

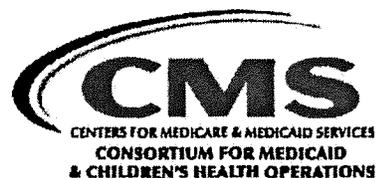
Table of Contents

State Plan Amendment (SPA) #: 16-0001 1915(i) HCBS-AMH Eligibility

This file contains the following documents in order listed:

1. CMS Approval Letter
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

December 18, 2017

Our Reference: SPA TX 16-0001

Ms. Stephanie Muth
State Medicaid Director
Texas Health and Human Services Commission
Mail Code: H100
P.O. Box 13247
Austin, Texas 78711

RECEIVED

DEC 21 2017

OFFICE OF THE STATE
MEDICAID DIRECTOR

Dear Ms. Muth:

We have reviewed the State's proposed amendment to your Medicaid State Plan submitted under Transmittal Number (TN) 16-0001, dated May 20, 2016. This amendment expands the needs-based eligibility criteria for the Home and Community-Based Services – Adult Mental Health (HCBS-AMH) 1915(i) programs to include adults with a diagnosis of a serious mental illness (SMI) who have a history of psychiatric crisis and repeated discharges from correctional facilities, as well as adults with a diagnosis of SMI who have a pattern of emergency department utilization. The proposed amendment also removes the one to three bed limit for homes owned or leased by an HCBS-AMH provider and approved by the State and revises the conflict of interest standards to mitigate conflict of interest if the individual performing the assessment works for the provider of last resort.

Based on the information submitted, we have approved the amendment for incorporation into the official Texas state plan with an effective date of July 1, 2016, as requested. A copy of CMS 179 form as well as the approved plan pages are included with this letter.

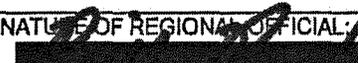
If you have any questions please contact Ford Blunt of my staff. Mr. Blunt may be reached at (214) 767-6381 or by e-mail at Ford.Blunt@cms.hhs.gov.

Sincerely,



Bill Brooks
Associate Regional Administrator

cc: Dana Williamson, Manager, Policy Development Support

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		1. TRANSMITTAL NUMBER: 16-0001	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: July 1, 2016	
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 8 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: SSA § 1915(l), 42 C.F.R. § 440.180(d)(2), 440.182(c)(8)		7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT a. FFY 2016 \$ 1,643,318 b. FFY 2017 \$ 13,674,530 c. FFY 2018 \$ 14,835,095	
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: <p>The purpose of this amendment is to expand the needs-based eligibility criteria for the Home and Community-Based Services-Adult Mental Health (HCBS-AMH) 1915(l) program to include adults with a diagnosis of a serious mental illness (SMI) who have a history of psychiatric crisis and repeated discharges from correctional facilities, as well as adults with a diagnosis of SMI who have a pattern of emergency department utilization. The proposed amendment also removes the one to three bed limit for homes owned or leased by an HCBS-AMH provider and approved by the State and revises the conflict of interest standards to mitigate conflict of interest if the individual performing the assessment works for the provider of last resort.</p>			
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: Gary Jesse State Medicaid Director Post Office Box 13247, MC: H-100 Austin, Texas 78711	
13. TYPED NAME: Gary Jesse			
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED: May 20, 2016			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: May 20, 2016		18. DATE APPROVED: December 18, 2017	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2016		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Bill Brooks		22. TITLE: Associate Regional Administrator Division of Medicaid and Children's Health	
23. REMARKS: <div style="text-align: center;">  RECEIVED DEC 21 2017 </div>			

Attachment to Blocks 8 & 9 of CMS Form 179

Transmittal Number 16-0001

**Number of the
Plan Section or Attachment**

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

Attachment 3.1-i

Attachment 3.1-i

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Page 6 (TN 14-014)
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Page 9 (TN 14-014)
N/A - New Page
Page 10 (TN 14-014)
Page 11 (TN 14-014)
Page 12 (TN 14-014)
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Page 66 (TN 14-014)
Page 67 (TN 14-014)
Page 68 (TN 14-014)
Page 79 (TN 14-014)
Page 82 (TN 14-014)

Effective:

Approved:

Supersedes:

(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, performs evaluations and reevaluations, 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, 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 unless the provider is the only willing and qualified entity in a geographic area who can be responsible for assessments and person-centered service plan development.

The individuals performing the assessments and IRPs are DSHS employees or contractors who are delegated this responsibility. Contractors must have the requisite experience and skill to perform assessments and/or IRPs. For assessments and person-centered service plan development, the contractors may be public or private sector entities, but may not be HCBS-AMH providers, unless they are the only willing and qualified entity in a geographic area who can be responsible for assessments and person-centered service plan development. The needs-based assessments are reviewed by 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 assessments and IRPs to ensure that they do not have an interest in or are under the control of a provider on the IRP. Contractors delegated the responsibility to perform assessments who are an HCBS-AMH provider of last resort will have a higher level of scrutiny.

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

Texas anticipates that some service areas may not have separate Provider Agencies and Recovery Management Entities, who develop the person-centered service plans that meet requirements of the program and provider agreement. 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 and instances in which contractors delegated the responsibility to perform assessments are an HCBS-AMH provider of last resort will occur in health manpower shortage areas, combined with rural and frontier counties.

- Health manpower shortage area designations can be found at: <http://hpsafind.hrsa.gov/>
- Rural county designations can be found at: <http://www.dshs.texas.gov/chs/hprc/counties.shtm>
- Frontier and Remote Area Codes as identified by the Economic Research Service of the United States Department of Agriculture can be found at: <https://www.ers.usda.gov/data-products/frontier-and-remote-area-codes/frontier-and-remote-area-codes/#2010> Frontier and Remote Area Codes Data Files

State: Texas

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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 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:

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

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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	350
Year 2	9/01/2016	08/31/2017	700
Year 3	9/01/2017	08/31/2018	750
Year 4	9/01/2018	08/31/2019	750
Year 5	9/01/2019	08/31/2020	750

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).

Effective:

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Supersedes:

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

[Empty text box for 1915(c) Waiver/Waivers]

and/or

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

[Empty text box for 1115 waiver(s)]

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.

Effective:

Approved:

Supersedes:

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*):

<p>1) Qualified Mental Health Professional -- a person who has demonstrated and documented competency in the work to be performed and:</p> <p>(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));</p> <p>(B) is a registered nurse; or</p> <p>(C) completes an alternative credentialing process identified by the Texas Department of State Health Services.</p> <p><u>or</u></p> <p>2) Licensed Practitioner of the Healing Arts:</p> <p>(A) a physician;</p> <p>(B) a licensed professional counselor;</p> <p>(C) a licensed clinical social worker;</p> <p>(D) a psychologist;</p> <p>(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</p> <p>(F) A licensed marriage and family therapist.</p> <p>and</p> <p>Has received DSHS-approved training in evaluating individuals for HCBS-AMH.</p>

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:

<p>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.</p>

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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:

1) A history of extended or repeated stay(s) in an inpatient psychiatric hospital (i.e., three years or more of consecutive or cumulative inpatient psychiatric hospitalization during the five years prior to initial enrollment in HCBS-AMH). Inpatient psychiatric 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.

Or

2) In the three years prior to initial enrollment in HCBS-AMH two or more psychiatric crises (i.e., inpatient psychiatric hospitalizations and/or outpatient psychiatric crisis that meets inpatient psychiatric criteria) and four or more repeated discharges from correctional facilities.

Or

3) In the three years prior to initial enrollment in HCBS-AMH two or more psychiatric crises (i.e., inpatient psychiatric hospitalizations and/or outpatient psychiatric crisis that meets inpatient psychiatric criteria) and fifteen or more total emergency department (ED) visits.

Effective:

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Supersedes:

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>OR</p> <p>Demonstrate in the three years prior to initial enrollment in HCBS-AMH two or more psychiatric crises (i.e., inpatient psychiatric hospitalizations and/or outpatient psychiatric crisis that meets inpatient psychiatric criteria) four or more repeated discharges from correctional facilities.</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; 	<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>	<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.

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<p>OR</p> <p>Demonstrate in the three years prior to initial enrollment in HCBS-AMH two or more psychiatric crises (i.e., inpatient psychiatric hospitalizations and/or outpatient psychiatric crisis that meets inpatient psychiatric criteria) and fifteen or more total emergency department (ED) visits.</p>	<p>* require the skills of a registered or licensed 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>* reflects the 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>(iv) Significant inability to comply with prescribed medical health regimens due to concurrent psychiatric illness and such failure to comply is potentially hazardous to the 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,</p>
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			<p>and the client is in need of 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, repeated discharges from correctional facilities, psychiatric crisis, or ED visits is not sufficient to admit an individual to a psychiatric facility.</p>
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*Long Term Care/Chronic Care Hospital

**LOC= level of care

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

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

8. **Adjustment Authority.** The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).
9. **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. Settings 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 and before renewing 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 including state licensure, assurances and attestations that non-residential settings will be compliant with HCB settings requirements and performs an on-site review of compliance with settings requirements. DSHS approves the IRPs on which the recovery manager confirms compliance with HCBS settings requirements. 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. DSHS conducts biennial on-site reviews of community-based settings to ensure that settings do not have the qualities of an institutional setting, meet HCBS setting requirements, and promote choice and community inclusion.

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; 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. Homes owned or leased by an HCBS-AMH provider cannot be greater than 15 beds. To be approved by the state, homes owned or leased by an HCBS-AMH provider greater than 8 beds will undergo a higher level of scrutiny and meet additional requirements. The state or its designee will complete a site visit specific to HCBS settings requirements and the applicable additional requirements for the state's continued approval, annually. Homes owned or leased by an HCBS-AMH provider greater than 8 beds must also provide additional characteristics that encourage the individual's recovery, independence and engagement in the community. Examples include additional space to receive guests, an area designated for recreational activity, access to additional household appliances to promote independence, increased access to community activities, close proximity to town center, access to employment options within walking distance.

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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“Leave this page blank.”

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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
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:	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> <p>This 1915(i) service is only provided to individuals age 21 and over. All medically necessary adaptive aid services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.</p>		
Additional needs-based criteria for receiving the service, if applicable <i>(specify):</i>		
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 <i>(chose each that applies):</i>		
<input checked="" type="checkbox"/> X	Categorically needy <i>(specify limits):</i>	

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<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>			
<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>			
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 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>
<p>Verification of Provider Qualifications (<i>For each provider type listed above. Copy rows as needed</i>):</p>			
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
<p>Service Delivery Method. (<i>Check each that applies</i>):</p>			
<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> <p>This 1915(i) service is only provided to individuals age 21 and over. All medically necessary non-emergency medical transportation services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.</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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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 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. DSHS conducts biennial on-site reviews of community-based settings to ensure that settings do not have the qualities of an institutional setting, meet HCB setting requirements, and promote choice and community inclusion. If the monitoring suggests that a change in service is needed, an independent re-assessment will be conducted by 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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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. DSHS conducts biennial on-site reviews of community-based settings to ensure that settings do not have the qualities of an institutional setting, meet HCB setting requirements, and promote choice and community inclusion. If the monitoring suggests that a change in service is needed, an independent re-assessment will be conducted by 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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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. DSHS conducts biennial on-site reviews of community-based settings to ensure that settings do not have the qualities of an institutional setting, meet HCB setting requirements, and promote choice and community inclusion. If the monitoring suggests that a change in service is needed, an independent re-assessment will be conducted by 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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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.			
This 1915(i) service is only provided to individuals age 21 and over. All medically necessary nursing services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.			
Additional needs-based criteria for receiving the service, if applicable (<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>):		
	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.		HCBS provider agency enrolled and contracted with DSHS to provide HCBS services, which employs or contracts with nursing providers. An individual service provider must be an RN (or licensed vocational nurse under the supervision of a registered nurse), licensed to practice in the state or otherwise authorized to practice in Texas under the Nurse Licensure Compact. Nurses providing this service must comply with the requirements for delivery of nursing services, which include requirements such as compliance with the Texas Nurse Practice Act and delegation of nursing tasks.
Verification of Provider Qualifications (<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	DSHS		Annual

Effective:

Approved:

Supersedes:

HCBS-AMH provider enrollment.		
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

Effective:

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Supersedes:

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

Effective:

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Supersedes:

	Treatment Programs.		personnel files. DSHS will conduct annual review to verify these requirements continue 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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<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 a representative sample, with a confidence level of 95 percent, of provider agencies, onsite reviews, and report of recovery managers of the number and percent of HCBS settings meeting appropriate licensure or certification and Federal HCBS requirements</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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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
<p>Program performance data</p> <ul style="list-style-type: none"> Track and trend system performance Analyze discovery 	<p>DSHS will collect, collate, review, and post. HHSC will review the data and have final direction over corrective action plans.</p>	<p>Updated monthly and reported quarterly</p>	<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.
<p>Quality management meetings</p> <ul style="list-style-type: none"> Assess system changes Focus on reporting requirements and refining reports 	<p>DSHS will collect, analyze, and report. HHSC provides oversight and direction.</p>	<p>Quarterly meetings</p>	<ul style="list-style-type: none"> Monitoring contract and HCBS compliance for service delivery Review of clinical assessment client outcome measures
<p>Onsite reviews</p> <ul style="list-style-type: none"> Documentation review Onsite interviews 	<p>DSHS coordinates and conducts onsite reviews and reports findings to HHSC. HHSC provides oversight and direction. Annually, DSHS [reviews] clinical operations (utilization management, quality management, care management, compliance with HCB settings requirements). Compliance issues will require the submission of a corrective action plan to DSHS for approval and ongoing monitoring.</p>	<p>Annually</p>	<ul style="list-style-type: none"> Review of clinical operations (utilization management, quality management, care management, compliance with HCB settings requirements) Compliance issues will require the submission of a corrective action plan to DSHS for approval and ongoing monitoring.
<p>Corrective action plans (CAP)</p>	<p>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 and includes analysis of performance data and onsite review findings of program non-compliance follow-up.</p>	<p>Areas for improvement will be monitored as per CAP and presented quarterly during Quality Management meetings</p>	<ul style="list-style-type: none"> Analysis of performance data Onsite review findings of program non-compliance follow-up

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