the individual in all aspects of their 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.

It 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, 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 DSHS staff or contractors. 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:*)

Each individual will be afforded the services of an independent 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. Documentation regarding provider choice is included in the individual's record and updates to that 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 is made subject to the approval of the Medicaid agency:*)

The Plan of Care (Individual Recovery Plan – IRP) will be developed by the individual's recovery manager, with full participation of the individual and significant others in a person-centered planning process that is based on the individual's preferences, needs, and personal goals. DSHS 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. DSHS will provide individual recovery plan (IRP) data to HHSC and provide aggregate reporting on utilization review findings.

DSHS will use an electronic data system to collect clinical information and authorize service plans/requests. The DSHS Clinical Management for Behavioral Health Services (CMBHS) system will provide a platform for DSHS employees and providers to electronically submit data. The CMBHS system will interface with the MMIS to allow service authorization and claims payment. This system will ensure that authorizations for services are in place ensuring correct claims payment to certified Medicaid providers. Until the MMIS is modified, DSHS will authorize individual recovery plans and pay claims manually. All claims will be subject to final review and approval by the single state Medicaid agency.

HHSC has delegated day-to-day operation of HCBS-AMH to DSHS. DSHS will perform first-level review of 100 percent of person-centered plans of care, referred to as the Individual Recovery Plans (IRPs), consistent with operating procedures approved by HHSC. DSHS will provide aggregate performance data to HHSC in the quarterly meetings. In addition, DSHS will provide individual IRP data to HHSC. 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.

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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. Restraint is used only as last resort after less restrictive measures have been found to be ineffective or are judged unlikely to protect the individual or others from harm. Other forms of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ other aversive methods to modify behavior are not allowable. Individuals must provide informed consent regarding the potential use of restrictive intervention. This potential use must be included on the individual's safety plan on the IRP, which must also confirm that the individual understands his/her rights and how to report abuse, neglect, and exploitation.

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.

Restrictive intervention is used for the shortest period possible and terminated as soon as the individual demonstrates safe behaviors.

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

Direct staff shall:

- Respect and preserve the rights of an individual during restrictive interventions;
- Provide an environment that is protected and private from other individuals and that safeguards the personal dignity and well-being of an individual placed in restrictive interventions;
- Ensure that undue physical discomfort, harm, or pain to the individual does not occur when initiating or using restrictive interventions;
- Use only the amount of physical force that is reasonable and necessary to implement a particular restrictive intervention.

The use of restrictive interventions is permissible on the provider's property or for transportation of an individual only if implemented:

- In accordance with state law regarding interventions in mental health services;
- When less restrictive interventions (such as those listed in the individual's safety plan) are determined ineffective to protect other individuals, the individual, staff members, or others from harm;
- In connection with applicable evaluation and monitoring;
- In accordance with any alternative strategies and special considerations documented in the IRP;
- When the type or technique of restrictive intervention used is the least restrictive intervention that will be effective to protect the other individuals, the individual, staff members, or others from harm; and
- Is discontinued at the earliest possible time.

The HCBS-AMH provider must take into consideration information that could contraindicate or otherwise affect the use of personal restraint, including information obtained during the assessment. This information includes, but is not limited to:

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- Techniques, methods, or tools that would help the individual effectively cope with his or her environment;
- Pre-existing medical conditions or any physical disabilities and limitations, including substance use disorders, that would place the individual at greater risk during restraint;
- Any history of sexual or physical abuse that would place the individual at greater psychological risk during restraint; and
- Any history that would contraindicate restraint.

An individual held in restraint shall be under continuous direct observation. The HCBS-AMH provider shall ensure adequate respiration and circulation during restraint.

The use of planned restrictive interventions is reflected on the individual's IRP, which is submitted to DSHS for approval. The use of physical restraints must be documented as a critical incident by the HCBS-AMH provider and reported to DSHS. Unauthorized use of restrictive interventions will be detected by record review and through complaints. The oversight of personal restraint for HCBS-AMH providers is accomplished through the quarterly risk assessment conducted by DSHS.

The HCBS-AMH provider shall record the following information in the clinical record:

- The circumstances leading to the use of personal restraint;
- The specific behavior necessitating the restraint and the behavior required for release;
- Less restrictive interventions that were tried before restraint began;
- The names of the direct service staff who implemented the restraint;
- The date and time the restraint began and ended; and
- The individual's response.

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.

The use of chemical restraints and mechanical restraints by HCBS-AMH providers is prohibited. The use of seclusion is prohibited.

Restraint shall not be used:

- As a means of discipline, retaliation, punishment, or coercion;
- For the purpose of convenience of staff members or other individuals; or
- As a substitute for effective treatment or habilitation.

Restraints that do any of the following are prohibited:

- Obstruct the individual's airway, including a procedure that places anything in, on, or over the individual's mouth or nose;
- Impair the individual's breathing, including applying pressure to the individual's torso or neck;
- Restrict circulation;
- Secure an individual to a stationary object;
- Cause pain to restrict an individual's movement (pressure points or joint locks);
- Inhibit, reduce, or hinder the individual's ability to communicate; and

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- Are protective or supportive devices that are not easily removable by the individual without assistance.

A prone or supine hold shall not be used during a personal restraint. Should an individual become prone or supine during a restraint, then any provider involved in administering the restraint shall immediately transition the individual to a side lying or other appropriate position.

Providers shall ensure that direct service members are informed of their roles and responsibilities and are trained and demonstrate competence accordingly.

Before assuming job duties involving direct care responsibilities, and at least annually thereafter, direct service staff must receive training and demonstrate competence in at least the following knowledge and applied skills that shall be specific and appropriate to the target population of HCBS-AMH:

- The use of restraint, including how to perform the restraint;
- Identifying the causes of aggressive or threatening behaviors of individuals who need mental health services, including behavior that may be related to an individual's non-psychiatric medical condition;
- Identifying underlying cognitive functioning and medical, physical, and emotional conditions;
- Identifying medications and their potential effects;
- Identifying how age, weight, cognitive functioning, developmental level or functioning, gender, culture, ethnicity, and elements of trauma-informed care, including history of abuse or trauma and prior experience with restraint or seclusion, may influence behavioral emergencies and affect the individual's response to physical contact and behavioral interventions;
- Explaining how the psychological consequences of restraint and the behavior of staff members can affect an individual's behavior, and how the behavior of individuals can affect a staff member;
- Applying knowledge and effective use of communication strategies and a range of early intervention, de-escalation, mediation, problem-solving, and other non-physical interventions, such as clinical timeout and quiet time; and
- Recognizing and appropriately responding to signs of physical distress in individuals who are restrained or secluded, including the risks of asphyxiation, aspiration, and trauma.

Before any direct service staff may initiate any restraint, direct service staff shall receive training and demonstrate competence in:

- Safe and appropriate initiation and use of restraint as a last resort in a behavioral emergency;
- Safe and appropriate initiation and application, and use of personal restraint as a last resort in a behavioral emergency;
- Safe and appropriate initiation and application, and use of restraint as a last resort in a behavioral emergency or as a protective or supportive device.
- Management of emergency medical conditions in accordance with the provider's policies and procedures and other applicable requirements for:
 - o obtaining emergency medical assistance; and
 - o obtaining training in and using techniques for cardiopulmonary respiration and removal of airway obstructions.

Before assuming job duties, and at least annually thereafter, a registered nurse or a physician assistant who is authorized to:

- Perform assessments of individuals who are in restraint shall receive training, which shall include a demonstration of competence in:
 - o monitoring cardiac and respiratory status and interpreting their relevance to the physical safety of the individual in restraint;

- o recognizing and responding to nutritional and hydration needs;
 - o checking circulation in, and range of motion of, the extremities;
 - o providing for hygiene and elimination;
 - o identifying and responding to physical and psychological status and comfort, including signs of distress;
 - o assisting individuals in de-escalating, including through identification and removal of stimuli, that meet the criteria for a behavioral emergency if known;
 - o recognizing when continuation of restraint is no longer justified by a behavioral emergency; and
 - o recognizing when to contact emergency medical services to evaluate and/or treat an individual for an emergency medical condition.
- Conduct evaluations of individuals, including face-to-face evaluations relating to initiation of restraint or in a behavioral emergency of individuals who are in restraint, shall receive training, which shall include a demonstration of competence in:
 - o identifying restraints that are permitted by the provider and by applicable law;
 - o identifying stimuli that trigger behaviors;
 - o identifying medical contraindications to restraint;
 - o recognizing psychological factors to be considered when using restraint, such as sexual abuse, physical abuse, neglect, and trauma.

Before assuming job duties, and at least annually thereafter, providers who are authorized to monitor, under the supervision of a registered nurse, individuals during restraint shall receive training, which shall include a demonstration of competence in:

- Monitoring respiratory status;
- Recognizing nutritional and hydration needs;
- Checking circulation in, and range of motion of, the extremities;
- Providing for hygiene and elimination;
- Addressing physical and psychological status and comfort, including signs of distress;
- Assisting individuals in de-escalating, including through identification and removal of stimuli, if known.
- Recognizing when continuation of restraint is no longer justified by a behavioral emergency; and
- Recognizing when to contact a registered nurse.

DSHS is responsible for overseeing the use of restrictive interventions with individuals enrolled in HCBS-AMH. The use of restrictive interventions, including personal restraints, are reported as critical incidents and managed as part of the contract oversight process by DSHS. DSHS' oversight of the use of personal restraints by HCBS-AMH providers is accomplished through annual risk assessment conducted by DSHS. Unauthorized use of restraint will be detected by record review, site review, and through complaints.

DSHS 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 DSHS. The State utilizes Critical Event or Incident Reporting and Management Processes that enable the State 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 home placement other than for the provision of respite;
- Incarceration;

- Restraint 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 DSHS the Critical Incident Report Form within 72 hours of notification of outcome of the incident with any updated information.

During DSHS site review of HCBS-AMH providers, DSHS reviews critical incident reports and reports data from critical incident reviews to HHSC on a quarterly basis.

The HCBS-AMH provider will cooperate with and assist HHSC, DSHS, and any state or federal agency charged with the duty of identifying, investigating, sanctioning or prosecuting suspected fraud and abuse, including the Office of Inspector General at HHSC.

The Department of Family and Protective Services (DFPS) is responsible for investigating abuse, neglect and exploitation and providing services to adults who are over age 65 or have a disabling condition such as a mental, physical, or developmental disability that substantially impairs their ability to live on their own or provide for their own self-care or protection.

The Department of Family and Protective Services (DFPS) will provide DSHS copies of each investigation of ANE allegations involving an individual enrolled in the HCBS-AMH. Regardless of the investigation findings, DSHS reviews each investigative report.

The Department of Aging and Disability Services (DADS) regulates assisted living facilities and associated complaints of abuse by providers of HCBS-AMH services in assisted living facilities and HCBS-AMH providers of respite in nursing home settings.

DSHS notifies individuals of his/her rights prior to enrollment into the HCBS-AMH Program. DSHS verifies notification of the individual of his/her rights through the individual or LAR's 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 DSHS Consumer Rights and Protection, 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 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 name, telephone number, and mailing address of the HCBS-AMH provider's rights protection officer must be prominently posted in every area that is frequented by HCBS-AMH participants. Individuals desiring to contact the rights protection officer must be allowed access to the HCBS-AMH Provider's telephones to do so.

The method used to communicate the information will be designed for effective communication, tailored to meet each person's ability to comprehend, and responsive to any visual or hearing impairment. Oral communications of rights will be documented on the Notification of Participant Rights Form bearing the date and signatures of the individual enrolled in HCBS-AMH and/or LAR and the staff person who explained the rights. The Notification of Participant Rights Form will be filed in the individual's clinical record.

HCBS-AMH Providers are responsible for monitoring participant medication regimens, including the administration of medications to individuals enrolled in HCBS-AMH who cannot self-administer and/or the oversight of individuals enrolled in HCBS-AMH who self-administer medications.

- At least annually, the HCBS-AMH Provider must assure that staff administering medications be qualified under their scope of practice.
- The HCBS-AMH provider must assure that staff who have been delegated the authority to administer medications or delegated oversight of individuals who self-administer medications receive instruction in medication administration and monitoring from a practitioner with delegation authority before assuming their duties and as indicated by changes in the client's condition or medication regimen. The staff delegated to administer the medications will be trained and have knowledge of each medication, what it is prescribed for, and the adverse reactions and side effects.
- The HCBS-AMH provider must monitor staff who have been delegated authority to administer medications or delegated oversight of individuals who self-administer medications. The frequency and monitoring is based on the individual's condition, medication regimen, and changes to the medication regimen.
- If applicable, the LAR must sign an authorization for the HCBS-AMH provider to administer each medication according to label directions.
- The medication must be in the original container labeled with the expiration date and the individual's full name.
- The HCBS-AMH provider must administer the medication according to the label directions or as amended by a physician.
- The HCBS-AMH provider must administer the medication only to the individual for whom it is intended.
- The HCBS-AMH provider must not administer the medication after its expiration date.
- If applicable, the HCBS-AMH provider may provide non-prescription medications if the HCBS-AMH provider obtains LAR consent prior to administration of the medication. Consent may be given over the phone and documented as such by the HCBS-AMH provider.
- At least quarterly, or more frequently if indicated by the individual's condition, medication regimen or changes to the regimen, HCBS-AMH providers shall review medication administration records to ensure that medications are correctly administered.

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

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

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Services

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

The State assures that any limitations noted in this 1915(i) state plan benefit cannot be imposed on services that would otherwise be provided through 1905(a) to individuals eligible for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

Service Specifications <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):			
<p>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.</p> <p>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).</p> <p>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.</p> <p>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.</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 for <i>(choose each that applies)</i> :			
<input checked="" type="checkbox"/>	Categorically needy <i>(specify limits)</i> :	<p>There is a \$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.</p> <p>There is a \$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.</p>	
<input type="checkbox"/>	Medically needy <i>(specify limits)</i> :	NA	
Provider Qualifications <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 Provider Agency that meets the minimum			HCBS provider agency enrolled and contracted with DSHS to provide HCBS services, which employs or contracts with a

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<p>eligibility and standards for HCBS-AMH provider enrollment.</p>			<p>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.</p> <p>Before entering into a provider agreement with the provider agency, DSHS 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. DSHS will conduct annual review to verify these requirements continue to be met after the provider and DSHS enter into an agreement.</p> <p>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.</p>
<p>Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):</p>			
<p>Provider Type (Specify):</p>	<p>Entity Responsible for Verification (Specify):</p>	<p>Frequency of Verification (Specify):</p>	
<p>HCBS Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.</p>	<p>DSHS</p>	<p>Annual</p>	
<p>Service Delivery Method. (Check each that applies):</p>			
<p><input type="checkbox"/> Participant-directed</p>	<p><input checked="" type="checkbox"/> Provider managed</p>		

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Service Specifications (<i>Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover</i>):	
Service Title:	HCBS Psychosocial Rehabilitation Services
Service Definition (Scope):	
<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. Skills include, but are not limited to: illness/recovery management, self-care, activities of daily living, and instrumental activities of daily living. The modality(ies) used must be approved by DSHS. A variety of evidence-based practices may be used as appropriate to individual needs, interests and goals. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual’s IRP. Rehabilitative services are face-to-face interventions with the individual present. Services may be provided individually or in a group setting.</p> <p>The provider must incorporate research-based approaches pertinent to the needs of the target population. Approaches used must be approved by DSHS. Examples of specific research-based approaches that could be used for various sub-populations of clients include, but are not limited to:</p> <p>Cognitive Adaptation Training (CAT): An evidence-based practice which provides assistance and environmental modifications to help individuals establish daily routines, organize their environment, and build social skills, with the ultimate goal of increasing independence. CAT compensates for cognitive deficits from mental illness (such as psychomotor speed, attention, and memory) by providing visual clues, signage, and organization of the individual’s environment, which results in increased independent functioning. CAT improves the individual’s ability to perform activities of daily living such as dressing, hygiene, social skills and communication, medication management, toileting, leisure skills, and transportation.</p> <p>Illness Management and Recovery (IMR): IMR gives individuals information about mental illnesses and coping skills to help them manage their illnesses, develop goals, and make informed decisions about their treatment. IMR practitioners help individuals define recovery for themselves and identify personally meaningful recovery goals. In IMR, education about mental illnesses is the foundation of informed decision-making. Practitioners help individuals build social networks and engage supporters in activities that promote recovery. Individuals learn to identify early warning signs and plan steps that they can take to prevent relapses. They also learn strategies to help them manage their symptoms, cope with stress, and significantly improve their lives.</p> <p>Seeking Safety: Present-focused therapy to help people attain safety from trauma, post-traumatic stress disorder, and substance abuse. This therapy was developed by Lisa M. Najavits at Harvard Medical School/McLean Hospital in 1992.</p> <p>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.</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 for (<i>chose each that applies</i>):	
X	<p>Categorically needy (<i>specify limits</i>):</p> <p>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.</p> <p>Services are subject to prior approval by DSHS 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</p>

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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 (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
HCBS Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.			<p>HCBS provider agency enrolled and contracted with DSHS to provide HCBS-AMH services, which employs or has a contract with the HCBS Psychosocial Rehabilitation practitioner.</p> <p>Before entering into a provider agreement with the provider agency, DSHS 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. DSHS will conduct annual review to verify these requirements continue to be met after the provider and DSHS enter into an agreement.</p> <p>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, DSHS-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.</p>

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 Provider Agency that meets the minimum eligibility and standards for HCBS-AMH	DSHS	Annual

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provider enrollment.		
Service Delivery Method. (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:	Adaptive aids	
Service Definition (Scope):		
<p>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.</p> <p>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.</p> <p>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.</p> <p>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 DSHS.</p> <p>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.</p> <p>Service animals must be provided in accordance with the IRP and documented as necessary for the individual to remain in the community.</p>		
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 DSHS.		
Specify limits (if any) on the amount, duration, or scope of this service for (chose each that applies):		
<input checked="" type="checkbox"/>	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.</p> <p>Adaptive aids are limited to those categories specified in the state plan amendment.</p>	
<input type="checkbox"/>	Medically needy (specify limits):	

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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.			<p>HCBS provider agency enrolled and contracted with DSHS to provide HCBS services, which employs or has contracts with adaptive aid providers.</p> <p>Before entering into a provider agreement with the provider agency, DSHS 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. DSHS will conduct annual review to verify these requirements continue to be met after the provider and DSHS enter into an agreement.</p> <p>Adaptive aid providers and their employees must comply with all applicable laws and regulations for the provision of adaptive aids.</p>
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.	DSHS	Annual	
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: 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 DSHS. 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;
- help individuals obtain jobs directly, rather than mandating lengthy pre-employment assessment, training, and counseling;
- 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 as 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 be self-employed, work from home, or perform in a work setting at which individuals without disabilities are employed. 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 be 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;
- helping individuals attend school and providing academic supports, when that is their preference;
- 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

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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 for (*chose each that applies*):

<input checked="" type="checkbox"/>	<p>Categorically needy (<i>specify limits</i>):</p> <p>Services do not include payment for the supervisory activities rendered as a normal part of the business setting.</p> <p>Services do not include payment for supervision, training, support, and adaptations typically available to other non-disabled workers filling similar positions in the business.</p> <p>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.</p> <p>Employment Services may be used for an individual to gain work-related experience considered crucial for job, placement (e.g., unpaid internship), only if such experience is vital to the person to achieve his or her vocational goal.</p> <p>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.</p> <p>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.</p> <p>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>
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	<ul style="list-style-type: none"> • Incentive payments made to an employer to encourage hiring the individual; • Payments that are passed through to the individual; <ul style="list-style-type: none"> ○ Payments for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business; or ○ Payments used to defray the expenses associated with starting up or operating a business. <p>The documentation of employment services must be available to DSHS 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>
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<input type="checkbox"/>	Medically needy (<i>specify limits</i>):
	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 Provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.			<p>HCBS provider agency enrolled and contracted with DSHS 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"> • have a bachelor's degree in rehabilitation, business, marketing, or a related human services field, and one year's paid or unpaid experience providing employment services to people with disabilities; • have an associate's degree in rehabilitation, business, marketing, or a related human services field, and two years' paid or unpaid experience providing employment services to people with disabilities; or • have a high school diploma or Certificate of High School Equivalency (GED credentials), and three years' paid or unpaid experience providing employment services to people with disabilities. <p>The individual provider must complete training required by DSHS.</p> <p>Before entering into a provider agreement with the provider agency, DSHS 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. DSHS will conduct annual review to verify these requirements continue to be met after the provider and DSHS enter into an agreement.</p>

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Verification of Provider Qualifications <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 Provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.	DSHS	Annual	
Service Delivery Method. <i>(Check each that applies):</i>			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed

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Service Specifications (<i>Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover</i>):			
Service Title:	Transportation		
Service Definition (Scope):			
<p>Transportation is offered in order to enable individuals served to gain access to services, activities, and resources, as specified in the IRP. This service is offered in addition to medical transportation required under 42 C.F.R. § 431.53 and transportation services under the State Plan, defined at 42 C.F.R. § 440.170(a) (if applicable), and will not replace them.</p> <p>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 medical transportation benefit.</p> <p>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.</p> <p>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.</p> <ul style="list-style-type: none"> • System edits will be in place to prevent duplicative billing. • All Medicaid transportation services will be coordinated by the individual's recovery manager and the relevant full-risk broker or managed transportation organization in the client's area. • The state Medicaid authority has final authority over approval of claims. • The state will perform periodic review of claims data to check for duplicative claims. • Where duplicative claims are found, the State will recoup claims payment. <p>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.</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 for (<i>chose each that applies</i>):			
<input checked="" type="checkbox"/>	Categorically needy (<i>specify limits</i>):		
	There is a limit of \$2000 per individual per year for this service.		
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):		
	NA		
Provider Qualifications (<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>):

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HCBS provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.			HCBS provider agency enrolled and contracted with DSHS to provide HCBS services, which employs or contracts with transportation vendors. 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.
Verification of Provider Qualifications <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>	
Transportation	DSHS	Annual	
Service Delivery Method. <i>(Check each that applies):</i>			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed

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Service Specifications (<i>Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover</i>):	
Service Title:	Community Psychiatric Supports and Treatment (CPST)
Service Definition (Scope):	
<p>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:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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:</p> <p>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.</p> <p>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.</p>	
Additional needs-based criteria for receiving the service, if applicable (<i>specify</i>):	

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Specify limits (if any) on the amount, duration, or scope of this service for <i>(chose each that applies)</i> :			
<input checked="" type="checkbox"/>	Categorically needy <i>(specify limits)</i> :		
	<p>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).</p> <p>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.</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>		
<input type="checkbox"/>	Medically needy <i>(specify limits)</i> :		
	N/A		
Provider Qualifications <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 Provider agency	LPC, LMFT, LCSW, PhD psychologist, RN or MD (for individual therapists). Licensure candidates may provide services as part of a graduate education program under the direct supervision of an appropriately licensed professional.		<p>HCBS provider agency enrolled and contracted with DSHS to provide HCBS services, which employs or contracts with licensed practitioners with demonstrated competence in specialized mental health therapies.</p> <p>Direct-care therapists must be trained, credentialed, and demonstrate competence in the specialized psychotherapy practice used.</p> <p>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).</p>
Verification of Provider Qualifications <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 Provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.	DSHS	Annual	

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Service Delivery Method. <i>(Check each that applies):</i>			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed

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Service Specifications (<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):			
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.			
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.			
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 for (<i>chose each that applies</i>):			
<input checked="" type="checkbox"/> Categorically needy (<i>specify limits</i>):			
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.			
Peer services are not a substitute for or adjunct to other HCBS services such as HCBS Psychosocial Rehabilitation or Community Psychiatric Supports and Treatment.			
<input type="checkbox"/> Medically needy (<i>specify limits</i>):			
N/A			
Provider Qualifications (<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 Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.		Peer Specialists must be recognized under a DSHS-approved process for MH or SUD peers.	HCBS provider agency enrolled and contracted with DSHS to provide HCBS services, which employs or has agreements with recognized Peer Specialists. Individual providers must maintain a DSHS-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..
Verification of Provider Qualifications (<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 Provider Agency that meets	DSHS		Annual

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the minimum eligibility and standards for HCBS-AMH provider enrollment.		
Service Delivery Method. <i>(Check each that applies):</i>		
<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: Host Home/Companion Care

Service Definition (Scope):

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

Home and Community-Based Settings must:

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

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

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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 will be documented in the IRP. The IRP will identify when persons other than the individual have access, what types of persons 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 provide 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 DSHS 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 DSHS.

DSHS 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. DSHS staff will conduct biennial reviews of residential services in all settings, and will 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 will be conducted by DSHS or its designee to re-evaluate the participant to determine the appropriateness of the service in accordance with DSHS 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.

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 (<i>specify</i>):	
Specify limits (if any) on the amount, duration, or scope of this service for (<i>chose each that applies</i>):	
<input checked="" type="checkbox"/>	<p>Categorically needy (<i>specify limits</i>):</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, non-medical transportation, or transition assistance 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"> • Nursing facilities; • Institutions for mental disease; • Intermediate care facilities for individuals with Intellectual or Developmental Disabilities; • Inpatient hospitals; or • Any other location that has qualities of an institutional setting.
<input type="checkbox"/>	<p>Medically needy (<i>specify limits</i>):</p> <p>N/A</p>

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Provider Qualifications (For each type of provider. Copy rows as needed): Comment –			
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.			<p>HCBS provider agency enrolled and contracted with DSHS to provide HCBS services, which employs or has agreements with Host Home/Companion Care 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 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 Host Home/Companion Care must complete initial and periodic training provided by HCBS provider agency which includes DSHS-required training in the HCBS-AMH program.</p> <p>Before entering into a provider agreement with the provider agency, DSHS 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. DSHS will conduct annual review to verify these requirements continue</p>

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			to be met after the provider and DSHS enter into an agreement.
Verification of Provider Qualifications <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 Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.	DSHS		Annual
Service Delivery Method. <i>(Check each that applies):</i>			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed

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Service Specifications (<i>Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover</i>):	
Service Title:	Supervised Living Services
Service Definition (Scope):	
<p>Supervised Living Services are supportive and health-related residential services provided to individuals in settings licensed or approved by the State of Texas. Residential services are necessary, as specified in the individuals person-directed IRP, to enable the individual to remain integrated in the community and ensure the health, welfare, and safety of the individual in accordance with 42 C.F.R. § 441.710. (Refer to Section 9 “Home and Community-Based Settings” for HCBS-AMH settings requirements.) Supervised Living Services include personal care and supportive services (homemaker, chores, attendant services, and meal preparation) that are furnished to individuals who reside in homelike, non-institutional, integrated settings. In addition, they include 24-hour onsite response capability to meet scheduled and unscheduled or unpredictable resident needs and to provide supervision and safety. Services also include social and recreational programming and medication assistance (to the extent permitted under state law).</p> <p>Home and Community-Based Settings must:</p> <ul style="list-style-type: none"> • Be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. • Be selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. • Ensure rights of privacy, dignity and respect, and freedom from coercion and restraint. • Optimize, but not regiment, individual initiative, autonomy, and independence in making life choices, daily activities, physical environment, and with whom to interact. • Facilitate individual choice regarding services and supports, and who provides them <p>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:</p> <ol style="list-style-type: none"> 1. 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 2. 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. <p>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 will be documented in the IRP. The IRP will identify 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</p>	

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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 provide 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.

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

This service will be provided to meet the individual's needs as determined by an individualized assessment performed in accordance DSHS 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 DSHS.

DSHS will review the authorized Supervised Living Service on an ongoing basis to ensure that it is community-based, inclusive, and meets federal and state HCBS setting requirements. DSHS staff will conduct biennial reviews of residential services in all settings, and will 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 will be conducted by DSHS or its designee to re-evaluate the participant to determine the appropriateness of the service in accordance with DSHS 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 for (*chose each that applies*):

Categorically needy (*specify limits*):

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<p>Supervised living services can only be provided in settings approved by DSHS or in licensed assisted living facilities with no more than 4 beds.</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, non-medical transportation, or transition assistance 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"> • Nursing facilities; • Institutions for mental disease; • Intermediate care facilities for individuals with Intellectual or Developmental Disabilities; • Inpatient hospitals; or • Any other location that has qualities of an institutional setting. 			
<input type="checkbox"/> Medically needy (<i>specify limits</i>):			
N/A			
Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>): Comment –			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
HCBS Provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.			HCBS provider agency enrolled and contracted with DSHS 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 provider must have a high school diploma or Certificate of High School Equivalency (GED)

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			<p>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 DSHS-required training in the HCBS-AMH program.</p> <p>Before entering into a provider agreement with the provider agency, DSHS 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. DSHS will conduct annual review to verify these requirements continue to be met after the provider and DSHS enter into an agreement.</p>
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Verification of Provider Qualifications <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 Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.	DSHS	Annual
Service Delivery Method. <i>(Check each that applies):</i>		
<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> X	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: Assisted Living Services

Service Definition (Scope):

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

Home and Community-Based Settings must:

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

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

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

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

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

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 will identify 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.

DSHS 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. DSHS staff will conduct biennial reviews of residential services in all settings, and will 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 will be conducted by DSHS or its designee to re-evaluate the participant to determine the appropriateness of the service in accordance with DSHS 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 for (*chose each that applies*):

Categorically needy (*specify limits*):

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<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>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 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"> • Nursing facilities; • Institutions for mental disease; • Intermediate care facilities for individuals with Intellectual or Developmental Disabilities; • Inpatient hospitals; or • Any other location that has qualities of an institutional setting. 			
<p><input type="checkbox"/> Medically needy (<i>specify limits</i>):</p> <p>N/A</p>			
<p>Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):</p>			
<p>Provider Type (<i>Specify</i>):</p>	<p>License (<i>Specify</i>):</p>	<p>Certification (<i>Specify</i>):</p>	<p>Other Standard (<i>Specify</i>):</p>
<p>HCBS Provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.</p>			<p>HCBS provider agency enrolled and contracted with DSHS 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 High School Equivalency (GED credentials) or</p>

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			<p>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 Assisted Living Services must complete initial and periodic training provided by HCBS provider agency which includes DSHS-required training in the HCBS-AMH program.</p> <p>Before entering into a provider agreement with the provider agency, DSHS 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. DSHS will conduct annual review to verify these requirements continue to be met after the provider and DSHS enter into an agreement.</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 Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.	DSHS	Annual

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: 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 setting licensed or approved by the State of Texas. Residential services are necessary, as specified in the individual's person-directed IRP, to enable the individual to remain integrated in the community and ensure the health, welfare, and safety of the individual in accordance with 42 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).

Home and Community-Based Settings must:

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

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

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

The individual receiving supported home living has a right to privacy. Sleeping and individual living units may be locked at the discretion of the individual, with keys available only to landlords or appropriate service providers. Service providers with access to living units will be documented in the IRP. The IRP will identify when service providers have access, what types of service providers have access, and under what circumstances service providers will be allowed to access an individual's unit. In order to justify a modification of person-centered residence requirements, the IRP must document: a specific and individualized assessed need; the

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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 DSHS 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 will be provided to meet the individual's needs as determined by an individualized assessment performed in accordance DSHS 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 DSHS. DSHS 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. DSHS staff will conduct biennial reviews of residential services in all settings, and will 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 will be conducted by DSHS or its designee to re-evaluate the participant to determine the appropriateness of the service in accordance with DSHS 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 for (*chose each that applies*):

Categorically needy (*specify limits*):

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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 integral to the delivery of this service.

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.

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:

- Nursing facilities;
- Institutions for mental disease;
- Intermediate care facilities for individuals with Intellectual or Developmental Disabilities;
- Inpatient hospitals; or
- Any other location that has qualities of an institutional setting.

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 Provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.			<p>HCBS provider agency enrolled and contracted with DSHS 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 the individual(s) to be served.</p> <p>Transportation of individuals must be</p>

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			<p>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 DSHS-required training in the HCBS-AMH program.</p> <p>Before entering into a provider agreement with the provider agency, DSHS 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. DSHS will conduct annual review to verify these requirements continue to be met after the provider and DSHS enter into an agreement.</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 Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.	DSHS	Annual

Service Delivery Method. (Check each that applies):

<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed
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Service Specifications (<i>Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover</i>):	
Service Title:	Respite Care
Service Definition (Scope):	
<p>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.</p> <p>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.</p> <p>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.</p> <p>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 DSHS requirements and afford 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.</p> <p>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.</p> <p>Out-of-home respite can be provided in the following locations:</p> <ul style="list-style-type: none"> • 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 (<i>specify</i>):	
Specify limits (if any) on the amount, duration, or scope of this service for (<i>chose each that applies</i>):	
<input checked="" type="checkbox"/>	<p>Categorically needy (<i>specify limits</i>):</p> <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. 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"/>	<p>Medically needy (<i>specify limits</i>):</p> <p>N/A</p>

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.			<p>HCBS provider agency enrolled and contracted with DSHS 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> <p>Before entering into a provider agreement with the provider agency, DSHS 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. DSHS will conduct annual review to verify these requirements continue to be met after the provider and DSHS enter into an agreement.</p>
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	DSHS		Annual

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Service Delivery Method. <i>(Check each that applies):</i>			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed
Service Specifications <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 for <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		
Provider Qualifications <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 Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.			<p>HCBS-AMH provider agency enrolled and contracted with DSHS to provide HCBS-AMH services, which employs or contracts with home-delivered meal providers.</p> <p>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.</p> <p>Before entering into a provider agreement with the provider agency, DSHS 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. DSHS will conduct annual review to verify these requirements continue to be met after the provider and DSHS enter into an agreement.</p>
Verification of Provider Qualifications <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 Provider Agency that meets the minimum eligibility and	DSHS		Annual

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standards for HCBS-AMH provider enrollment.			
Service Delivery Method. <i>(Check each that applies):</i>			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed
Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):</i>			
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 DSHS. 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 <i>(specify):</i>			
The minor home modifications must be necessary to address specific functional limitations documented in the individual’s recovery plan and must be approved by DSHS.			
Specify limits (if any) on the amount, duration, or scope of this service for <i>(chose each that applies):</i>			
<input checked="" type="checkbox"/>	Categorically needy <i>(specify limits):</i>		
	<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		
Provider Qualifications <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 provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.			<p>HCBS provider agency enrolled and contracted with DSHS 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>

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			<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>
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.	DSHS		Annual
Service Delivery Method. (Check each that applies):			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed

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Service Specifications (<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):			
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.			
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 for (<i>chose 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>):			
NA			
Provider Qualifications (<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 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.		<p>HCBS provider agency enrolled and contracted with DSHS 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>
Verification of Provider Qualifications (<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 provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.	DSHS		Annual

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Nurse	HCBS Provider agency	Annual
Service Delivery Method. <i>(Check each that applies):</i>		
<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed	
HCBS provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.	DSHS	Annual

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Service Specifications (<i>Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover</i>):			
Service Title:		Substance Use Disorder (SUD) Services (abuse and dependence)	
Service Definition (Scope):			
<p>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 DSHS. Services may be provided in the individual’s home or other community-based setting. Individuals must exhaust other state plan SUD benefits before choosing the HCBS SUD benefit unless other state plan benefits are not appropriate to meet the individual’s needs, limitations, and recovery goals as determined by the independent evaluation (e.g. severe cognitive or social functioning limitations, or a mental disability). Services are designed to assist the individual in achieving specific recovery goals identified in the IRP and in preventing relapse. Services are also designed to respect the individual’s culture, while addressing attitudinal and behavioral challenges that may impede the individual from realizing their desired recovery goals. Therapeutic modalities may include motivational interviewing; individual, group, and family counseling; psycho-education; medication management; harm reduction; and relapse-prevention. SUD treatment plans will be developed with active participation of the individual to specifically address and accommodate the individual’s needs, goals, and preferences and will support the overall HCBS recovery goals. Services will be provided using a team approach which integrates other HCBS services, such as peer support as appropriate to the individual’s needs and preferences.</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 for (<i>chose each that applies</i>):			
<input checked="" type="checkbox"/>	Categorically needy (<i>specify limits</i>):		
	This service may not be provided on the same day and at the same time as state plan SUD services.		
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):		
	N/A		
Provider Qualifications (<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 provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment, which employs or contracts and directly supervises Licensed Chemical Dependency Treatment providers	Individual counselors providing the SUD service must be Qualified Credentialed Counselors (QCCs) as defined by DSHS. SUD treatment programs must be licensed by the Texas Department of State Health Services as Chemical Dependency Treatment Programs.		<p>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.</p> <p>Individual providers must be licensed and/or appropriately credentialed to provide services and act within the scope of their licensure and/or credentialing.</p> <p>Before entering into a provider agreement with the provider agency, DSHS 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. DSHS will conduct annual review to verify these requirements continue to be met after the provider and DSHS enter</p>

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			into an agreement.
Verification of Provider Qualifications <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 provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.	DSHS	Annual	
Service Delivery Method. <i>(Check each that applies):</i>			
<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: **HCBS – AMH Recovery Management**

Service Definition (Scope):

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

- Coordinates / leads development of the IRP using a person-centered planning approach which supports the individual in directing and making informed choices according to the individual’s needs and preferences;
- Provides supporting documentation to be considered by DSHS in the independent evaluation and reevaluations;
- Identifies services / providers, brokers to obtain and integrate services, facilitates, and advocates to resolve issues that impede access to needed services;
- Develops / pursues resources to support the individual’s recovery goals including non-HCBS Medicaid, Medicare, and/or private insurance or other community resources;
- Assists the individual in identifying and developing natural supports (family, friends, and other community members) and resources to promote the individual’s recovery;
- Informs consumers of fair hearing rights;
- Assists HCBS-AMH consumers with fair hearing requests when needed and upon request;
- Educates and informs individuals about services, the individual recovery planning process, recovery resources, rights, and responsibilities;
- Actively coordinates with other individuals and/or entities essential to physical and/or behavioral services for the individual (including the individual’s MCO) to ensure that other services are integrated and support the individual’s recovery goals, health, and welfare;
- Monitors health, welfare, and safety through regular contacts (visits with the individual, paid and unpaid supports, and natural supports) at a minimum frequency required by DSHS;
- Responds to and assesses emergency situations and incidents and assures that appropriate actions are taken to protect the health, welfare, and safety of individuals;
- Reviews provider service documentation and monitors the individual’s progress;
- Initiates recovery plan team discussions or meetings when services are not achieving desired outcomes. Outcomes include housing status, employment status, involvement in the criminal justice system, response to treatment and other services, and satisfaction with services; and
- Through the recovery plan monitoring process, solicits input from consumer and/or family, as appropriate, related to satisfaction with services.

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

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

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 DSHS, and includes individuals in other waiver or state plan programs and other funding sources, unless the requirement is

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waived by DSHS.

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.

Specify limits (if any) on the amount, duration, or scope of this service for *(choose each that applies)*:

Categorically needy *(specify limits)*:

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

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

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

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

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

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

When an HCBS provider of last resort also provides recovery management services, DSHS 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. DSHS 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. DSHS will also review resulting IRPs to ensure that there is no conflict of interest.

<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"/> Medically needy (<i>specify limits</i>):			
NA			
Provider Qualifications (<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>):
Recovery management provider enrolled and contracted with DSHS to provide recovery management services, or a recovery management entity which employs or contracts with individual recovery management providers			Individual providers of recovery management must: <ul style="list-style-type: none"> • 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 • Demonstrate knowledge of issues affecting people with severe mental illness and community-based interventions/resources for this population; and • Complete DSHS-required training in the HCBS-AMH program.
Verification of Provider Qualifications (<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 provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.	DSHS		Annual
Service Delivery Method. (<i>Check each that applies</i>):			
<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/>	Provider managed	

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

The State does not make or permit HCBS agencies to make payment to legally responsible individuals, or legal guardians for furnishing State Plan HCBS.

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Participant-Direction of Services

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

b. 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. <i>(Specify criteria):</i>

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. <i>(Specify the areas of the State affected by this option):</i>

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, a person-centered process produces a person-centered service plan for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual’s ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;

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- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

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6. 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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7. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff). *(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"/>	Participant/Co-Employer. The participant (or the participant’s representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
<input type="checkbox"/>	Participant/Common Law Employer. The participant (or the participant’s representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant’s agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget). *(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.
	Participant-Directed Budget. <i>(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, 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>
	Expenditure Safeguards. <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>

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Quality Improvement Strategy

(Describe the State’s quality improvement strategy in the tables below):

Discovery Activities					Remediation	
Requirement	Discovery Evidence <i>(Performance Measures)</i>	Discovery Activity <i>(Source of Data & sample size)</i>	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	Frequency	Remediation Responsibilities <i>(Who corrects, analyzes, aggregates, and reports on remediation activities)</i>	Frequency <i>(of Analysis and Aggregation)</i>
The processes and instruments described in the approved 1915(i) SPA are applied appropriately and according to the approved description to determine if the needs-based criteria were met.	1. The number and percent of individuals that were determined to meet needs-based criteria requirements prior to receiving 1915(i) services. 2. The number and percent of individuals’ initial needs-based criteria determination forms/instruments that were completed, as required in the approved SPA. 3. The number and percent of individuals’ initial determinations, where level of need criteria was applied correctly.	Record review, onsite; Representative sample with a confidence level of 95 percent.	DSHS collects, generates, aggregates, and analyzes	Annually	DSHS	Annually
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	1. Number and percent of participants with current individual recovery plans (IRPs) updated annually 2. Number and percent of	Record review, onsite; Representative sample with a confidence level of 95 percent.	DSHS collects, generates, aggregates, and analyzes	Annually	DSHS	Annually

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	<p>participants with IRPs which document the individual's choice among and between HCBS-AMH services.</p> <p>3. Number and percent of participants with IRPs which document providers and individual goals consistent with their individual assessments.</p> <p>4. 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>5. Number and percent of participants with services delivered in accordance with the IRP, including the type, scope, amount, duration, and frequency specified in the service plan.</p>					
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<p>HCBS-AMH Provider Agencies and HCBS-AMH service providers meet required qualifications.</p> <p>HCBS-AMH Provider agencies must meet the minimum eligibility and standards for HCBS-AMH provider enrollment, which include:</p> <ul style="list-style-type: none"> • Must have experience with and / or demonstrated capacity to administer services for people with severe mental illness or related populations • Must be a legal entity under state law, have the authority to do business in Texas, and be in good standing to do business in Texas and conduct the activities required by DSHS. • Must have a Texas address; and • Must have organizational policies and procedures acceptable to DSHS to deliver HCBS-AMH services 	<p>1. Number and percent of HCBS providers initially meeting licensure and certification requirements prior to furnishing HCBS services.</p> <p>2. Number and percent of HCBS providers meeting licensure and certification requirements while furnishing services.</p> <p>3. Number and percent of HCBS-AMH provider agencies with an active agreement with DSHS/HHSC.</p> <p>4. Number and percent of HCBS providers who meet training requirements for delivering HCBS services.</p> <p>5. Number and percent of enrolled HCBS providers serving HCBS clients (by provider type).</p>	<p>Representative sample, with a confidence level of 95 percent, of provider agencies, open enrollment applications, provider agreements, state licensure authorities, and provider personnel records.</p>	<p>DSHS collects, generates, aggregates, and analyzes</p>	<p>Annually</p>	<p>DSHS</p>	<p>Annually</p>
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<p>Settings meet the home and community-based setting requirements as specified in this SPA.</p>	<p>1. Number and percent of HCBS settings meeting appropriate licensure or certification and Federal HCBS requirements.</p>	<p>Representative sample, with a confidence level of 95 percent, of provider agencies, on-site reviews, and report of recovery managers</p>	<p>DSHS collects, generates, aggregates, and analyzes</p>	<p>Annually</p>	<p>DSHS</p>	<p>Annually</p>
<p>The SMA retains authority and responsibility for program operations and oversight.</p>	<p>1. Number and percent of aggregated performance measure reports generated by the Operating Agency (DSHS) and reviewed by the State Medicaid Agency that contain discovery, remediation, and system improvements for ongoing compliance of the assurances.</p> <p>2. Number and percent of SPA amendments, renewals, and financial reports approved by HHSC prior to implementation by DSHS.</p> <p>3. Number and percent of SPA concepts and policies requiring MMIS programming approved by HHSC prior to the development of a formal implementation plan by DSHS.</p>	<p>Reports to HHSC on delegated administrative functions; 100 percent sample size</p>	<p>DSHS collects, generates, aggregates, analyzes, and sends to State Medicaid Agency</p>	<p>Annually</p>	<p>DSHS</p>	<p>Annually</p>

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<p>HHSC maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.</p>	<p>1. Number and percent of providers that have payment recouped for HCBS services without supporting documentation.</p> <p>2. Number and/or percent of claims verified through the DSHS compliance audit to have paid in accordance with the participant's IRP.</p> <p>3. Number and/or percentage of rates which remain consistent with the approved rate methodology throughout the five year SPA cycle.</p>	<p>Routine claims verification audits; Representative sample, with a confidence level of 95 percent of case managers.</p> <p>Annual review of rate setting methodology</p>	<p>DSHS collects, generates, aggregates, and analyzes</p>	<p>Annually</p>	<p>DSHS</p>	<p>Annually</p>
<p>The State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation (ANE), including the use of restraints.</p>	<p>1. Number and/or percent of reports related to the abuse, neglect, exploitation, and unexplained deaths of participants where an investigation was completed within time frames established by State law.</p> <p>2. Number and percent of participants who received information on how to report the suspected abuse, neglect, or exploitation of adults.</p> <p>3. Number and percent of participants who received information regarding their rights to a state fair hearing via the</p>	<p>100 percent sample, DSHS 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.</p>	<p>DSHS collects, generates, aggregates, and analyzes</p>	<p>Annually</p>	<p>DSHS</p>	<p>Annually</p>

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	<p>official state form.</p> <p>4. Number and percent of grievances filed by participants that were resolved within 14 calendar days according to approved SPA guidelines.</p> <p>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>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>7. Number and percent of unauthorized uses of restrictive interventions that were appropriately reported.</p> <p>8. Number and percent of HCBS participants who received physical exams consistent with state 1915(i) policy.</p>					
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System Improvement: <i>(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)</i>			
Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
Program performance data <ul style="list-style-type: none"> Track and trend system performance Analyze discovery 	DSHS will collect, collate, review, and post. HHSC will review the data and have final direction over corrective action plans.	Updated monthly and reported quarterly	<ul style="list-style-type: none"> Set performance benchmarks Review of service trends Review program implementation Track and trend system performance Analyze the discovery; synthesize the data; DSHS, with HHSC, will make corrective action plans regarding quality improvement (QI). DSHS will review QI recommendations quarterly and build upon those improvements through continuous quality improvement.
Quality management meetings <ul style="list-style-type: none"> Assess system changes Focus on reporting requirements and refining reports 	DSHS will collect, analyze, and report. HHSC provides oversight and direction.	Quarterly meetings	<ul style="list-style-type: none"> Monitoring contract and HCBS compliance for service delivery Review of clinical assessment client outcome measures
Onsite reviews <ul style="list-style-type: none"> Documentation review Onsite interviews 	DSHS coordinates and conducts onsite reviews and reports findings to HHSC. HHSC provides oversight and direction.	Annually	<ul style="list-style-type: none"> Review of clinical operations (utilization management, quality management, care management) Compliance issues will require the submission of a corrective action plan to DSHS for approval and ongoing monitoring.
Corrective action plans (CAP)	The provider shall be actively engaged in the development of the corrective action plan (CAP) to the satisfaction of the State. The CAP is monitored by DSHS—subject to the authority of the state Medicaid agency, which has final direction over the CAP..	Areas for improvement will be monitored as per CAP and presented quarterly during Quality Management meetings	<ul style="list-style-type: none"> Analysis of performance data Onsite review findings of program non-compliance follow-up

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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"/>	<p>HCBS Respite Care</p> <ul style="list-style-type: none"> 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. 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. 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. 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. 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.
For Individuals with Chronic Mental Illness, the following services:	
<input type="checkbox"/>	HCBS Day Treatment or Other Partial Hospitalization Services
<input checked="" type="checkbox"/>	<p>HCBS Psychosocial Rehabilitation</p> <p>The rates for psychosocial rehabilitative services are based on the established State Plan Medicaid fee schedule.</p>
<input type="checkbox"/>	HCBS Clinic Services (whether or not furnished in a facility for CMI)

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<input checked="" type="checkbox"/>	<p>Other Services (specify below)</p> <p><u>General Rate Setting</u> The rates for all services in the HCBS-AMH program are available on the HHSC Rate Analysis Department’s website, as outlined on Attachment 4.19-B, Page 1. Unless otherwise specified, all rates are effective as of January 1, 2015.</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. Providers of these services are required to submit annual cost reports to HHSC. 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 in the course of the review or on-site audit. Audited cost reports are used in the determination of statewide prospective rates.</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>Additionally for the HCS and TxHmL programs, the initial model-based rates for these services were determined using cost, financial, statistical, and operational information collected during site visits performed by an independent consultant. The data was collected from cost reports and the service providers' accounting systems. Additionally, the state fiscal year (SFY) 1996 state wage data, the SFY 1994 cost data, and the SFY 1995 data from service providers was reviewed and analyzed. The base model rate year was calendar year 1997. Data from SFY 1994-1996 were used to develop the current rate structure; rates are rebased every biennium from the most recent projected cost report data, within available appropriations.</p> <p>In order to project costs to the prospective reimbursement period, HHSC uses the Personal Consumption Expenditures (PCE) chain-type price index as the general cost inflation index. The PCE chain-type price index is a nationally recognized measure of inflation published by the Bureau of Economic Analysis of the U.S. Department of Commerce. To project or inflate costs from the reporting period to the prospective reimbursement period, HHSC uses the lowest feasible PCE chain-type price index forecast consistent with the forecasts of nationally recognized sources available to HHSC at the time proposed reimbursement is prepared for public dissemination and comment. HHSC uses specific indices in place of the general cost inflation index when appropriate item-specific or program-specific cost indices are available from cost reports or other surveys, other Texas state agencies or independent private sources, or nationally recognized public agencies or independent private firms, and HHSC have determined that these specific indices are derived from information that adequately represents the program(s) or cost(s) to which the specific index is to be applied. Nursing wages are inflated by wage inflation factors based on wage and hour survey information submitted on cost reports or special surveys, Social Security payroll taxes are inflated by FICA inflation factors based on data obtained from the Statistical Abstract of the United States, and federal and state unemployment taxes are inflated by FUTA/SUTA inflation factors based on data obtained from the Texas Workforce Commission.</p>
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Arrayed rates are determined by combining all costs from programs with sufficient reliable cost report data into a single array. The rate methodology is then applied to this array to determine a reimbursement rate.

The following rates are set based on cost reports:

The Host Home/Companion Care, Supervised Living Services and Supported Home Living rates are based on the HCS rates, and the Assisted Living Services rate is based on the CBA Assisted Living rate. 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.

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.

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.

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.

Modeled Rates

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) § 355.105(h) (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

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.

The following rates are modeled using a pro-forma analysis:

The rate for Transition Assistance Services is a one-time payment for the procurement of items and services the participant needs to move from an institution, a provider-operated setting, or family home to

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their own private community residence. 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.

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.

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.

Peer support rates are modeled based on the estimated salary for a person with the necessary skills and training to provide peer support.

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.

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Groups Covered

Optional Groups other than the Medically needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the State is **also** covering the optional categorically needy eligibility group of individuals under 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the State under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate. (select at least one):

The State covers all of the individuals described in item 1(a) and (b) as described below.

Complete 1(a) and 1(b):

1(a). Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services.

Income Standard

150% FPL

Methodology used (Select one)

SSI

OTHER (describe):

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For states that have elected the SSI methodology, the State uses the following less restrictive 1902(r)(2) income disregards for this group. There is no resource test for this group. (specify):

1(b). Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate. For individuals eligible for 1915(c), (d) or (e) waiver services, this amount must be the same amount as the income standard specified under your state plan for the special income level group. For individuals eligible for 1915(c) like services under an approved 1115, this amount must be the same as the amount of the income standard used for individuals using institutional rules. (Select one):

- 300% of the SSI/FBR
- (Specify) _____% Less than 300% of the SSI/FBR

The State uses the same eligibility criteria that it uses for the special income level group.

The State covers only the following group individuals described below. Complete 1(a) or 1(b):

1(a). Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services.

Income Standard

- 150% FPL

Methodology used (Select one)

- SSI
- OTHER (describe):

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For states that have elected the SSI methodology, the State uses the following less restrictive 1902(r)(2) income disregards for this group. There is no resource test for this group. (specify):

1(b). Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate. For individuals eligible for 1915(c), (d) or (e) waiver services, this amount must be the same amount as the income standard specified under your state plan for the special income level group. For individuals eligible for 1915(c) like services under an approved 1115, this amount must be the same as the amount of the income standard used for individuals using institutional rules. (Select one):

- 300% of the SSI/FBR
- (Specify) _____% Less than 300% of the SSI/FBR

The State uses the same eligibility criteria that it uses for the special income level group.

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