



Home and Community- Based Services –Adult Mental Health

Provider Manual

Health and Human Services Commission

December 2023



TEXAS
Health and Human
Services

Table of Contents

1000 Contact Information	1
Email Addresses	1
Website	1
Mailing Address	1
2000 Definitions	2
3000 Service Definitions	14
4000 Program Overview	17
4100 Introduction.....	17
4200 Background	17
4300 Administrative Structure	18
4400 Target Population	19
4500 Community-Based Service Provision	19
4600 HCBS-AMH Services.....	19
4700 Confidentiality	20
4800 Clinical Management for Behavioral Health Services	20
4900 Program Communications	21
5000 Program Roles and Responsibilities	21
5100 Roles and Responsibilities of the Recovery Management Entity and Provider Agency	21
5200 Roles and Responsibilities of the Recovery Management Entity	23
5210 Roles and Responsibilities of the Recovery Manager	26
5300 Roles and Responsibilities of the Provider Agency.....	30
5400 Roles and Responsibilities of State Hospitals	32
5500 Roles and Responsibilities of Local Mental Health or Local Behavioral Health Authorities	33
5600 Roles and Responsibilities of HHSC and HCBS-AMH Staff	34
5700 Roles and Responsibilities of Enrolled Participants	34
6000 Program Eligibility	36
6100 Initial Criteria.....	36
6200 Clinical Needs-Based Eligibility	37

6300 Financial Eligibility	37
6400 Evaluation and Eligibility Determination	37
7000 HCBS-AMH Needs-Based Eligibility Evaluation	38
7100 General HCBS-AMH Needs-Based Eligibility Evaluation Information	38
7110 Annual Clinical Needs-Based Eligibility Reevaluation.....	40
7200 Maintenance of ANSA Records.....	40
7300 Adult Needs and Strengths Assessment	40
8000 Referral and Pre-Enrollment Process	41
8100 Referral Process from a State Hospital.....	41
8110 Initial Criteria Report and MBOW Report	42
8120 State Hospital Interdisciplinary Treatment Team	42
8200 Referral Process from Community.....	43
8210 LMHA/LBHA Community Referral	43
8300 Recovery Management Entity Capacity	45
8310 Good Faith Effort Exception.....	45
9000 Enrollment Process	47
9100 Notification of Eligibility and Enrollment.....	47
9200 Notification of Ineligibility.....	47
9300 Referring Entity Post-Enrollment Documents	47
9400 No Reject Appeals Policy	49
9410 Community Discharge Readiness Review Process	49
9420 Determination of Review Process	51
9500 Recovery Manager Meets with Participant	52
9510 Initial Contact Post Enrollment	52
9520 Initial Contact after Discharge from a State Hospital	53
9530 Consents	53
10100 Commitment Types	53
46B Incompetency to Stand Trial.....	53
46C Not Guilty by Reason of Insanity	54
10200 Required Documents for Participant	54
10300 Required Involvement and Communication.....	54
11000 Individual Recovery Plan	57
11100 Individual Recovery Plan Requirements	58
11200 Secondary Assessments Co-Occurring Diagnoses Needs Assessment	60
11300 Developing and Submitting the Initial Individual Recovery Plan	61
11400 Updating and Submitting the Individual Recovery Plan	62

11500 Individual Recovery Plan Approval Process	63
11600 Role of the Recovery Manager in the Development of the Individual Recovery Plan	64
11700 Deviations from Service Standards.....	64
11800 Quality Management Requirements.....	65
12000 Person-Centered Recovery Planning.....	66
12100 Essential Components of a Person- Centered Recovery Plan	66
12110 Strengths.....	66
12120 Barriers and Needs	67
12130 Goal Statements	68
12140 Objectives.....	68
12150 Interventions (Services)	69
12200 The Safety Plan and the ANE Prevention Plan.....	70
12210 The Safety Plan.....	70
12220 The ANE Prevention Plan	71
12300 Qualities of Person-Centered Recovery Planning	72
12310 Identification of Person-Centered Recovery Planning Participants	72
12320 Qualities of the Process	73
12330 Qualities of Person-Centered Recovery Planning	74
12400 Peer Support in Person-Centered Recovery Planning	74
13000 Provision of Services	75
13100 Telehealth Delivery of Services.....	76
13110 Synchronous Audiovisual Technology.....	76
13120 Synchronous Telephone (Audio-Only) Technology	77
13130 Telehealth Delivery of Service Limitations.....	78
13140 Existing Clinical Relationship	78
13200 Description of Service Provision 1 Adaptive Aids.....	78
13300 Description of Provider Qualifications.....	96
13400 Responsibility of the Recovery Manager in Service Provision.....	104
13410 Developing, Monitoring, Reviewing, and Updating the Individual Recovery Plan	106
13420 Service Coordination	108
13430 Frequency of Recovery Management Service Provision.....	109
14000 Provider Training and Resources.....	111
14100 Training Requirements	111
1 Assisted Living	111
2 Community Psychiatric Supports and Treatment	112
3 Employment Services	113
4 HostHome/Companion Care	113
5 Nursing Services	114

6	Peer Support Services	115
7	Psychosocial Rehabilitation.....	115
8	Recovery Management Services	116
9	Respite Care	117
10	Substance Use Disorder.....	118
11	Supervised Living	118
12	Supported Home Living	119
15000 Transfer, Suspension, and Disenrollment		120
15100	Transfer	120
15110	HHSC Designated Transfer.....	121
15120	Standard Provider Transfer Process	121
15130	Additional Requirements for Court Supervised.....	122
15200	Suspension	123
15210	Suspension Procedure	124
15220	Recovery Management Entity and Provider Agency Responsibilities during Suspension	124
15230	Extension of Suspended Services	125
15240	Suspension to Enrollment Status Change	125
15250	Suspension to Disenrollment Status Change	125
15300	Disenrollment.....	126
15310	Disenrollment Procedure.....	127
16000 Settings Requirements.....		129
16100	General Settings Requirements	129
16200	Provider-Owned and Operated Housing.....	131
17000 Utilization Management.....		133
17100	HHSC Functions	133
17200	Utilization Management Guidelines.....	133
17300	Provider UM Functions	133
17310	Recovery Management Entity Functions	134
17320	Provider Agency Functions	134
17400	Minimum Amount of Services	135
17500	Reduction in Services.....	135
18000 Maintenance of Records, Documentation, and Reporting		136
18100	Provider Maintenance of Records	136
18200	HHSC Maintenance of Records.....	137
18300	Recovery Management Entity Maintenance of Records.....	137
18400	Provider Agency Maintenance of Records	138
18500	Documentation Requirements	139

18510 Documentation of Provider Choice	139
18520 Progress Notes.....	139
18530 Frequency of Documentation	139
18540 Retention	139
18550 Error Correction	140
18560 Documentation Specific to Certain Services	140
18600 Reporting	140
18610 Service Reporting	140
18620 Quarterly and Annual Reports.....	140
18630 Critical Incidents	141
18640 Abuse, Neglect, and Exploitation.....	145
18700 Reporting Emergencies	152
18800 Personnel Records.....	152
18810 Minimum Standards	152
18820 Credentialing for Service Provision Within the State Hospitals.....	153
19000 Benefits, Entitlements, and Financial Resources	154
19100 Medicaid Eligibility Determination	154
19110 Social Security Administration Prerelease Program.....	154
19120 Medicaid Application for Non-SSI Eligible Individuals in a State Hospital	155
19130 Community Applications for Medicaid Benefits	155
19140 Recovery Manager’s Role in Obtaining and Maintaining Benefits	155
19200 Medicaid Eligibility Resources	156
19210 SSI Application and Resources.....	156
19220 Medicaid Application and Resources.....	156
19300 Dual Eligibility	157
19400 STAR+PLUS.....	158
19500 Federal Insurance Exchange	158
19600 Texas Supplemental Nutrition Assistance Program	159
19700 Texas Department of Home and Community Affairs Programs	159
19800 County Indigent Health Care Program	159
20000 Quality Management	159
20100 HHSC Responsibilities	160
20200 Recovery Management Entity and Provider Agency Responsibilities	162
20210 Quality Improvement Processes and Management of Risk to Participants, Staff, and Others.....	163
21000 Health and Safety	165
21100 Suicide Prevention and Intervention Protocol	165
21200 Use of Restrictive Interventions	165

21210 Documentation and Reporting of Restrictive Interventions.....	166
21220 Prohibited Restrictive Interventions	168
21230 Training Requirements Regarding Restrictive Interventions	169
21300 Medication Safety and Management	172
21310 Medication Management General Standards	172
21320 Self-Administration of Medications.....	173
21330 Medication Errors	173
21340 Medication Administration Records	174
21350 Storing Medications	174
21360 Destruction of Medication and Empty Prescription Bottles.....	175
21370 Required Health and Nursing Documentation	175
21380 Screening for Tuberculosis	177
22000 Consumer Rights	177
22100 Administrative Appeals and Medicaid Fair Hearings	178
22110 Conditions for Requesting an Administrative Appeal and Medicaid Fair Hearing	179
22120 Requirements for Notification	179
22130 Administrative Appeal and Medicaid Fair Hearing Process	179
22200 Complaints.....	180
22210 HCBS-AMH Provider Agency and Recovery Management Entity Policy	180
22220 HHSC HCBS-AMH Program Provider Complaint Process	181
22230 Complaints Involving Allegations of Abuse, Neglect, and Exploitation	181
22240 Complaints Involving Community Mental Health Center/Local Mental Health Authority	181
22250 HHS Office of the Ombudsman– Behavioral Health Ombudsman.....	181
22300 Advanced Directives	182
22310 Declaration for Mental Health Treatment	183
22320 Directives to Physicians, Family, or Surrogates.....	183
22330 Medical Power of Attorney.....	183
22340 Out-of-Hospital Do Not Resuscitate	183
22350 Statutory Durable Power of Attorney	183
23000 Managing Conflicts of Interest	184
23100 Conflict of Interest Standards.....	184
23110 Standards	184
23120 Ensuring Individual Choice	185
23200 Administrative Firewall.....	185
23210 Agency Roles and Responsibilities	185
23220 Agency Policies	186
24000 Non-Duplication of Services	186
24100 Role of the Recovery Manager in Non- Duplication of Medicaid Services	186
24200 Role of the Recovery Manager in Nonduplication of Services for Participants 18-21.....	187

25000 Contract Action for Non-Compliance	188
25100 Corrective Action Plan	188
25200 Participant Referral Hold.....	189
25300 Demand for Payment or Recoupment	189
25400 Terminate the Contract	189
25500 Administrative Hearing Request.....	189

1000 Contact Information

Email Addresses

General Inquiries

Enrollment and Referral

Individual Recovery Plan, Recovery Management, and Provider Agency Communication

Billing and Utilization Management

Quality Management

Critical Incident Reports

Complaints

Website

Home and Community-Based Services-Adult Mental Health (HCBS-AMH) program information, including forms and the HCBS-AMH Billing Guidelines, can be found on the [Home and Community-Based Services-Adult Mental Health](https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-servicesproviders/home-community-based-services-adult-mental-health)¹ webpage.

Mailing Address

Health and Human Services Commission

Attn: HCBS-AMH Program

Mail Code 2012

P.O. Box 149347,

Austin, Texas 78714-9347

¹ <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-servicesproviders/home-community-based-services-adult-mental-health>

2000 Definitions

The following words and terms, when used in this document, shall have the following meanings unless the context clearly indicates otherwise.

Term	Definition
Abuse, Neglect, and Exploitation (ANE) Prevention Plan	A plan that focuses on the prevention of behaviors that put an individual at risk, and the interventions needed if such behaviors occur. These plans are required for individuals with identified risks.
Activities of Daily Living (ADL)	Routine daily activities, such as performing personal hygiene activities; dressing; meal planning and preparation; managing finances; shopping for food, clothing, and other essential items; performing essential household chores; communicating by phone or other media; navigating public transportation; participating in the community; and other activities as defined by HHSC.
Administrator	The person in charge of an HCBS-AMH Recovery Management Entity or Provider Agency.
Adult Needs and Strengths Assessment (ANSA), also referred to as the Uniform Assessment (UA)	Current Uniform Assessment (UA) tool. A multi-purpose tool developed for behavioral health services of adults to support decision making, including selection of the level of care, recovery or treatment planning, quality improvement initiatives, and monitoring of service outcomes. Used as the clinical eligibility tool to determine needs-based eligibility for HCBS-AMH.
Advanced Directive	Legal documents that allow an individual to convey decisions about end-of-life care ahead of time. They provide a way for an individual to communicate wishes to family, friends, and health care professionals.

Term	Definition
Assessor	The person who conducts the HCBS-AMH Needs-based Eligibility Evaluation to assess the need of an individual for HCBS-AMH. Assessors shall, at a minimum, be a qualified mental health professional-community services as defined in Title 26, Texas Administrative Code (TAC), Chapter 301, Subchapter G (relating to Mental Health Community Services Standards).
Capacity	The total number of participants to whom the HCBS-AMH provider can provide HCBS-AMH services.
Clinical Management for Behavioral Health Services (CMBHS)	An electronic health record created and maintained by HHSC for the use of contracted mental health and substance use services. Contracted HCBS-AMH provider agencies shall use CMBHS, when available, as directed by HHSC.
Cognitive Adaptation Training (CAT)	An evidenced-based psychosocial intervention using a motivational strengths perspective to facilitate initiative and independence in an individual.
Cognitive Behavioral Therapy for Psychosis (CBTp)	An evidence-based treatment primarily designed to target psychotic symptoms, such as delusions and hallucinations, that persist despite appropriate treatment with anti-psychotic medications.

Term	Definition
Credentialing	Process whereby a provider reviews and approves education, experience, licensure, trainings, and certification (as applicable) of a staff member to ensure they meet Health and Human Services Commission's (HHSC) requirements for service provision (e.g., criminal history and registry checks). The process includes primary source verification of credentials; establishing and applying specific criteria and prerequisites to determine the staff member's initial and ongoing competency; and assessing and validating the staff member's qualification to deliver care. The credentialing process may require periodic evaluation of the competency and qualifications of the staff member.
Critical Incident	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 .
Desk Review	Process through which HHSC receives electronic or paper copies of documentation to be reviewed from the state office and not onsite at the provider's location.
Direct Service Staff	An employee or a subcontractor of an HCBS-AMH Provider Agency who provides an HCBS-AMH service directly to the participant.
Duplication of Services	A situation in which an HCBS-AMH participant receives similar services from two different providers at the same time.
Enrollment Date	Start date for participant to begin services as determined by HCBS-AMH staff.

Term	Definition
Encounter Data	Details related to HCBS-AMH services rendered by a provider to a participant of the program.
Fair Hearing	A formal proceeding requested by an individual to appeal an agency action to an impartial HHSC hearings officer.
Formal Supports	Professional services provided by a formal structure, agency, network, etc. Examples of formal supports include counselors, recovery managers, and medical care.
Harm Reduction	Policies, programs, and practices that aim to reduce the harm associated with the use of psychoactive drugs, illicit or illegal drugs, or alcohol on participants unable or unwilling to stop. Defining features include focus on the prevention of harm (versus drug use) and the participant who is using.
Home and Community Based Services (HCBS)	Services provided in one's own home or local community instead of institutions or other non-integrated settings.

Term	Definition
Individual Recovery Plan (IRP)	A written, individualized plan developed in accordance with 26 TAC Chapter 306, Subchapter D (relating to Mental Health Services--Admission, Continuity, and Discharge) and 26 TAC Chapter 301, Subchapter G, Section 301.353 (relating to Provider Responsibilities for Treatment Planning and Service Authorization) and in consultation with the participant, LAR (if applicable), interdisciplinary team, and other providers or persons according to the needs and desires of the participant. The plan identifies and serves as the authorization document for HCBS-AMH services and must be approved by HHSC prior to the provision of services.
Invoice	The file that an HCBS-AMH Provider submits to HHSC as a claim of HCBS-AMH services provided. This file is generated by encounter data.
Legally Authorized Representative (LAR)	A person, judicial, or other body authorized by law to act on behalf of an individual regarding a matter. The term may include the parent of a minor, legal guardian, or managing conservator of a minor.
Licensed Practitioner of the Healing Arts (LPHA)	A person who is a physician, licensed professional counselor, licensed clinical social worker, licensed psychologist, advanced practice nurse, or a licensed marriage and family therapist as defined in Title 26, Texas Administrative Code (TAC), Chapter 301, Subchapter G (relating to Definitions), Rule §301.303 .

Term	Definition
Local Mental Health Authority (LMHA)	An entity designated as the local mental health authority by the department in accordance with the Texas Health and Safety Code, §533.035(a) as defined in Title 26, Texas Administrative Code (TAC), Chapter 301, Subchapter G (relating to Definitions), Rule §301.303 .
Local Behavioral Health Authority (LBHA)	Local behavioral health authority. An entity designated as an LBHA by HHSC in accordance with Texas Health and Safety Code §533.0356 as defined in Title 26, Texas Administrative Code (TAC), Chapter 301, Subchapter G (relating to Definitions), Rule §306.153 .
Medication Administration Record (MAR)	A report, commonly referred to as drug charts, that serves as a legal record of the drugs administered to a patient by a health care professional or authorized designee. It is part of a patient's permanent record on their medical chart, and the health care professional or authorized designee signs off on the record at the time the drug or device is administered.
Motivational Interviewing	A counseling style that is goal-directed and assists in facilitating and engaging intrinsic motivation within the individual to change behavior.
Natural Supports	Relationships and abilities that already exist, or can be developed, that enhance the quality and security of life for an individual. Natural supports may include people (family, neighbors), places (church, community center, school), or things (artistic ability, family pet, positive attitude).

Term	Definition
Participant	An individual enrolled in HCBS-AMH and receiving services or in the process of enrolling in HCBS-AMH.
Representative Payee	A person or organization selected to receive benefits on behalf of a recipient, if the recipient is not able to manage or direct the management of benefit payments in his or her own interest as defined in Title 1, Texas Administrative Code (TAC), Part 15, Chapter 358, Subchapter A (relating Definitions), Rule §358.103 .
Person-Centered Recovery Planning (PCRP)	Collaborative process used by the recovery manager and directed by the participant, to develop the individual recovery plan. The process occurs in partnership with others involved in the PCRP process (providers and non-providers), supports preferences of the participant, and has a recovery orientation.
Pre-Authorization	Requested by a recovery manager for billing purposes prior to assisting an individual transitioning from another home and community-based services program or nursing facility to the HCBS-AMH program.

Term	Definition
Pre-Engagement Services	Services provided by the local authority to perform the referral and enrollment process for individuals seeking enrollment in HCBS-AMH who reside in the community of the LMHA/LBHA service area. Pre-engagement services include completing the HCBS-AMH application; obtaining and completing referral documentation required to determine program eligibility; and working to obtain necessary documents for determining Medicaid eligibility.
Provider	Person or legal entity with a legal agreement with HHSC to provide HCBS-AMH services.
Provider Agency (PA)	An agency, organization, or person that meets credentialing standards defined by HHSC, and enters into a provider agreement for HCBS-AMH. The HCBS-AMH Provider Agency must ensure provision of all HCBS-AMH services directly or indirectly by establishing and managing a network of subcontractors. The HCBS-AMH Provider Agency has the ultimate responsibility to comply with the Provider Agreement, Provider Manual, and Billing Guidelines regardless of service provision arrangement (i.e., directly or via subcontractors).
Provider Agreement	An executed contract between HHSC and the HCBS-AMH Provider Agency or Recovery Management Entity.

Term	Definition
Qualified Credentialed Counselors	<p>A licensed chemical dependency counselor or one of the practitioners listed below who is licensed and in good standing in the State of Texas, and has at least 1,000 hours of documented experience treating substance related disorders:</p> <ul style="list-style-type: none"> • Licensed professional counselor; • Licensed master social worker; • Licensed marriage and family therapist; • Licensed psychologist; • Licensed physician; • Licensed physician's assistant; • Certified addictions registered nurse (CARN); or <p>Advanced practice nurse practitioner recognized by the Board of Nurse Examiners as a clinical nurse specialist or nurse practitioner with a specialty in psych-mental health (APN-P/MH).</p>
Quality Management	<p>A program developed and implemented by the provider by which organizational performance and services are assessed and evaluated to ensure the existence of those structures and processes necessary for the achievement of individual outcomes and continuous quality improvement.</p>
Recovery	<p>The process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.</p>
Recovery Manager (RM)	<p>An employee assigned by the Recovery Management Entity who provides recovery management services to a participant.</p>

Term	Definition
Recovery Management Conversion Services	Preauthorized work, not billable to Medicaid, conducted by the recovery manager when an individual enrolled in another home and community-based services program decides to discontinue services in that program.
Recovery Management Entity (RME)	An agency, organization, or person that meets credentialing standards defined by HHSC and enters into a provider agreement for HCBS-AMH to provide recovery management services.
Recovery Management Facility Discharge Services	Work, conducted by the recovery manager while a participant is still residing in a state hospital, that helps the participant prepare for community living and develop community-based supports. Includes coordinating the provision of allowable HCBS-AMH services and development of the individualized recovery plan inside the state hospital for up to 180 days prior to discharge from the hospital.
Referring Entity	The entity that initiates the referral process of the person to HCBS-AMH.
Restrictive Interventions	The use of personal or mechanical restraint or seclusion.
Safety Plan	A plan that is developed by the participant, recovery manager, and others involved in the PCRCP process that focuses on planning for, predicting, and preventing the occurrence of a crisis. A safety plan: establishes clear roles when a participant is in a crisis; describes interventions to try; identifies supportive persons; and details steps to take to access crisis services when needed.

Term	Definition
Serious Mental Illness (SMI)	<p>An illness, disease, or condition (other than a sole diagnosis of epilepsy, dementia, substance use disorder, or intellectual or developmental disability) that:</p> <ul style="list-style-type: none"> • Substantially impairs thought, perception of reality, emotional process, development, and/or judgment; or • Grossly impairs a person's behavior as demonstrated by recent disturbed behavior.
Service Area (i.e., catchment area)	Geographical area for which the provider is contracted to provide HCBS-AMH services.
Subcontractor	A single person, organization, or agency that enters into an agreement with an HCBS-AMH Provider Agency to provide one or more HCBS-AMH services.
Suspension	Time-period during which all HCBS-AMH services, except recovery management services, cease for a participant.
Texas Resilience and Recovery (TRR)	Term used by local authorities to describe the service delivery system in Texas.
HCBS-AMH Needs-Based Eligibility Evaluation	A standardized assessment identified by HHSC to determine HCBS-AMH needs-based clinical eligibility. The evaluation is conducted using the UA (ANSA).

Term	Definition
Utilization Management (UM)	<p>The planning, organizing, directing, and controlling of the healthcare product/service that balances cost-effectiveness, efficiency, and quality to meet the overall goals of the LMHA/LBHA. Use of systematic, data-driven processes to influence the person's care and decision making to ensure an optimal level of service is provided consistent with the person's diagnosis and level of functioning within the financial constraints of funding. Includes service authorization; prospective, concurrent, and retrospective reviews; discharge planning; and utilization care management.</p>

3000 Service Definitions

The following is a list of HCBS-AMH services and their definitions.

Service	Definition
Supported Employment	<p>Provides individualized services to sustain persons 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 persons without disabilities are employed.</p>
Flexible Funds	<p>Monies used for supports that augment the existing HCBS-AMH services and are documented on the IRP to reduce symptomatology and maintain quality of life and community integration. Flexible funds may be used in accordance with the following guidelines:</p> <ul style="list-style-type: none"> • Reserved for indigent persons. • Used for enhanced observation needs; • Temporary psychiatric hospitalization; • Medication related expenses; and • Room and board. <p>All services provided with flexible funds must be identified on the IRP for review and prior approval by HHSC.</p> <p>HHSC reviews the request for flexible funds before approving to ensure that the indicated service does not fall within the scope of the HCBS-AMH service array.</p>

Service	Definition
Peer Support	Services provided by people with lived experience who are in recovery from mental illness and/or substance use to help persons reach their recovery goals. Services promote coping skills, facilitate use of natural resources/supports, and enhance recovery-oriented attributes such as hope and self-efficacy.
Pre-Engagement	Services provided by the LMHA/LBHA to perform the referral and enrollment process for persons seeking enrollment as an HCBS-AMH participant who reside in the LMHA's/LBHA's service area.
Home Delivered Meals	Provides a nutritionally sound meal, delivered to the person's home.
Minor Home Modifications	Physical adaptations to a person's home that are necessary to ensure the person's health, welfare, and safety, or that enable the person to function with greater independence in the home.
Nursing	Services that are within the scope of the Texas Nurse Practice Act and are provided by a registered nurse (RN) (or licensed vocational nurse under the supervision of an appropriate clinical supervisor RN), licensed to practice in the state. HCBS- AMH nursing services cover ongoing chronic conditions such as wound care, medication administration (including training, monitoring, and evaluation of side effects), and supervising delegated tasks. 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

Services	Definition
Recovery Management	Services assisting persons in gaining access to needed Medicaid State Plan and HCBS-AMH services, as well as medical, social, educational, and other resources, regardless of funding source.
HCBS-AMH Psychosocial Rehabilitation Services	Evidence-based or evidence-informed interventions which support the person's recovery by helping the person develop, refine, and/or maintain the skills needed to function successfully in the community.
Respite Care	Provides temporary relief from care giving to the primary caregiver of a person during times when the person's primary caregiver would normally provide care.
Substance Use Disorder Services	Assessment and outpatient group and individual counseling for substance use disorders. Services are specialized to meet the needs of persons who have experienced extended institutional placement.
Transition Assistance Services	Payment of set-up expenses for persons transitioning from institutions into community settings necessary to enable persons to establish basic households.
Transportation Services	Non-medical transportation that enables persons to gain access to services, activities, and resources, as specified in the IRP.

4000 Program Overview

4100 Introduction

Many individuals with a diagnosis of SMI have complex, unmet needs that have led to repeated psychiatric hospitalizations, arrests, or emergency department visits. Some individuals have resided in mental health facilities for extended periods of time and, in some cases, years. Other individuals experience psychiatric crises and frequently cycle out of city or county jails or emergency departments.

The HCBS-AMH program provides specialized supports through the provision of home and community-based services to adults diagnosed with an SMI and extended tenure in psychiatric hospitals, frequent arrests, or emergency department visits.

The flexible array of services offered by HCBS-AMH is designed to meet the unique needs of a participant which may not currently be addressed by other means and to assist in their recovery. The goal of the HCBS-AMH program is to enable individuals to live and experience successful tenure in the community of choice and improve quality of life and functioning.

4200 Background

In 2010, the Department of State Health Services (DSHS) formed the Continuity of Care Task Force comprised of LMHA leadership, advocates, behavioral health service recipients, law enforcement, judges, inpatient providers, and agency staff. DSHS charged the task force with developing recommendations for resolving barriers to discharging individuals with complex needs from state psychiatric facilities. The task force conducted public meetings, key informant interviews, meetings with key professional groups, four public forums in various locations around the state, and recommended a range of reforms. Among their recommendations was the development of a home and community-based program for adults with SMI.

Their recommendations led to approval of Senate Bill 1, 83rd Texas Legislature, Regular Session, 2013 and appropriation of funds to establish a home and community-based services program through a Medicaid 1915(i) state plan amendment.

Through House Bill 1, 84th Texas Legislature, Regular Session, 2015, HHSC was directed to expand the program to divert individuals with SMI from county jails and emergency departments to community treatment programs. HHSC sought extensive external stakeholder input from community

providers, the criminal justice system, advocacy agencies, potential beneficiaries, emergency department staff, and MCOs to inform the eligibility criteria and services needed for the jail and emergency department diversion populations.

4300 Administrative Structure

HHSC is the single State Medicaid Agency and administers the program. HHSC is responsible for initial and on-going independent assessments, evaluation of program candidates, quality assurance, reporting, provider recruitment and enrollment, claims payment, and program oversight. HHSC is not, and shall not become, a provider of HCBS-AMH services. HHSC approves contractors to perform the independent assessments and HHSC completes the process by authorizing all services.

HCBS-AMH has two types of program providers: HCBS-AMH Recovery Management Entities (RMEs) and HCBS-AMH Provider Agencies (PAs). RMEs administratively oversee recovery management services, and recovery managers (RMs) coordinate, monitor, link, advocate, and assist participants in gaining access to needed Medicaid services as well as other medical, social, and educational resources, regardless of funding source. Except for recovery management services, PAs provide the full array of HCBS-AMH services. Services are provided either directly by the PA or indirectly via subcontract agreements with other service providers in home and community-based settings.

4400 Target Population

The target population of the program is individuals who are 18 years of age or older, diagnosed with a SMI, and require the intensity of services provided by the HCBSAMH program to improve functioning and establish or maintain stability in the preferred community. Individuals must meet clinical, financial, and need-based criteria to be eligible for participation in the program and cannot be dually enrolled or receiving home and community-based services by any other means (See Section 6000-Program Eligibility for more information).

4500 Community-Based Service Provision

HCBS-AMH services are provided in home and other community settings, such as individual homes, apartments, assisted living facilities, and small community-based residences. Home and community-based settings must meet certain qualifications to receive HCBS-AMH services (See Section 16000-Settings Requirements for more information).

4600 HCBS-AMH Services

Following are the services available in the program (See Section 13000-Provision of Services and 14000-Provider Training and Resources for more information).

- Adaptive aids
- Assisted living
- CPST
- Employment assistance and supported employment
- Home-delivered meals
- HCBS-AMH psychosocial rehabilitation
- Host home/companion care
- Minor home modifications
- Nursing
- Peer support
- Recovery management
- Respite care (short-term)
- Substance use disorder (SUD)

- Supervised living
- Supported home living
- Transition assistance
- Transportation (non-duplicative of state plan medical transportation)

Other state plan services shall be provided, as medically necessary, to individuals eligible for Medicaid through the State's Medicaid managed care system and should be closely coordinated with HCBS-AMH (See Sections 13420 Service Coordination and 24000 Non-Duplication of Services for more information).

4700 Confidentiality

All parties involved with HCBS-AMH must maintain and protect the confidential information to the extent required by law. The exchange or sharing of confidential information, particularly protected health information (PHI) or other sensitive personal information, must be done via a Health Insurance Portability and Accountability Act (HIPAA) compliant secure process (for more information, visit [HHS Health Information Privacy](#)). In addition, all encrypted email sent to HCBS-AMH will remain confidential and shall be maintained by the program. All encrypted email sent to the state shall be sent without an expiration or "self-destruct" date.

Data collected and published for stakeholder meetings are available to others under the Freedom of Information Act. This information is presented in summary form only, with no identification of HCBS-AMH participants.

4800 Clinical Management for Behavioral Health Services

CMBHS is the state-sponsored electronic healthcare record system used by state contracted HCBS-AMH providers. CMBHS provides a platform for HCBS-AMH providers to electronically submit data to the state. When available, the RME and PA shall use CMBHS as an electronic healthcare record system to document clinical information, such as participant information, claims, IRPs, and progress notes. HHSC, or an independent qualified agent, shall use CMBHS to process UA's (ANSA's), enrollments, and authorize IRPs. When CMBHS has the capacity to support these functions, submission of information shall be as otherwise outlined by HHSC.

CMBHS shall be used to:

- Verify the enrollment status of an individual;

- Verify the provision of HCBS-AMH services;
- Authorize IRPs, including service delivery start date approval;
- Accurately complete all data elements required by HHSC in a timely manner; and
- Verify service delivery date, time, and location for services delivered to a participant (this is to be completed in a manner prescribed by HHSC).

4900 Program Communications

To ensure HCBS-AMH contractors stay informed and continue receiving updated information, the contractor must assign one or more staff responsible for tracking policy updates posted on HHSC’s identified platform and disseminating information within the organization.

5000 Program Roles and Responsibilities

5100 Roles and Responsibilities of the Recovery Management Entity and Provider Agency

The following roles and responsibilities apply to all RMEs and PAs. RMEs and PAs shall:

- Adhere to applicable laws and regulations to include all applicable mental health and SUD rules found at title 25 tac, part 1, chapters 401, 404, 405, 411, 412, 414, 415, 417, 419, and 421; 26 tac, part 1, chapters 301-303, 306, 307, and 321, as they currently exist and as they may be amended during the PAs’ contract with HHSC; the code of federal regulations (CFR) 42 CFR, parts 440, 441, 455 and 456; and applicable subchapters of 1 tac chapter 355; 45 CFR parts 46, 80, 84,

90 and 91; and the laws, rules and regulations cited in the various sections of this provider manual;

- Operate under an HCBS-AMH provider agreement with HHSC, and maintain the requirements therein, for the provision of HCBS-AMH services to include adherence to the HCBS-AMH Provider Manual, HCBS-AMH Billing Guidelines and all other relevant HCBS-AMH policies and procedures;
- Meet all HHSC credentialing criteria (see sections 13300-provider qualifications and 14000-provider training and resources for more information);
- Maintain privacy and confidentiality to the extent required by law (see section 4700-confidentiality for more information);
- Execute a provider agreement with Texas Medicaid and Healthcare Partnership to obtain reimbursement via the Medicaid management information system (see section 4800- clinical management for behavioral health services for more information);
- Adhere to HCBS-AMH Billing Guidelines and submit correct billing/invoices to HHSC by developing a process for the correct and accurate submission of invoices to include a process for verifying the Medicaid status of participants for a billing period (see HCBS-AMH billing guidelines for more information);
- Ensure the timely payment of employees, subcontractors, or both;
- Submit accurate and timely encounter data to HHSC that include all HCBS-AMH service encounters via the encounter and invoicing template in accordance with

the HCBS-AMH Billing Guidelines (see HCBS-AMH Billing Guidelines for more information);
- Maintain personnel records of direct service staff;
- Ensure ongoing staff development and maintenance of training records by participating in required trainings and ensuring direct service staff (i.e., employees, sub-contractors, or both, meet minimum training standards for the provision of services);

- Implement a 'no reject policy' that complies with the HCBS-AMH no reject policy (see section 9400-no reject appeals policy for more information);
- Develop, implement, and adhere to a quality management (QM) plan to include participating in QM oversight activities, as requested by HHSC;
- Make every effort to protect the safety, dignity, and respect of HCBS-AMH participants by maintaining a recovery focus;
- Use a PCR, adhering to the requirements of federal standards, rules, and guidance for Medicaid services under 1915(i);
- Ensure that participants select a primary care provider and receive an annual physical (wellness) exam (documentation of primary care provider visits or aftercare summaries must be maintained in participant record);
- Obtain and complete necessary consent forms; inform participants of their rights and the procedure for filing grievances; and inform participants of their right to a Medicaid fair hearing;
- Report all critical incidents to HHSC; inform participants of how to report ANE; and report ANE in accordance with applicable laws; and
- Minimize the use of behavior management-restrictive interventions and implement crisis and safety planning.

5200 Roles and Responsibilities of the Recovery Management Entity

RMEs shall directly provide recovery management services to participants via employed RM's. RMEs shall not provide any other service in the HCBS-AMH service array. Following are the roles and responsibilities specific to the RME and RM. RMEs shall:

- Provide directly to participants recovery management services and support the role of the RM;
- Ensure recovery management services are accessible to all participants in the service area (coordination and provision of services includes routine and emergency appointment availability);

- Ensure caseload sizes for the RM are no more than 15 participants; preferably 10 participants or less (maximum caseload limit shall account for individuals in other waiver or state plan programs and other funding sources and shall remain in effect unless waived by HHSC);
- Ensure an alternate RM acts as the assigned RM if the assigned rm for a participant is not available (see section 11000-individual recovery plan for more information);
- Ensure services are delivered in a manner that supports the communication needs of a participant, including age-appropriate communication and translation services for beneficiaries who are of limited-English proficiency or have other communication needs requiring translation assistance;
- Comply with the HCBS-AMH Provider Agreement, HCBS-AMH Provider Manual, and HCBS-AMH Billing Guidelines regardless if the service provision is provided directly by the contractor or by provider subcontractor;
- Retain and maintain progress notes and clinical records regarding HCBS-AMH service provision (see section 18000- maintenance of records, documentation, and reporting);
- Coordinate all services with the PA to include appointments and programmatic schedules, completion of a program settings check for provider owned and operated housing, and monitoring of services;
- Coordinate all interdisciplinary team (IDT) meetings to develop the initial, and update, IRPs. This coordination includes contacting the assigned RM and designated pa within 72 hours of notification of participant enrollment to schedule an IDT meeting to develop the initial IRP;
- Involve the PA in all subsequent IDT meetings and IRP updates, appointments, and programmatic schedules;
- Monitor services by the assigned or alternate RM;
- Coordinate with MCOs to include communicating with the assigned MCO service coordinator and point of contact; conducting teleconferences with the MCO service coordinator based on the needs of the participant; obtaining pertinent documents regarding the services of the participant; planning and delivery of care; evaluation

- and adjustment of the IRP; understanding available benefits for the participant through MCO; making referrals to specialists or state plan services; arranging for special and insured services with any available community services; coordinating disenrollment from STAR+PLUS waiver if/when applicable; disenrolling, suspending, or transferring services, if/when applicable; and ensuring non-duplication of Medicaid services;
- Coordinate with housing providers, when applicable, to include evaluating 42 CFC §441.710 rule settings requirements (evaluation of the housing settings shall occur prior to the provision of HCBS-AMH services and documented in the IRP); planning and delivery of services; coordinating services with other providers; coordinating transition assistance services, home modifications and residential services (i.e., supported home living, assisted living, supervised living services, or host-home/companion care); monitoring and advocating for participant needs during eviction proceedings; and coordinating and monitoring discharge and transferring of housing;
 - RME contractors shall complete a program settings check for all provider-owned and operated housing using Form 8201, Recovery Manager Settings Checklist and enter the form using the HHSC preferred electronic version within 3 days of completion.
 - If a location has all “yes” responses to Form 8201, then participants are allowed to move to the location. If a new location has any “no” responses to Form 8201, then participants are not allowed to move to the location.
 - Only HCBS-AMH has the authority to pass or fail a settings check. HHSC HCBS-AMH will not accept supportive documentation for any RM Settings Check. RM must contact HHSC to report any health and safety risks identified through an RM Settings Check within 24 hours.
 - Coordinate with the MMHA/LBHA, when applicable, to include admissions and discharges to/from state hospitals, referrals, crisis services, planning and delivery of services on the IRP, monitoring of tenure of participants in the community, disenrollment, transfer, suspension of services and assessments;
 - Create and adhere to a QM plan to include oversight of recovery management services including training, supervision, and monitoring

to ensure competencies and that RM services are appropriate according to participant's IRP;

- Create and adhere to a UM plan by creating improvement measures regarding clinical practice improvement initiatives, service/billing integrity verification and compliance risk monitoring, and assuring the plan identifies roles and responsibilities for service, authorization functions and how those activities are implemented, monitored, and managed;
- Develop housing and placement policies and procedures to include monitoring and tracking of housing placement and evictions; ensuring knowledge of the 42 CFR §441.710 home and community-based setting requirements for provider owned and operated and non-provider owned and operated settings and expansion of community housing relationship plan, and other procedures; and resources regarding housing rights and eviction proceedings; and
- Develop and maintain policies and procedures that support the participant and their recovery to include supervision and coaching on PCRPs; notification of participant's rights and Medicaid fair hearing process; outreach and conflict resolution; disenrollment procedures that address participant choice and continuity of care, and adhere to HCBS-AMH; and transfer of participants to another program RME or PA that promote participant choice, continuity of care, and adhere to HCBS-AMH.

5210 Roles and Responsibilities of the Recovery Manager

The following are the roles and responsibilities specific to the RM. RMs shall:

- Meet the minimum training and credentialing requirements for the provision of recovery management services (See Sections 13300-Description of Provider Qualifications and 14000-Provider Training and Resources for more information);
- Be available to the participant 24/7/365 (See Section 5200-Roles and responsibilities of the Recovery Management Entity for information on caseload restrictions);
- Provide an intensive level of recovery management services, i.e., three face-to-face contacts per week, if clinically indicated, for the first three months of a participant's enrollment (note: it is

expected by HHSC that the frequency and intensity of recovery management services shall decrease with time as progress by the participant is made; continuation of an intensive level of recovery management services shall require justification and approval by HHSC);

- While telehealth delivery of RM services are allowed, best practice is to provide recovery management services predominately face-to-face, please see section 13100 Telehealth Delivery of Services for more information; Use a PCRCP approach;

- Provide recovery management services predominately face-to-face, with only 10 percent by phone contact per month, unless prior authorization to waive this requirement is obtained from HHSC;

- Use a PCRCP approach;

- Meet the participant face-to-face within 14 days of notification of selection to facilitate the IDT meeting to develop the initial IRP and to:
 - Educate and inform the participant about the PCRCP format;
 - Explain rights as a participant of the program;
 - Explain the HCBS-AMH services available (as related to their goals);
 - Assist the participant with fair hearing requests, when needed and upon request;
 - Assist the participant with completion of necessary consent forms and other program documentation; and
 - Assist the participant with retaining HCBS-AMH and Medicaid eligibility; assist participant in acquiring Medicaid or reactivating Medicaid benefits if benefits have been suspended or terminated.

Provide Recovery Management Facility Discharge Services which includes collaborating with the PA to coordinate the provision of HCBS-AMH services while a participant is in a state hospital for up to 180 days prior to discharge from said state hospital, and providing regular updates to the LMHA/LBHA for impending state hospital discharge which should be done at each contact made by the RM with the participant and/or state hospital social worker;

- Attend continuity of care appointment with the participant and LMHA/LBHA when a participant is discharged from a state

hospital; Complete fingerprinting and credentialing needed prior to working in a state hospital (See Section 18820-Credentialing for Service Provision Within the State Hospitals for more information);

- Review requests from the state hospital, LMHA/LBHA, and court officials for service provision for participants on forensic commitments;
- Coordinate with the referring entity to include contacting the referral source to coordinate completion of enrollment activities, development of initial IRP, and initiation of services
- Identify the date and time of discharge from the state hospital and the location of the participant's new home. Once the participant is discharged from the state hospital, RM will meet with participant at new home at time of arrival to coordinate initial face-to-face with housing provider and answer any questions or concerns that may arise;
- Contact the LMHA/LBHA on a regular and ongoing basis if the participant is receiving services at the LMHA/LBHA;
- Include the LMHA/LBHA in the PCRCP process to include attendance at IDT meetings;
- Review requests from the LMHA/LBHA and the courts for service provision for participants in the community who are on a forensic commitment;
- Coordinate with courts, probation and parole officers, state hospital staff, emergency department staff, and crisis service providers, when applicable, to ensure participants gain access to needed services;
- Provide recovery management conversion services to individuals enrolled in another home and community-based services program that prevents the individual from participating in HCBS-AMH and coordinate the disenrollment/enrollment process (See Section 13200, sub-section 12 Recovery Management for Recovery Management Conversion Services for more information);
 - ▶ Provide Recovery Management Conversion Services to individuals residing in a nursing facility;
- Coordinate the development of the IRP to include identifying services that may be helpful to the participant, as identified on the Uniform Assessment (UA), using a PCRCP approach (See Section 12000-Person-Centered Recovery Planning for more information);

- Ensure the provision of services to support the recovery goals of participants by facilitating the PCRCP process, with the participant present, to assist the participant in:
 - Identifying and obtaining needed services;
 - Monitoring the IRP;
 - Coordinating services with providers;
 - Meeting with the participant to monitor services;
 - Developing and pursuing services to include non-HCBS-AMH services and services provided under Medicare, private insurance, or other community resources; and
 - Identifying and developing natural supports and resources to promote the recovery of the participant;
- Integrate and coordinate with MCOs, private insurances and providers, and LMHAs/LBHAs;
- Ensure the health, safety, and welfare of participants by assessing participants to ensure their needs are met and monitoring the PA, subcontractors, and all other support system personnel to ensure service provision is performed according to the IRP and in accordance with legal requirements;
- Respond to and assess emergency situations and incidents to ensure the needs and goals of participants;
- Coordinate services with the PA and non-HCBS-AMH providers to ensure the safety of participant;
- Coordinate with the LMHA/LBHA any hospitalizations at an inpatient facility;
- Submit online Critical Incident Report (CIR) when applicable (See Section 18630-Critical Incidents for more information);
 - Monitor and update the IRP, as clinically indicated and per IRP schedule; and
- Aid in the accuracy of reevaluations by:
 - Providing supporting documentation to personnel completing the reevaluation;

- Verifying services on the IRP are identified on the UA (ANSA);
- Notifying the LMHA/LBHA if an update UA is clinically indicated; and
- Completing additional assessment of the participant, as needed, to identify needs of a participant that may not be present on the UA (ANSA) but are essential to success in the community.

5300 Roles and Responsibilities of the Provider Agency

Except for recovery management services, PAs shall provide the full array of HCBS-AMH services, as listed in section 4600-HCBS-AMH Services, either directly or indirectly via subcontractors. To ensure consistent availability of all HCBS-AMH services, PAs shall establish (via written binding agreements), maintain, and manage a network of subcontractors. If a service is unavailable for any period, the PA shall notify HHSC within one business day. Following are the roles and responsibilities of PAs. PAs shall:

- Provide or arrange for the provision of all HCBS-AMH services;
- Ensure HCBS-AMH services are accessible to all HCBS-AMH participants in the service area (coordination and provision of services includes routine and emergency appointment availability);
- Ensure services are delivered in a manner that supports the communication needs of a participant, including age-appropriate communication and translation or interpreter services for beneficiaries who are of limited-English proficiency or have other communication needs requiring translation or interpreter assistance;
- Comply with the provider agreement, provider manual, and billing guidelines regardless if service is provided directly by provider or by provider subcontractors;
- Retain and maintain progress notes and clinical records of HCBS-AMH participants regarding HCBS-AMH service provision;
- Provide progress notes, clinical records and other supporting documentation to RMs and personnel completing the HCBS-AMH;
 - ▶ Ensure participants have access to their clinical records, in accordance with

- Texas Health and Safety Code, §611.0045;
- Coordinate with the RME, LMHAs/LBHAs, and state hospital staff to:
 - Ensure all employees and subcontractors participate in IDT meetings to develop and update the IRP (participation shall be face-to-face if the participant is in the community or via teleconference if the participant is in an institution);
 - Participate in meetings with the RM, MCO, and any other service provider or service coordinator;
 - Participate in the IRP development process using a PCRCP approach;
 - Be available to the participant in the development of the IRP within the established timeframes, including coordination with the RME within 72 hours of receiving notification of selection to schedule the IDT meeting;
 - Use the RM as the first point of contact regarding questions or concerns about services;
 - Provide documentation about the participant to the RM when requested;
 - Collaborate with the RM in the transfer, suspension, or disenrollment of a participant; and
 - Review requests for service provision from the state hospital, LMHA/LBHA, and court officials for participants in the community who are on a forensic commitment;
 - Coordinate with other entities involved in the care of the participant when applicable (e.g., emergency departments, criminal justice system);
 - Coordinate with the MCO providing services to the participant to include planning and delivery of care, evaluation and adjustment of the IPR, available benefits, disenrollment, suspension, and transfer of services, and nonduplication of Medicaid services (See Section 24000 Non-Duplication of Services for more information);
 - Develop, implement and adhere to a QM plan to include oversight of provider services including training, supervision, and monitoring to ensure competencies and appropriate service delivery according to participant's IRP;
 - Develop, implement, and adhere to a UM plan, to include monitoring of service utilization for each participant, that complements quality improvement activities to include clinical practice improvement initiatives, service/billing integrity verification, and compliance risk monitoring;

- Develop housing and placement policies and procedures to include monitoring and tracking of placement, adherence to 1915(i) settings requirements for provider-owned and operated and non-provider owned and operated settings, Expansion of Community Housing Relationship Plan, and other procedures;
- Develop and maintain policies and procedures that support the participant in their recovery to include procedures for disenrollment or transfer of a participant to another provider that address and promote participant choice, continuity of care and adherence to HCBS-AMH standards and guidelines;
- and • Maintain policies and procedures for medication safety.

5400 Roles and Responsibilities of State Hospitals

State hospital staff shall:

- Adhere to applicable state and federal laws and HHSC policies and procedures;
- Complete the referral process for individuals residing in a state hospital;
- Provide supporting documentation to staff completing the application;
- Perform the UA for individuals residing in a state hospital, as indicated by HHSC;
- Maintain privacy protect the confidential information to the extent required by law. The exchange or sharing of confidential information, particularly PHI or other sensitive personal information shall be done via a HIPAA compliant secure process (See Section 4700-Confidentiality for more information);
- Complete social security pre-release application, if applicable;
- Provide additional clinical documentation to providers once participant is enrolled (See Section 9300-Referring Entity Post-Enrollment Documents for more information);
- Participate in discharge planning;
- Participate in IDT meetings and assist in developing the IRP using the PCR approach;
- Coordinate service delivery with the RME and PA direct service staff; and
- Adhere to policy and procedures regarding privileges of RME and PA direct service staff to provide certain services to HCBS-AMH participants in the state hospital (See Section 18820-Credentialing for Services Providers Within the State Hospitals for more information).

5500 Roles and Responsibilities of Local Mental Health or Local Behavioral Health Authorities

LMHAs and LBHAs shall:

- Adhere to applicable state and federal laws and HHSC policies and procedures;
- Provide pre-engagement services (See Section 8221-Pre-Engagement Services for more information);
- Designate a point of contact to coordinate the referral process for individuals residing in the community (designated staff shall also serve as the point of contact for HHSC communications);
- Review the Mental Retardation and Behavioral Health Outpatient Warehouse (MBO) 1915i reports located in the "CA Continuity of Care" folder for evidence or supporting documentation of meeting initial eligibility criteria;
- Coordinate with state hospital staff, as necessary, for individuals referred to the program who currently reside in a state hospital;
- Coordinate with criminal justice or emergency department staff, as necessary, for individuals referred to the program;
- Complete the referral process for individuals residing in the community;
- Provide additional clinical documentation to providers once the individual is enrolled;
 - Participate in IDT meetings and assist in the development of the IRP using the PCR approach;
- Coordinate service delivery with the RME and PA direct care staff if providing TRR services to the individual;
- Maintain privacy and confidentiality (all parties must maintain and protect the confidential information to the extent required by law). The exchange or sharing of confidential information, particularly PHI or other sensitive personal information, must be done via a HIPAA compliant secure process (See Section 1700-Confidentiality for more information);
- Complete annual HCBS-AMH reassessments, which include an annual HCBS-AMH ANSA as the UA and updated diagnosis in CMBHS for all HCBS-AMH participants in the relevant LMHA/LBHA region or as indicated by HHSC;

- Coordinate state hospital discharge planning with the assigned or alternate RM and state hospital staff; and
- Serve as the single point of contact with the judicial system, unless otherwise delegated by the LMHA/LBHA, for participants on a forensic commitment.

5600 Roles and Responsibilities of HHSC and HCBS-AMH Staff

HHSC and HCBS-AMH staff shall:

- Promulgate rules, policies, procedures, and information development governing the program;
- Develop and implement a referral and enrollment process;
- Determine eligibility;
- Track enrollment;
- Recruit and enroll providers via an open enrollment process;
- Participate in marketing and outreach for potential HCBS-AMH participants by disseminating programmatic information through regular interaction with the community and stakeholders, having an online presence, responding to inquiries or requests for information, and conducting other outreach efforts;
- Perform and maintain records of assessments and evaluations of individuals:
 - Develop and maintain billing guidelines;
 - Review and approve IRPs;
 - Develop and implement policy and procedures regarding privileges of program direct service staff to provide certain services to participants in a state hospital;
 - Conduct UM; and
 - Conduct quality assurance and quality improvement activities pursuant to HHSC and the state's Quality Improvement Strategy policies and procedures.

5700 Roles and Responsibilities of Enrolled Participants

Participants enrolled in the program shall:

- Choose to participate in the program;
- Choose an RME and PA in the service area of choice;
- Abide by program rules;
- Participate in the development of, and updates to, the IRP;
- Participate in HCBS-AMH services, as identified in the IRP (a participant shall receive at least one service to remain active in the program);
- Apply for, and complete, requirements to maintain Medicaid eligibility;
- Notify the RME and PA upon notice from HHSC that Medicaid coverage has been, or will be, renewed or denied or is expired;
- Notify the RME and PA if place of residence changes, to include a residence change outside of the HCSB-AMH service area or a change in living arrangement (e.g., community setting to an institutional setting); and
- Notify the RME upon enrollment into another home and community-based program that precludes participation in HCBS-AMH.

Additional information regarding agreements and responsibilities of the participant and/or their LAR are identified in the HCBS-AMH Enrollment Consent Form.

6000 Program Eligibility

HCBS-AMH eligibility is determined using demographic, clinical, and financial criteria.

6100 Initial Criteria

An individual shall meet the following initial criteria to be eligible for the program:

- Have a diagnosis of SMI;
 - HCBS-AMH State Plan Amendment defines serious mental illness as an illness, disease, disorder, or condition (other than a sole or primary diagnosis of epilepsy, dementia, substance use disorder, or intellectual or developmental disability) that:
 - Substantially impairs a person's thought, perception of reality, emotional process, development, or judgment; and
 - Grossly impairs a person's behavior as demonstrated by recent disturbed behavior.
- Meet one of the following needs-based criteria:
 - Long Term Psychiatric Hospitalization (LTPH): Three or more years (cumulative or consecutive) in an inpatient psychiatric hospital during the five years prior to referral; or
 - Jail Diversion (JD): Two or more psychiatric crises, i.e., inpatient psychiatric hospitalizations or an outpatient psychiatric crisis that meets inpatient psychiatric criteria, and four or more discharges from correctional facilities or arrests during the three years prior to the referral; or
 - Emergency Department Diversion (EDD): Two or more psychiatric crises, i.e., inpatient psychiatric hospitalizations or outpatient psychiatric crisis that meets inpatient psychiatric criteria, and 15 or more total ED visits during the three years prior to the referral; and
- Not be dually enrolled or receiving home and community-based services by any other means, including enrollment in Community Living Assistance and Support Services, Deaf Blind with Multiple Disabilities, Home and Community-based Services Waiver, Texas Home Living Waiver, Youth Empowerment Services, or STAR+PLUS Waiver. If determined eligible for the program, the individual will be placed on pending enrollment status until the individual makes an informed decision about which program is desired.

6200 Clinical Needs-Based Eligibility

Clinical needs-based eligibility shall be determined as part of an independent evaluation of the individual. HHSC has identified the ANSA as the standardized uniform assessment (UA) tool to determine clinical eligibility.

6300 Financial Eligibility

Participants enrolled in the program must meet Medicaid eligibility requirements in accordance with an income level less than or equal to 150 percent of the federal poverty level and be eligible for an accepted Medicaid type under the program. Only Medicaid types that provide full Medicaid coverage and benefits are accepted. The most common form of acceptable Medicaid for the HCBS-AMH program is SSI (Social Security Income) Medicaid.

Individuals residing in a state hospital must be Medicaid eligible but do not have to be actively enrolled with Medicaid to be eligible for the program; whereas, individuals residing in the community at the time of enrollment must be actively enrolled with Medicaid to be eligible for the program.

Individuals residing in a state hospital may qualify for the Social Security Administration (SSA) Pre-Release Application process (See Section 19110-Social Security Administration Pre-Release Program for more information).

6400 Evaluation and Eligibility Determination

HHSC determines eligibility through completion of the evaluation of all factors affecting the eligibility of an individual (See Section 9000-Enrollment Process for more information).

7000 HCBS-AMH Needs-Based Eligibility Evaluation

7100 General HCBS-AMH Needs-Based Eligibility Evaluation Information

The referring entity assists individuals interested in applying with an initial screening to determine if they meet the population and Medicaid requirements. Once confirmed, the ANSA as the UA is completed with the individual in accordance with 26 TAC Chapter 307, Subchapter B (Home and Community-Based Services-Adult Mental Health Program). The ANSA portion of the application is used as the assessment tool for evaluating needs-based eligibility. The ANSA is a person-centered process, guided by best practice and research on effective strategies that result in improved health and quality of life outcomes.

The initial HCBS-AMH ANSA is performed face-to-face by the referring entity approved by HHSC and by persons who are not direct service providers of HCBS-AMH services to the individual. Information from an ANSA completed within six months of the initial ANSA may be used to complete the ANSA if there are no changes in the clinical information of the individual. Persons performing the ANSA may not be employed by an HCBS-AMH RME or PA unless there is no other willing and qualified entity in the geographic area as part of the evaluation process. If no other entity is willing or qualified to conduct the evaluation, the RME or PA shall notify HHSC and request approval before proceeding and ensure that there is an administrative firewall between rendered RME or PA services and the process for performing the ANSA.

Upon completion of the UA (ANSA), the referring entity assists the individual with completing and providing copies of the following forms in the HCBS-AMH enrollment packet. All HCBS-AMH enrollment forms must be submitted online through the CMBHS system, and include hard-copies of all forms that require a wet-signature from the applicant.:

- HCBS-AMH Clinical Eligibility Form;
- HCBS-AMH Provider Selection Form;
- HCBS-AMH Notification of Individual Rights Form;
- CMBHS Diagnosis Form
- HCBS-AMH Participant Handbook; and
- HHSC Handbook of Consumer Rights: Mental Health Services.

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Upon completion of the enrollment packet, the referring entity shall submit the application appropriately in the CMBHS system, and attach any relevant PDF documents to the online HCBS-AMH Clinical Eligibility form or email them directly to the [HCBS-AMH Enrollment and Referral Liaison](#).

An evaluation using the UA (ANSA) is conducted at least every 12 months or when the circumstances or needs of the participant significantly change. HHSC evaluates the UA (ANSA) annually and determines ongoing eligibility.

The UA (ANSA) is based on the following:

- Consultation with the individual and LAR (if applicable) and includes the opportunity for the individual to identify other persons to be consulted, such as a spouse, family member, guardian, and treating and consulting health and support professionals responsible for the care of the individual;
- Examination of the relevant history and medical records of the individual, objective evaluation of their functional ability, and any other records or information needed to develop the IRP; and
- Examination of the physical, cognitive, and behavioral health care; support needs, strengths, and preferences of the individual; available service and housing options; and a caregiver assessment if/when unpaid caregivers are relied upon to implement the IRP.

When necessary and at any time during the eligibility and enrollment process, HHSC may contact the referring entity with requests for additional information. RMEs and PAs are not directly involved in determining HCBS-AMH eligibility; however, RMEs and PAs may be consulted to provide information to aid in the completion of annual reevaluation.

A reevaluation using the ANSA occurs no more than one year from the initial enrollment date of the individual. After the first year, a reevaluation using the ANSA occurs no more than one year from the date of the last assessment. Authorization for services cannot occur without an active ANSA. A reevaluation using the ANSA may be requested by the RME, PA, HHSC, or other involved parties if/when the individual's circumstances or needs significantly change.

7110 Annual Clinical Needs-Based Eligibility Reevaluation

The reevaluation is performed by the LMHA/LBHA. The annual reevaluation shall be submitted in the CMBHS system within 30 days prior to the annual reevaluation expiration date.

Upon receipt, HHSC shall evaluate the UA (ANSA) to determine ongoing eligibility.

Participants enrolled in the program will continue to meet the needs-based criteria to remain enrolled in the program on an annual basis if the participant either:

- Has one of the required needs-based risk factors and requires the HCBS level of service to maintain stability, improve functioning, prevent relapses, maintain residence in the community, and is assessed and found but for the provision of HCBS for stabilization and maintenance purposes, would decline to prior levels of need, i.e., subsequent medically necessary services and coordination of care for stabilization and maintenance is needed to prevent decline to previous need-based functioning; or
- Previously met the needs-based criteria above and is assessed and found but for the provision of HCBS for stabilization and maintenance purposes, would decline to prior levels of need, i.e., subsequent medically necessary services, and coordination of care for stabilization and maintenance is needed to prevent decline to previous needs-based functioning.

7200 Maintenance of ANSA Records

HHSC shall maintain records of evaluations and reevaluations. The evaluations shall be made available to the RME for creation of the IRP. RMEs and PAs shall maintain records of evaluations in the clinical record of the participant.

7300 Adult Needs and Strengths Assessment

The [ANSA](#) is designed to support recovery planning, facilitate quality improvement, and allow for monitoring of clinical outcomes.

The ANSA was developed from a communication perspective and can facilitate a relationship between the assessment process and the development of IRPs, including the application of evidence-based practices. As such, providers should be familiar with how the ANSA functions and communicates the needs and strengths of an individual.

Broadly speaking, each item on the ANSA can communicate a focus for recovery planning for the individual in question. There are four levels of each item on the ANSA with anchored definitions. The assessor uses these definitions to determine a score which is then translated into the following action levels that are 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

If there is a clinical disagreement between the independent assessor and the RME or PA concerning the scores generated by the ANSA, all parties shall submit the clinical justification for the disagreement to HHSC within three business days of receipt of notification of continued eligibility from HHSC. Based on all submitted documentation, HHSC shall render an administrative decision within three business days of receiving the information.

8000 Referral and Pre-Enrollment Process

An individual may be referred to the program by a state hospital or the LMHA/LBHA.

8100 Referral Process from a State Hospital

Eligibility determinations are made by HHSC. Once an individual is referred, an independent evaluation shall be conducted to verify the individual meets initial criteria and clinical, functional, and financial eligibility. Individuals who are determined eligible shall be enrolled in the program. It is important to note: participation in the program is voluntary. Participants may discontinue participation in the program at any time and for any reason.

8110 Initial Criteria Report and MBOW Report

HHSC shall create and provide monthly to appropriate state hospital staff the Initial Criteria Report (ICR) and MBOW 1915i report. The ICR is a list of individuals who have spent three of the last five years (cumulatively or consecutively) in a state-operated psychiatric hospital in Texas and the MBOW 1915i report includes individuals who meet one of the three target populations, i.e., LTPH, JD or EDD, and have interacted with the LMHA/LBHA. The MBOW report shall also be sent to the points of contact for all LMHAs/LBHAs currently active with the HCBS-AMH program.

8120 State Hospital Interdisciplinary Treatment Team

The assigned state hospital social worker shall convene the hospital interdisciplinary treatment team to review the ICR, MBOW 1915i report, and other documentation as needed, to identify eligible individuals currently residing in a state hospital. The assigned state hospital social worker shall assist the individual in completing the application forms for the program. Upon completion, the state hospital social worker shall electronically submit the application forms in the CMBHS system: :

- HCBS-AMH Clinical Eligibility Form;
- HCBS-AMH UA (ANSA);
- HCBS-AMH Provider Selection form;
- HCBS-AMH Notification of Individual Rights Form;
- CMBHS Diagnosis Form
- Documentation supporting Medicaid eligibility; and
- Documentation supporting the individual meets target population criteria if they do not appear on the ICR or MBOW 1915i report.

The assigned state hospital social worker shall assist the individual and LAR (if applicable) in the selection of an RME and PA using the *HCBS-AMH Provider Selection* form. The referring entity shall gather from the HCBS-AMH website and provide to the individual or LAR (if applicable) a list of approved HCBS-AMH providers, i.e., RMEs and PAs, to include location, contact, and phone number information, serving the county of residence of the individual. Referral sources should use the "HCBS-AMH Questions to Ask" flyer found on the HCBS-AMH

website (See Section "Contact Section") in helping participant make decision on which providers best meet their needs.

The date the referral and enrollment forms are received electronically in the CMBHS system is the date HHSC shall use to verify an individual meets initial eligibility criteria once reviewed and approved.

The assigned state hospital social worker shall provide general information about the program to the individual and LAR (if applicable). Information that may be provided at any time during the eligibility and enrollment process includes:

- Demographic eligibility criteria;
- Clinical eligibility criteria;
- Financial eligibility criteria; and • Service array description.

8200 Referral Process from Community

8210 LMHA/LBHA Community Referral

The LMHA/LBHA accepts an inquiry about HCBS-AMH from the interested individual and reviews the MBOW report to identify eligible individuals currently residing in the LMHA/LBHA service area. The LMHA/LBHA shall assist the individual in completing the application forms for the program that are accessible on the [CMBHS](#) webpage. The LMHA/LBHA may provide HCBSAMH pre-engagement services during this process (See 5221-Pre-Engagement Services for more information).

If there are issues accessing and/or submitting the forms in the CMBHS system, the LMHA/LBHA may request the forms and/or referral submission assistance via email from the [HCBS-AMH Enrollment and Referral Liaison](#).

Upon completion of the application form, the LMHA/LBHA shall electronically submit to the CMBHS system:

- HCBS-AMH Clinical Eligibility Form;
- HCBS-AMH UA (ANSA/Needs Based Evaluation);
- HCBS-AMH Provider Selection form
- HCBS-AMH Notification of Individual Rights Form;
- CMBHS Diagnosis Form; and
- Documentation supporting the individual meets target population criteria if they do not appear on the MBOW 1915i report.

8211 Pre-Engagement Services

Pre-engagement services are provided by the LMHA/LBHA to individuals who are seeking enrollment in the program and reside in the State of Texas.

Once the LMHA/LBHA completes the referral and receives notification from HHSC that an individual is enrolled, the HCBS-AMH point of contact at the LMHA/LBHA shall notify the case manager assigned to the participant, and other mental health service providers, if applicable.

HCBS-AMH pre-engagement services include:

- Responding to inquiries from individuals residing in the community about the program;
- Reviewing the MBOW 1915i report to identify potential HCBS-AMH participants;
- Scheduling and performing initial HCBS-AMH eligibility screening via inquiry phone line and scheduling initial assessment appointment;
- Assisting individuals or LARs in completing HCBS-AMH enrollment forms;
- Assisting individuals or LARs in selecting an RME and PA;
- Scheduling and conducting the HCBS-AMH screening process, which includes completion of the UA (ANSA), to determine HCSB-AMH eligibility;
- Gathering, or assisting the individual in gathering, documentation that is required to determine HCBS-AMH eligibility;
- Assisting in obtaining the documents necessary to determine Medicaid eligibility;

- Assisting the individual in the submission of Medicaid eligibility paperwork to system agency for processing if the individual is currently inactive with Medicaid; and
- Completing enrollment activities in accordance with the provider manual to include coordination with state hospital, criminal justice system, and/or emergency department staff.

8300 Recovery Management Entity Capacity

RMEs shall set the limit of their capacity to serve participants enrolled in the program upon entering into a Provider Agreement with HHSC. Prior to accepting HCBS-AMH participants, RMEs shall inform HHSC of their capacity. RMEs may determine their capacity to serve HCBS-AMH participants by evaluating direct service staff resources, administrative staff resources, and other characteristics.

Although HCBS-AMH staff may enroll participants at any time, verification of the selection of the RME by the individual is dependent upon the capacity of RME.

8310 Good Faith Effort Exception

In extreme or unusual circumstances, provider may request a good faith exemption when unable to provide one or more services to a particular participant or for a specific length of time. HHSC will consider these requests on a case-by-case basis and will consider the documented effort to provide the services in question, the unique barriers, and the plan for making the services available in the future.

An RME or PA may identify they are unable to serve a HCSB-AMH participant because of the inability to provide a service for the participant which meets the needs identified on the ANSA and ensures the health, safety, and success of the participant in the community. In this instance, the PA or RME shall conduct the following:

- Complete a Good Faith Effort Exception form; and
- Submit the Good Faith Effort Exception form to HCBS-AMH Enrollment and Referral Liaison with the subject line "Good Faith Effort Exception" for consideration.

Through completion of this form, the RME or PA shall articulate reasonable efforts taken to provide the identified service(s) for the participant. The RME or PA shall

document how each identified service is fundamental in maintaining the health, safety, and success of the participant in the community.

HHSC shall respond to the submission of the Good Faith Effort Exception form within five business days with a request for additional information or approval of the exception to the HCBS-AMH PA contractual requirement.

9000 Enrollment Process

9100 Notification of Eligibility and Enrollment

If an individual is determined eligible for the program, HHSC shall:

- Provide the notification of eligibility and enrollment determination letter to the individual and LAR (if applicable); and

Notify, via email, the referring entity, RME, PA, MCO, and LMHA/LBHA (as applicable) selected by the individual and identified on the *HCBS-AMH Provider Selection* form of the enrollment of the eligibility decision and effective date of enrollment. The notification email will include the eligibility determination letter as an attached; while all other enrollment documents will be found in the CMBHS system. The selected RME and PA shall each maintain a copy of all enrollment documents submitted in CMBHS, as well as the eligibility determination letter attached to the enrollment notification email, in the clinical record of the participant.

9200 Notification of Ineligibility

If an individual is determined ineligible for the program, HHSC shall:

- Provide the notification of ineligibility letter and the following information to the individual and LAR (if applicable):
 - Confirmation the individual is denied enrollment in HCBS-AMH;
 - Reason for ineligibility determination;
 - How to reapply; and
 - Information on the fair hearing process and contact person/s to begin the process;
- Notify the referring entity; and
- Refer the individual to other known available services and community resources, as applicable.

9300 Referring Entity Post-Enrollment Documents

Once notification of enrollment is received, the state hospital social worker or LMHA/LBHA shall send the RM, PA, HHSC, LMHA (if referred by the state hospital), and MCO, via secure email, the following clinical documents:

- Most recent social assessment;
- Most recent psychiatric evaluation;
- Face-sheet/client demographic sheet;
- Annual physical;
- Diagnosis report;
- Current medication list;
- Lab orders from "client profile/physicians orders";
- Most recent nursing assessment;
- Functional needs assessment (if applicable);
- Recovery plan;
- Most recent inventory for client and agency planning (if applicable); and
- Outpatient management plan, clinical care review, and community support plan if the participant is on an outpatient forensic commitment.

The LMHA/LBHA shall send:

- Face-sheet/client demographic sheet;
- Psychiatric evaluations;
- Current medications;
- Treatment plan; and
- Outpatient commitment paperwork and court documents, as applicable.

9400 No Reject Appeals Policy

HCBS-AMH operates with a 'No Reject Policy.' When an RME and PA are selected by an individual, they shall fulfill the respective roles as outlined in the Provider Agreements and HCBS-AMH Provider Manual. If a provider believes they cannot serve the

individual in the community, the provider shall follow the steps in the Community Discharge Readiness Review process below.

9410 Community Discharge Readiness Review Process

When a participant is in a state hospital, the RM shall work with the participant, state hospital recovery team, the PA, LMHA/LBHA, as applicable, and other individuals involved in the participant's care to plan for the participant's discharge into the community. If an HCBS-AMH RME or PA has significant concerns about the participant's readiness to discharge into the community and/or the provider's ability to address the needs of the participant, the provider should take the following steps:

- The provider with the concern contacts the other HCBS-AMH provider to discuss concerns and identify gaps/barriers creating the concern (e.g., PA has the concern, so he/she contacts the RME).
- Convene an additional IDT meeting to discuss the concern with the state hospital recovery team and other involved individuals, to include, but not limited to the PA, state hospital recovery team members, LBHA/LMHA staff, guardian, and participant, if appropriate.
 - At the meeting, the goal should be to share concerns and discuss solutions to address the barriers/gaps prior to the participant's discharge. Solutions can include:
 - ◇ Identifying additional resources, services, and staff needed to meet participant's needs;
 - ◇ Requesting an extension of the state hospital discharge date up to an additional 30 days to allow for more time to establish rapport between participant and providers and to set up additional identified services/supports;
 - ◇ Using 24-72-hour passes (participant leaves state hospital and temporarily lives in the community with HCBS-AMH services in

place), possibly a few different times, to aid in transition into the community;

- ◇ Using approved PA services while in the state hospital, such as peer support and psychosocial rehab, to establish rapport and address barriers/concerns prior to discharge; and
- ◇ The PA/RME obtaining additional training/support from state hospital staff to individualize supports for participant.

➤ RME should document the outcome of the IDT meeting and submit a new IRP to HHSC for approval, if applicable.

➤ If, at the end of the meeting or after implementing steps to address concerns, the provider(s) still has concerns and does not feel that they are able to provide the intensity of support necessary to support the participant in the community, they should communicate the concern to the other program provider and the state hospital social worker.

- If no solutions can be implemented that the provider believes will sufficiently address the participant's needs, the provider should submit a "Community Discharge Readiness Review" form to HCBS-AMH Enrollment and Referral Liaison within 24 hours of his/her decision. The provider should include the following documents with the form, as applicable:

➤ Initial program enrollment packet documents

➤ Most recent psychiatric evaluation

➤ State hospital face sheet

➤ State hospital annual physical

➤ State hospital diagnosis report

➤ Medication list

➤ Lab orders

➤ Most recent state hospital nursing assessment

➤ State hospital Recovery Plan

➤ Most recent Inventory for Client and Agency Planning, if applicable

➤ Outpatient Management Plan, if applicable (46C)

➤ Clinical Case Review, if applicable (46C)

- If participant is discharged prior to HHSC conducting a review, the provider(s) are responsible and bound by contract to provide HCBS-AMH services according to the approved IRP on file while the review is in process.
- Once the Community Discharge Readiness Review form and associated required documents are received by HHSC, HHSC will review and provide a response within 10 business days of receipt.
- HHSC will send a notification to RM, PA, LMHA, and state hospital social worker that a review has been requested.
- The review may include:
 - An updated ANSA, completed by an independent evaluator;
 - A conference call with providers, state hospital social worker, and HHSC staff; and
 - A conference call with state hospital treating psychiatrist/medical director, HHSC Community Behavioral Health Medical Director, LMHA/LBHA medical director, and HCBS-AMH leadership.

9420 Determination of Review Process

If it is determined that the individual is not appropriate for the program as the program is unable to provide the level of services and supports to safely transition the participant into the community, HHSC leadership will contact the specific state hospital leadership, including the social work director, to provide an update and inform that the participant is not eligible for HCBS-AMH.

HHSC will send out an updated eligibility determination to the participant/guardian, state hospital, RME, PA, and LMHA/LBHA.

If it is determined that the program can appropriately provide the level of services and supports needed to safely transition the participant into the community, HHSC will notify both the PA and RME of the decision, and providers shall deliver needed services to the participant.

If a provider refuses to deliver services, HHSC may take contract action due to refusal to serve participant.

At this time, HHSC may recommend that the participant select a new provider.

9500 Recovery Manager Meets with Participant

Upon receipt of notification of participant enrollment, the RME shall assign an RM to the participant, giving choice of the direct staff assigned to the participant, whenever possible. The assigned RM is expected to serve as the primary and sole manager assigned to the participant with an assigned back up RM if unavailable.

Immediately upon notification of enrollment, the assigned RM shall contact the selected PA and the referring entity, i.e., state hospital or LMHA/LBHA, to coordinate and facilitate an IDT meeting with the participant and LAR (if applicable) to develop the initial IRP. It is important to note: in some cases the RM may need more than one meeting with the participant, LAR (if applicable), and the IDT to complete the initial IRP (See Section 11000-Individual Recovery Plan for more information).

9510 Initial Contact Post Enrollment

When the RME is selected by an individual who currently resides in a state hospital, the RME shall:

- Complete the credentialing process (See Section 18820-Credentialing for Services Providers Within the State Hospitals for more information);
- Coordinate with the state hospital point of contact;
- Notify and coordinate with the selected PA to ensure an IDT meeting is convened to determine HCBS-AMH services and develop an initial IRP within 14 days of the enrollment date (See Section 11000-Individual Recovery Plan for more information); and
- Ensure that the assigned RM is present when the individual moves from hospital or other setting into community-based living setting to support a safe transition.

When the RME is selected by an individual who currently resides in the community, the RME shall:

- Notify and coordinate with the selected PA to ensure an IDT meeting is convened to determine HCBS-AMH services and develop an initial IRP within 14 days of the enrollment date (See Section 11000-Individual Recovery Plan for more information).

9520 Initial Contact after Discharge from a State Hospital

Identify the date and time of discharge from the state hospital and the location of the participant's new residence. Once the participant is discharged from the state hospital, the RM shall be physically present to facilitate the transition to the new residence. The RM will coordinate the initial face-to-face with the housing provider and answer any questions or concerns that may arise.

9530 Consents

The RM shall maintain open communication and coordination with each PA by obtaining appropriate written consent from each participant for the disclosure of PHI or other sensitive personal information. Likewise, PAs shall obtain appropriate written consent from each participant for the disclosure of PHI or other sensitive personal information.

10000 Provider Requirements for Participants on Forensic Commitments

Participants may be on a court commitment at the time of HCBS-AMH enrollment. Both RMEs and PAs are responsible for following the guidance below when a participant is on one of the following commitments.

10100 Commitment Types

46B Incompetency to Stand Trial

46B incompetency to stand trial is a commitment in a criminal proceeding. An individual is incompetent to stand trial, pursuant to Code of Criminal Procedure (CCP) 46B.003(a) if the individual does not have:

- Sufficient present ability to consult with the person's lawyer with a reasonable degree of rational understanding; or
- A rational as well as factual understanding of the proceedings against the person.

46C Not Guilty by Reason of Insanity

46C not guilty by reason of insanity is a commitment after a person is acquitted of a criminal offense by reason of insanity. Under Texas Penal Code, Section 8.01 (Insanity), it is an affirmative defense to prosecution that, at the time of the conduct charged, the actor, as a result of severe mental disease or defect, did not know that their conduct was wrong.

10200 Required Documents for Participant

The documents listed below must be kept updated in the participant's file throughout enrollment in the program. Providers must ensure that when updates or modifications are made to any document listed below, a copy of the updated version is placed in the participant's file.

- Updated IRP with the following items included:
 - Current contacts and information related to commitment, LMHA staff, district attorney, defense attorney, court of jurisdiction phone number, name of the presiding judge, and parole/probation officer, if applicable;
 - Recommitment dates, timeout date for commitment, and timeout date for second- or third-degree felony, as applicable;
 - Documentation on the Safety Plan of legal requirements and restrictions; and
 - All services provided by HCBS-AMH should be listed under service tab of IRP. Non-HCBS-AMH services provided by LMHA or private provider must be documented under the Non-HCBS-AMH Services section of the IRP.
- Approved Outpatient Management Plan
- Copy of LMHA Comprehensive Plan of Care

10300 Required Involvement and Communication

Providers shall be involved in meetings and communications related to a participant's commitment to ensure appropriate service coordination. Providers must ensure the following:

- RM and PA participation via phone, in person, or video for Clinical Case Review as applicable (may also be called Forensic Consultation Committee or Not Guilty by Reason of Insanity Security Review Board). This meeting takes place prior to state hospital discharge.
- RM must notify and invite all necessary parties to IRP meetings, including the defense attorney, the probation officer, (as applicable), and the assigned LMHA care coordinator.
- If participant is still in the state hospital at the time of the initial IRP, the services that he/she believes are needed to help reintegrate in the community and support recovery are placed on the IRP, with additional recommendations, as appropriate, from IDT members based on the participant's history and commitment type. IDT members must inform the participant that the IRP is subject to modification by the court or Community Supervision and Corrections Department (CSCD), and any conflicting court orders or requirements take priority over the IRP.
- RM must provide a copy of the approved IRP to all necessary parties, including, the defense attorney, the probation officer (as applicable), and the assigned LMHA care coordinator.
- RM should request to attend the initial LMHA treatment plan meeting and intake appointment post-state hospital discharge and review which services the LMHA will provide. Upon completion of LMHA treatment plan, the RM should convene an IDT and complete an updated IRP to reflect the revised service provision based on which services the LMHA will provide. If the LMHA is able to provide the majority of services needed by the participant, then HCBS-AMH should only be used for services (i.e., supervised living, host home, assisted living, nursing apart from psychiatric needs, adaptive aids, transportation) that the LMHA does not provide.
- The PA must ensure that residential housing staff and all service providers are familiar and provided with an accessible copy of the current, approved IRP and list of legal requirements and restrictions. The PA must ensure that PA service providers do not engage participants in restricted activities or services that place the participant at risk for noncompliance with legal requirements and restrictions.
- Any HCBS-AMH provider transfer requests that require a physical move of the participant to a new residence require advance approval by the judge in the court of jurisdiction and submitted to HHSC in writing. If no physical move is required, the RM must update the LMHA care coordinator and legal team about provider transfer/change in writing via email.

- RM shall be the direct contact with the LMHA and legal team when any needs or changes are identified for the participant. The LMHA and/or the probation officer assigned to the case will address with the court additional services or changes in services, and the court's decision will be communicated to the RM by the LMHA. Once the court has approved of changes to HCBS-AMH services, the RM should convene an IDT meeting to complete an updated IRP.
- The LMHA is the primary service provider of record and is directed, by court order, to provide a comprehensive program of care. All HCBS-AMH services are intended to supplement the LMHA and must be approved by the supervising court and CSCD, as applicable, prior to service delivery. The court's approval may be communicated to the RM and the PA by the LMHA and the probation officer assigned to the case, if applicable.
- All services are subject to medical necessity as determined by the physician at the receiving LMHA who is court-ordered to provide the comprehensive program of treatment. Any additional services provided by HCBS-AMH over and above the units provided by the LMHA must be reported by email to the LMHA and CSCD, as applicable, along with a brief description of the therapy or service.
- If the judge modifies or adjusts the participant's housing, level of court supervision, reporting requirements, or other factors within the court's jurisdiction in a way that impacts the IRP, the IDT, along with the participant, should discuss and revise the IRP as appropriate.
- Any participant or program-related questions the court may have will be communicated to the RM by the LMHA. The RM shall provide requested information within 48 hours of request (or sooner if requested) for report to the court by the LMHA and/or the probation officer assigned to the case.
- The PA must respond to RM inquiries requested by the LMHA or court within 24 hours to provide ample response time for RM to report to the court.

11000 Individual Recovery Plan

The program IRP serves as the plan of care for participants and the authorization document for services. Except for dollar-based services, i.e., flexible funds, adaptive aids and minor-home modifications, HCBS-AMH services should begin on the effective date of the IRP; however, claims shall not be paid unless and until an IRP is approved by HHSC. In addition, services shall not be reimbursed prior to the effective date of, or after an expiration date, of an IRP (see table below).

Date Type	Description
Completion/effective date	The date the IRP is signed by the RM, PA, and participant or LAR (if applicable).
Authorization date	The date the IRP is authorized, i.e. approved, by HHSC.
Expiration date	Either the day after the next due date of an IRP, as indicated on the IRP, or the day after the expiration date of the active HCBS-AMH ANSA.

All HCBS-AMH participants shall have an initial IRP developed upon enrollment in the program, and updated IRPs throughout the lifetime of enrollment, to include an annual update IRP at the enrollment anniversary of the participant (See Sections 11300-Developing and Submitting the Initial Individual Recovery Plan and 11400-Updating and Submitting the Individual Recovery Plan for more information).

IRPs shall be developed face-to-face with the participant and with their informed consent, in a person-centered planning process, in accordance with 42 CFR §441.725 Person-centered Service Plan (See Section 12000-Person-Centered Recovery Planning for more information). If circumstances prevent a face-to-face meeting for the initial IRP, an audio/visual medium shall be used; solely a teleconference meeting is insufficient. Justification for not meeting face-to-face shall be documented in a progress note. The IRP shall be based on the recovery goals (short- and long-term), strengths, needs, preferences for service delivery, and desired outcomes of the participant and information from the HCBS-AMH ANSA, and shall consider the biopsychosocial needs and service history of the participant. In addition, when applicable the RM may use supplemental functional needs assessments to ascertain additional needs of the participant. This information shall be used to determine the nature, amount, and scope of Medicaid and non-Medicaid services. Only services discussed during the IDT meeting shall

be included in the IRP of a participant. Discussions about additional services between the participant, RM, PA, and other providers outside of the IDT meeting shall not be included on the IRP until an update IDT meeting is convened. If a participant who resides in the community requests additional services that are not on the most recent, approved IRP, the RM shall schedule an IDT meeting within 48 hours of the request.

The PCR approach requires the development of the IRP with the full participation of the participant, LAR (if applicable), RME, PA, referring entity (LMHA/LBHA or state hospital social worker/staff), MCO (if applicable), and other service providers and natural supports, according to the needs and desires of the participant. If the participant is receiving TRR services from the LMHA/LBHA, the RM shall coordinate all IDT meetings with the LMHA/LBHA.

The RM shall contact the selected PA within 72 hours of receipt of selection notification from HHSC. If the RM is unable to establish contact with the PA within 72 hours, the RME shall notify HHSC. The PA may also contact the RM during this 72-hour phase to coordinate the development of the initial IRP. If the PA has not been contacted by the RM within 72 hours of receipt of selection notification from HHSC, or if the PA is unable to contact the RM, the PA shall notify HHSC. If no contact is made during the first 72 hours, the PA is required to contact the RME and HHSC to coordinate the IRP development within the next 24 hours.

The RM shall coordinate and facilitate all IDT meetings to develop or update the IRP. The RM shall attend, in-person with the participant present, all IDT meetings to develop and update the IRP, despite the current location of the participant, i.e. in the community or at a state hospital. If the travel distance to the participant is greater than 300 miles, then the RM may coordinate a meeting using teleconferencing technology. The PA shall also attend in-person all IDT meetings for participants residing in the community; however, if a participant resides in a state hospital at the time of the initial or update IRP IDT meeting, the PA may attend the meeting via teleconference. PAs shall be active participants in the development and update of all IRPs for HCBS-AMH participants. At a minimum, all IDT meetings to develop or update the IRP shall include the RM, PA, and participant or LAR (if applicable).

11100 Individual Recovery Plan Requirements

The IRP shall include all HCBS-AMH services to be provided to a participant and reflect coordination with the LMHA/LBHA and MCO (if applicable) by the inclusion of non HCBS-AMH services, i.e. other non-HCBS-AMH Medicaid State Plan services or services provided by other funding sources. In addition, the IRP shall reflect the most appropriate type, frequency, and amount of HCBS-AMH services to meet the needs and recovery goals and objectives of a participant. If one or more of the

pro services specified in the IRP does not meet standard UM guidelines, HHSC shall:

- Notify the RME of services that require additional information; and
- Send written notice to the participant or LAR (if applicable) that the services selected require additional information for approval.

Upon receipt of the notification from HHSC, the RM shall coordinate with the PA to obtain justification for a service and report back to HHSC by the deadline indicated (See Section 17000-Utilization Management for more information).

IRP development shall use a PCR process, approved by HHSC and authorized prior to the provision of services. For approval by HHSC, the IRP shall be developed in accordance with 26 TAC, Chapter 307, Subchapter B (relating to Home and Community-Based Services—Adult Mental Health) and include the following:

- Attestation to needs-based criteria, signed by the RM;
- Narrative summary, including but not limited to:
 - Any pertinent information regarding treatment, medical history, criminal history, etc.
 - Participant's psychiatric, incarceration, and hospitalization history
 - Any updates or changes in behavior or treatment from the previous IRP
 - Medicaid application status, including any appeals, denials, or changes to benefits.
 - Providers must document in the participant's IRP the reason(s) why services were delivered by synchronous audiovisual or telephone (audio-only) technology.
- Psychiatric, substance use, and medical diagnoses;
- Psychiatric and medical medication/s;
- Type of residence, e.g., supervised living, assisted living, family home;
- Strengths, barriers, immediate needs of the participant, and other non-HCBS Services (private and public);
- Goal statement/s;

- Objective/s;
- Interventions/services to include the type, amount, and frequency of services;
- Safety plan;
- ANE prevention plan (if applicable);
- Service providers and credentials (when applicable);
- Modification form (if applicable); and
- Signatures by the RM, PA, and participant or LAR (if applicable) wherever signatures are required, i.e., signature page, summary sheet, safety and ANE prevention plans. The signature page shall be uploaded to the IRP in CMBHS, as applicable.

In addition to the above requirements, the RM must document a link between the service, objectives, goals, and identified needs of the participant.

For more information on the PCRCP approach, including information on the essential components of an IRP, i.e., strengths, barriers, immediate needs, goal statements, objectives, and interventions, as well as the safety and ANE prevention plans, see Section 12000-Person-Centered Recovery Planning.

11200 Secondary Assessments Co-Occurring Diagnoses Needs Assessment

When applicable, the RM may use supplemental functional needs assessments to ascertain additional needs of the participant. Additional assessment and planning may need to occur for participants who have co-occurring diagnoses from the following neurodevelopmental and neurocognitive disorders:

- Intellectual and developmental disability diagnosis: mild, moderate, severe, profound, or unspecified severity;
- Autism spectrum disorder;
- Traumatic brain injury; or • Dementia.

11300 Developing and Submitting the Initial Individual Recovery Plan

The RM shall coordinate and convene an IDT meeting to include the participant and/or LAR (if applicable), PA, referring entity, MCO, and other providers and natural supports identified and approved by the participant or LAR (if applicable) to develop the initial IRP and submit to HHSC for review and approval within 14 business days of receipt of notification of selection by HHSC. RMs shall use the [HCBS-AMH Individual Recovery Plan Template](#) available on [HCBS-AMH website](#) (See Forms Information) and select "Initial IRP" from the IRP type drop-down menu on the first page of the template. Providers will use CMBHS to complete and send in IRPs for HHSC approval.

The initial IRP shall meet all requirements set forth in Section 11100-Individual Recovery Plan Requirements and Section 12000-Person-Centered Recovery Planning.

If the participant resides in the community at the time of the initial IRP IDT meeting, the RM may bill for eight units of recovery management services (see HCBS-AMH Billing Guidelines for more information). If the IRP cannot be completed and submitted to HHSC within 14 business days of the enrollment notification, then the RM shall immediately notify HHSC by sending a secure email to the [HCBS-AMH Individual Recovery Plan](#) mailbox, and document in the clinical record of the participant.

Upon completion of the initial IRP, the RM shall submit the IRP, i.e. all pages of the IRP template to include the safety plan, ANE prevention plan, modification form, summary sheet, and signature pages, as well as any clinical documentation that provides justification for services selected, to HHSC for review and approval via secure email to the [HCBS-AMH Individual Recovery Plan](#) mailbox with copy to the PA and, if applicable, state hospital social worker, LMHA/LBHA representative, and MCO representative. The RM shall use the following naming convention for the subject line of the email: Initial IRP Approval Request, initials of the participant and the last four digits of the CARE identification number, e.g., Initial IRP Approval Request, TB 9999.

Providers will begin submitting IRPs via the CMBHS system and not via email once mandated by HCBS-AMH.

Electronic signatures by all parties shall be accepted; however, the RM and PA shall retain a hard copy of all IRPs, including the signature pages, in the clinical record of each participant.

If desired, a hard copy of all IRPs shall be provided to the participant and/or LAR (if applicable). If the participant resides in a supervised living or assisted living residence, then a hard copy of the IRP shall be provided to house staff on a need-to-know basis and retained in a secure location that is accessible only to those staff persons.

11400 Updating and Submitting the Individual Recovery Plan

At a minimum, the RM shall convene a face-to-face IDT meeting to include the participant and/or LAR (if applicable), PA, referring entity, MCO, and other providers and natural supports identified and approved by the participant or LAR (if applicable) to update the IRP of a participant every 90 days for the first year of enrollment and every 180 days for all subsequent years of enrollment. The due dates for the update IRP are based on the effective date of the initial IRP. For example, if the effective date of the initial IRP for a participant is January 1, 2020, then the first update IRP is due to HHSC for review and approval no later than March 31, 2020.

In addition, the RM shall convene an IDT meeting to update the IRP of a participant:

- At the request of the participant;
- If the needs or circumstances of a participant significantly change;
- If the participant is scheduled to discharge from a state hospital;
- If the participant is placed in or removed from suspended status; (see section 12200 suspension for more information);
- If the participant transfers to another provider, i.e. RME, PA, or both (see section 12100-transfer for more information);
- If clinically indicated; or
- If a crisis event has occurred (See Section 18630-Critical Incidents for more information).

At the time of the scheduled updates, i.e. 90-day and 180-day updates, the entire IRP shall be reviewed and updated by IDT members according to the needs and recovery goals of the participant and/or LAR (if applicable). Update IRPs shall

demonstrate progress toward the recovery goals and objectives of the participant or LAR (if applicable), and if needed, make changes accordingly. Update the narrative section at each update IRP to include significant life events, progress in meeting goals, or decline in functioning. RMs shall use the [HCBS-AMH Individual Recovery Plan Template](#) available on [HCBS-AMH website](#) (See Forms Information) and select "Update IRP" from the IRP type drop-down menu on the first page of the template.

Upon completion of an update IRP, the RM shall submit the IRP, i.e. all pages of the IRP template to include the safety plan, ANE prevention plan, modification form, summary sheet, and signature pages, as well as any clinical documentation that provides justification for services selected, to HHSC for review and approval via secure email to the [HCBS-AMH Individual Recovery Plan](#) mailbox with copy to the PA and, if applicable, state hospital social worker, LMHA/LBHA representative, and MCO representative within 72 hours of update. The RM shall use the following naming convention for the subject line of the email: Update IRP Approval Request, initials of the participant and the last four digits of the Client Assignment and Registration System, i.e. CARE, identification number, e.g., Initial IRP Approval Request, TB 9999.

Electronic signatures by all parties shall be accepted; however, the RM and PA shall retain a hard copy of all IRPs, to include the signature pages, in the clinical record of each participant.

If desired, a hard copy of all IRPs shall be provided to the participant and/or LAR (if applicable). If the participant resides in a supervised living or assisted living residence, then a hard copy of IRPs shall be provided to staff and retained in a secure location that is accessible only to those staff persons.

11500 Individual Recovery Plan Approval Process

Upon receipt of an initial or update IRP via email or through the CMBHS approval process, HHSC shall review the IRP for completeness, and to ensure the clinical needs, as identified in the most recent HCBS-AMH ANSA, and recovery goals of the participant are addressed, as evidenced by the objectives and interventions/services selected. In addition, HHSC shall review the type, frequency, and amount of services to ensure the request is clinically justified and meets the recovery goals and objectives of the participant.

Within five business days of receipt of an IRP via email or through the CMBHS approval process, HHSC shall approve or deny the IRP. If approved, HHSC will provide a copy of the approved IRP. Once providers submit IRPs in CMBHS, the approved IRP will be available in the CMBHS client workspace. If denied, HHSC shall include a justification for the denial and a due date for when a corrected

IRP shall be resubmitted for additional review and approval. The RM shall ensure the IRP is corrected and additional information, if requested by HHSC, submitted by the deadline indicated in the reply email from HHSC.

11600 Role of the Recovery Manager in the Development of the Individual Recovery Plan

In addition to the roles and responsibilities identified in Section 5210-Roles and Responsibilities of the Recovery Manager in the development or update of an IRP, the RM shall ensure:

- The participant directs the PCRCP process to the maximum extent possible and is enabled to make informed choices and decisions;
- The participant and/or LAR (if applicable) and PCRCP participants are informed of qualified provider options (documentation regarding provider choice to include any updates, shall be included in the clinical record of the participant);
- The IRP is signed by all parties participating in the IDT meeting (RM, PA, and participant or LAR [if applicable] are required to sign);
- All parties are provided an electronic or hard copy of the IRP (if desired);
- and • The IRP is kept in the clinical record of the participant.

11700 Deviations from Service Standards

The modification form of the IRP records any planned intervention that could potentially impinge on individual autonomy, especially for community-based residential services and administration of medication (See Section 16000 Settings Requirements, 21200 Use of Restrictive Interventions, and 21300 Medication Safety and Management). These planned interventions shall be documented as modifications on the modification form of the IRP and include:

- Informed consent of the participant as well as their LAR (if applicable) specific to the intervention;
- Specific need for the intervention in supporting the participant achieving their recovery goals;
- Assurance the intervention is the most inclusive and person-centered option;
- Time limits for the intervention;
- Periodic reviews of the intervention to determine continued need;
- Assurance the intervention will cause no harm to the participant; and
- Confirmation the participant has received information on how to report incidences of ANE.

Informed consent by the participant regarding the potential use of a restrictive intervention is required and the potential use shall be included on the ANE plan of the IRP to include understanding of their rights and how to report ANE.

11800 Quality Management Requirements

QM IRP activities include ensuring the elements of the PCRCP process are reflected on the IRP by assuring the IRP:

- Documents strengths, progress toward goals, preferences, and desires with housing;
- Narrative section is current and updated with significant life events, including change in providers and behavioral or physical health;
- Prevents the provision of unnecessary or inappropriate care;
- Prepares for the participant's effective transition to the community;
- Promotes the participant's inclusion into the community;
- Is updated to include strategies and interventions to protect the participant's health and welfare in the community;
- Supplements, rather than replaces, the participant's natural support systems and resources;
- Is designed to prevent or reduce the likelihood of the participant's admission into an inpatient psychiatric facility; and
- Is understandable to the participant, and the individuals important in supporting them, using the participant's own words to the greatest extent possible (for Medicaid purposes, some adaptation may be required).

12000 Person-Centered Recovery Planning

PCRCP is the collaborative process, used by the RM, PA, and other IDT members, and directed by the participant, to develop and update the IRP. PCRCP uses a recovery orientation and team approach that includes the participant, formal supports, and natural supports to best support the recovery, goals, and objectives of the participant. The process provides necessary information and support to ensure the participant directs the process to the maximum extent possible and is enabled to make informed choices and decisions.

The IRP is developed and updated collaboratively, and in accordance with 42 CFR §441.725 (Person-Centered Service Plan), with the participant, LAR (if applicable), treatment providers (formal supports), and others chosen by the participant (informal or natural supports). The goal of this collaboration is to develop and update and implement a plan of action, i.e. IRP, that assists the participant in achieving their unique goals along their journey to recovery.

Every IRP, i.e. initial and updates, shall include the essential components which are strengths, barriers, immediate needs, goal statements, objectives, and interventions/services. Following is a description of each essential component.

12100 Essential Components of a Person-Centered Recovery Plan

12110 Strengths

Strengths and abilities refer to characteristics of the participant that are elements in their life, used in the past or present, to help them cope with stressful situations. The strengths of a participant shall be used to help promote the success of the participant in reaching their goals.

Strengths of a participant include anything that may aid in the pursuit of their identified goal(s), including factors that are both internal and external to the participant. These factors may include personal characteristics or attributes, access to concrete resources, abilities of the participant or natural support system, personal interests, skills, past achievements, and cultural factors. Strengths shall be identified and captured in a way that enables their use toward achieving the goals and objectives of the participant. Providers shall assist participants (and natural supports/LARs) to identify a diverse range of strengths that may be actively used in the plan for recovery. If the participant is unable to

communicate their strengths, then a family member, LAR (if applicable), or other representative may help clarify or identify the strengths of the participant to help shape the recovery process. Examples of strengths include:

- Principles;
- Religious beliefs and/or rituals;
- Supportive friends;
- Supportive family;
- Ability to work;
- Hope; and • Resilience.

Examples of abilities include:

- Attending to activities of daily living (ADLs);
- Skills in reading and writing;
- Saving money;
- Following instructions;
- Recognizing side effects of medication; and • Asking for help.

12120 Barriers and Needs

Barriers and needs on an IRP identify what is keeping the participant from achieving their goals. Barriers should communicate the true nature of the obstacle to be overcome. Barriers should be specific enough to suggest next steps for measuring the progress of a participant and what services may benefit the participant. Barriers and needs may fall under one of the following categories:

- Need for development of skills;
- Intrusive or burdensome symptoms;
- Lack of resources;
- Need for assistance/supports;
- Challenges in ADLs; and
- Threats to basic health and safety.

12130 Goal Statements

The foundation of IRP goals is the strengths, needs, abilities, and preferences of the participant. Discussion of goals shall occur throughout the assessment process and result in the selection of one or more goals that guide the planning process. The goal statement on the IRP shall capture the goals selected by the participant to guide services. IRP goal statements shall:

- Reflect the primary reason for seeking help and receiving services;
- Acknowledge that the goals of a participant are the motivating force for engagement;
- Be developed from information gained during the HCB-AMH ANSA and interpretive summary;
- Be broad, general statements that express the desires of the participant for change and improvement in their lives;
- Be the result of a goal discovery process (facilitated by the RM and other providers) when the participant is unclear on their vision for recovery and may include contributions from natural supports when the participant has difficulty communicating; and
- Be determined by the participant and stated in their own words whenever possible.

If a participant is unable to communicate their own goals, then a family member, LAR (if applicable), or the clinician the participant chooses to represent them may help clarify or provide initial treatment goals until the participant is able to actively participate in the development of their treatment plan.

12140 Objectives

Objectives on an IRP are the short-term changes needed for the participant to progress toward goals. Objectives shall:

- Describe how progress is measured;
- Be linked to an immediate barrier that is the focus of treatment;
- Be simple, specific, and straightforward;
- Describe a desired change in behavior (strengths-based);

- Be reasonable and achievable based on the current needs and preferences of the participant;
- Communicate the expected time for completion, including specific target dates;
- Be written in behaviorally specific language;
- Appropriate to the age, development, and culture of the participant;
- Understandable to the participant;
- Appropriate for the setting of the participant;
- Be consistent with the readiness, preferences, and expectations of the participant; and
- Go beyond service participation to define the intended result of actions and services.

12150 Interventions (Services)

Interventions on an IRP are actions taken by providers, peers, family, friends, and natural supports of the participant, to include other persons identified by the participant, in attaining the desired changes of the participant. Interventions shall:

- Be specific to an objective;
- Respect the choices and preferences of a participant;
- Incorporate identified strengths and abilities/skills of a participant;
- Take into consideration cultural factors;
- Specify provider and professional discipline;
- Specify modality;
- Specify frequency, amount, and duration; and • Specify purpose, intent, and impact.

12200 The Safety Plan and the ANE Prevention Plan

In addition to the essential components described above, every IRP shall include a Safety Plan (formerly referred to as the Crisis Plan) and, if needed, an ANE Prevention Plan (formerly referred to as the Safety Plan). Following are descriptions of the Safety Plan and the ANE Prevention Plan to include requirements for each.

12210 The Safety Plan

The Safety Plan focuses on planning for, predicting, and preventing crisis (as identified by the participant, LAR (if applicable), or others involved in the IRP planning process) from occurring. Every participant shall have a Safety Plan. The Safety Plan is part of the IRP and shall be developed during the initial IRP IDT meeting with the participant, LAR (if applicable), and PCRCP participants, and reviewed and updated, at a minimum, during every scheduled update IRP IDT meeting and documented in the clinical record of the participant. In addition, the Safety Plan shall be submitted with the IRP to HHSC for review and approval, in accordance with Section 11000-Individual Recovery Plan. The Safety Plan shall address any identified risk that could place the participant or others in danger of deterioration of mental health, physical harm, or exploitation. Submit a new Safety Plan annually at the time of the annual IRP IDT meeting.

Identification of accessible crisis related services shall be included in the IRP in collaboration with the participant, LAR (if applicable), PA, LMHA/LBHA representative, MCO representative, and/or state hospital social worker (if applicable). This could include stabilization through Medicaid funded crisis or emergency services (outside of the HCBS-AMH), such as mobile crisis outreach services, emergency departments, or psychiatric hospitals and services at the LMHA/LBHA Crisis Services program.

Identify the availability of the RM and alternate RM as part of the safety plan. If the RM is not available to the person 24/7, then an alternative RM contact shall be identified on the team contacts page of the IRP and the safety plan. If the RM is part of an LMHA/LBHA, the RM may also use the LMHA/LBHA Crisis Services program as an alternate contact for the participant. The RM shall coordinate with the LMHA/LBHA to ensure they are notified when a participant accesses the Crisis Services program.

The Safety Plan of a participant shall include:

- Identifying information;
- Emergency contact(s);
- Service providers;
- Cultural and spiritual beliefs;
- Supports that are most helpful to the participant when in a crisis;
- Persons the participant wants contacted or consulted in a crisis; and
- Alternate contact information of qualified person(s) if the RM is not available.

12220 The ANE Prevention Plan

The ANE Prevention Plan (if applicable) focuses on the prevention of risk behaviors and interventions needed for such behaviors. When developing an ANE Prevention Plan, RMs shall ensure the plan meets the expectations of the participant and those involved in Person Centered Recovery Planning (PCRP).

If it is identified that the participant requires an ANE Prevention Plan through review of the HCBS-AMH ANSA and supporting documents, the participant shall be assessed for susceptibility to abuse by others, as well as the risk of the participant of abusing other vulnerable people, in the following areas:

- Physical abuse;
- Mental and/or emotional abuse;
- Sexual abuse;
- Neglect;
- Self-abuse; and
- Financial exploitation.

If a participant is deemed susceptible to abuse or exploitation, as identified above, the RM, PA, participant, LAR (if applicable), and PCRP participants shall:

- Indicate reason(s) the participant is susceptible;
- Identify specific measures to be taken to minimize the risk within the scope of licensed services;

- Identify referrals needed when the participant is susceptible outside the scope or control of the licensed services; and
- Identify entity and process where providers, friends, or family report threats or concerns.

12300 Qualities of Person-Centered Recovery Planning

12310 Identification of Person-Centered Recovery Planning Participants

The RM shall work with the participant, LAR (if applicable), and referring entity in identifying, coordinating, and involving persons identified by the participant in the PCRCP process.

The PCRCP process assesses the strengths and needs of a participant with input from the participant and persons providing services. PCRCP participants shall work to develop, update, and implement the IRP of a participant. In addition to the participant, RM, PA, and the referring entity and/or MCO representatives, PCRCP participants may include the following persons, based on the needs and preferences of the participant:

- Psychologist/psychiatrist;
- Social worker;
- Medical doctor
- Nurse;
- Nutritionist;
- Occupational therapist;
- Physical therapist;
- Residential representative;
- Day program representative;
- Vocational representative or job coach;
- Mental health service providers;
- Friends;

- Family;
- LARs;
- Certified peer specialists (CPSs); and
- Others as identified by the participant.

If the participant is receiving TRR services from an LMHA/LBHA, the RM shall contact the LMHA/LBHA caseworker to coordinate development of the IRP and initiate services. The RM shall provide regular and ongoing updates to the LMHA/LBHA caseworker, while the participant continues to receive TRR services at the LMHA/LBHA.

12320 Qualities of the Process

PCRP requires that the process to develop and update the IRP shall:

- Provide necessary information and support to ensure the participant directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
- Be timely and occur at times and locations of convenience to the participant;
- Reflect cultural considerations of the participant;
- Include strategies for solving conflict or disagreement with the process to include clear conflict of interest guidelines for all planning participants;
- Ensure the choices and preferences of the participant are always honored and considered, if not always granted;
- Offer choices to the participant regarding the services and supports received and from whom;
- Include a method for the participant to request updates to the IRP, as needed; and
- Record the alternative home and community-based settings that were considered by the participant.

12330 Qualities of Person-Centered Recovery Planning

For an IRP to be considered person-centered and not provider-driven, the IRP needs to:

- Be oriented toward promoting recovery rather than minimizing symptoms of illness;
- Be written in clear language that does not use professional jargon;
- Express the goals and aspirations of a participant (in the participant's own words whenever possible);
- Articulate the participant's own role and the role of both paid (formal supports) and natural supports in assisting the participant in achieving their goals;
- Focus and build on the capacities, strengths, and interests of the participant;
- Emphasize the use of natural community settings rather than segregated settings;
- Allow for uncertainty, setbacks, and disagreements as inevitable steps on the path to greater determination;
- Include person-defined goals and realistic objectives that address relevant and immediate barriers and impediments, as well as effective services and interventions; and
- Be "outcome-oriented."

12400 Peer Support in Person-Centered Recovery Planning

Peer support providers are encouraged to be involved in all PCRPs activities, and the RM and other direct service providers are encouraged to work in collaboration with them. CPSs have the unique ability to foster healing relationships and create an environment conducive for recovery with the individual through the sharing of lived experience with mental health, substance use, or both. By building trust and credibility through shared experience, CPSs can bring an authenticity and connectedness to both recovery-oriented transformation work and work with the

individuals who receive the service in a way that traditional providers are not able.

CPSs provide support in advance of or during the PCRP process. This support can:

- Increase the comfort level and participation of the individual;
- Provide practical and meaningful insight, contributing to recovery as a whole; and
- start the planning conversation in advance of the meeting, promoting both quality and efficiency.

Additionally, CPSs can be valuable assets in conflict resolution, assisting in building relationships with the RM and other direct service providers, and advocating for the individual in all areas of recovery.

13000 Provision of Services

HCBS-AMH services shall be provided in accordance with the most recent, approved IRP (See Sections 11000-Individual Recovery Plan and 16000 Settings Requirements for more information). An IRP shall not be authorized without an active UA (ANSA) (See 11000-Individual Recovery Plan for more information). Except for recovery management services, the PA is responsible for the provision of all HCBS-AMH services in quantities detailed on the IRP to include those provided through subcontract arrangements. The RME shall directly provide recovery management services.

All HCBS-AMH services must be provided in the manner outlined in the Medicaid 1915(i) state plan amendment unless otherwise approved by HHSC by means of written communication of approval.

All HCBS-AMH services, non-HCBS-AMH services, and state plan services shall be identified during the PCRP process; however, only services billable to HCBS-AMH shall be reflected on the IRP services section. State plan services, other than HCBS-AMH services, are provided as medically necessary and shall be coordinated with HCBSAMH services. Non-HCBS-AMH services and state plan services shall be identified and listed on the narrative section of the IRP. For more information regarding requirements and standards for HCBS-AMH services, such as documentation requirements, needs-based criteria, rates, units, and billable and non-billable services, see the [HCBS-AMH Billing Guidelines](#).

The PA shall ensure coverage of key positions. In the event of a vacancy of the registered nurse the PA shall inform HHSC in writing of the name(s) and qualifications of individuals who are appointed to serve in an interim and permanent basis to these key positions within five working days of the vacancy. The PA shall also submit evidence of the appointee's qualifications to HHSC.

13100 Telehealth Delivery of Services

Telehealth services enhance community integration by providing more flexibility for participation in community activities. Telehealth services can connect participants to a broad range of services and community resources by removing barriers related to physical distance and expanding provider options thereby increasing participant choice. Telehealth services serve to promote independence and improve patient/provider relationships as services can be provided in individualized preferred settings and provides participants ownership to their own treatment of care, thereby increasing opportunities for engagement on their own schedule. Allowing telehealth services supports community integration by increasing choice and access to multiple providers and community resources in the setting of participants choosing and affording participants equal opportunity to telehealth services as other individuals in the community.

13110 Synchronous Audiovisual Technology

Synchronous audio-visual technology means an interactive, two-way audio and video telecommunications platform that meets the privacy requirements of the Health Insurance Portability and Accountability Act. ^{xii}

The following HCBS-AMH services may be provided by synchronous audiovisual technology if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages an in-person interaction over the use of synchronous audiovisual technology. Providers must document in the participant's IRP the reason(s) why services were delivered by synchronous audio-visual technology.

HCBS-AMH services provided by synchronous audiovisual technology must be billed using modifier 95.

- HCBS Psychosocial Rehabilitation Services Individual
- HCBS Psychosocial Rehabilitation Services Group
- Community Psychiatric Supports and Treatment
- Employment Services Supported Employment
- Employment Services Employment Assistance
- HCBS-AMH Recovery Management
- Nursing registered Nurse (RN)*
- Nursing Licensed Vocational Nurse (LVN)*

HCBS-AMH providers must refer to the Texas Medicaid Provider Procedures Manual, Behavioral Health and Case Management Handbook Section 9, "Substance Use Disorder Services" and Section 6, "Peer Specialist Services" for the below HCBS-AMH services:

- Substance Use Disorder Services Assessment
- Substance Use Disorder Services Individual
 - Important note: Chemical Dependency Treatment Facilities (CDTF) and Opioid Treatment Program (OTP) must comply with all applicable rules relating to telehealth services.

- Substance Use Disorder Services Group
- Peer Support

*HCBS-AMH providers may deliver nursing care via telenursing if the nature of the care does not require in person contact. Direct care nursing services, such as wound care, blood draws, and essential (non-routine) blood pressure monitoring, should continue to be provided in person when indicated as appropriate. Telenursing is permitted under the Texas Nursing Practice Act and [Texas Board of Nursing](#) rules. xⁱⁱⁱ

13120 Synchronous Telephone (Audio-Only) Technology

Synchronous, audio-only, including telephone technology, means an interactive, two-way audio telecommunications platform that uses only sound and meets the privacy requirements of the Health Insurance Portability and Accountability Act. xⁱⁱ

The following HCBS-AMH services may be provided by synchronous telephone (audio-only) technology to persons with whom the treating provider has an existing clinical relationship as defined below, and, if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology. Providers must document in the person’s medical record the reason(s) why services were delivered by synchronous telephone (audio-only) technology.

HCBS-AMH services provided by synchronous telephone (audio-only) technology must be billed using modifier FQ.

- HCBS Psychosocial Rehabilitation Services Individual
- Community Psychiatric Supports and Treatment
- Employment Services Supported Employment
- Employment Services Employment Assistance
- HCBS-AMH Recovery Management
- Nursing registered Nurse (RN)*
- Nursing Licensed Vocational Nurse (LVN)*

HCBS-AMH providers must refer to the [Texas Medicaid Provider Procedures Manual](#), Behavioral Health and Case Management Handbook Section 9, “Substance Use Disorder Services” and Section 6, “Peer Specialist Services” for the below HCBS-AMH services:

- H0004 – Substance Use Disorder Services Individual
 - Important note: Chemical Dependency Treatment Facilities (CDTF) and Opioid Treatment Program (OTP) must comply with all applicable rules relating to telehealth services.
- H0038 – Peer Support

*HCBS-AMH providers may deliver nursing care via telenursing if the nature of the care does not require in person contact. Direct care nursing services, such as wound care, blood draws, and essential (non-routine) blood pressure monitoring, should continue to be provided in person when indicated as appropriate. Telenursing is permitted under

the Texas Nursing Practice Act and [Texas Board of Nursing](#) rules. xⁱⁱⁱ

13130 Telehealth Delivery of Service Limitations

Audio-visual or audio-only options are not to be used 100% of the time. All HCBS-AMH participants will receive at least one in-person visit during each IRP period for each service type. HIPAA compliance remains the responsibility of the HCBS-AMH provider delivering the services. In order to ensure the privacy of individuals is respected, HCBS-AMH providers will be required to sign and submit an attestation form developed by HHSC that ensures they maintain service delivery in a private space. In addition, contracted providers will ensure, through verbal confirmation, each participant is in a private and safe space.

13140 Existing Clinical Relationship

An existing clinical relationship occurs when a person has received at least one in-person or synchronous audiovisual HCBS-AMH service for each service type within the IRP period prior to the initial service delivered by synchronous telephone (audio-only) technology. The IRP period requirement for at least one in-person or synchronous audiovisual service of the same type prior to the initial synchronous telephone (audio-only) service may not be waived.

HCBS-AMH providers may refer to the [Texas Medicaid Provider Procedures Manual](#), Behavioral Health and Case Management Handbook for more information on Telemedicine and Telehealth Services or reach out to HCBS-AMH.Services@hhs.texas.gov.

13200 Description of Service Provision

1 Adaptive Aids

Adaptive aids are available only after benefits available through Medicare, other Medicaid benefits, or other third-party resources have been documented as exhausted. Adaptive aids are limited to vehicle modifications, service animals and supplies, environmental adaptations, and aids for daily living, such as researchers, adapted utensils, certain types of lifts, pill keepers, reminder devices, signs, calendars, planners, and storage devices. Other items may be included if specifically required to realize a goal specified in the IRP and previously approved by HHSC.

Items over \$500.00 must be recommended in writing by a service provider qualified to assess the need for the specific adaptive aid and be previously approved by HHSC. For more information on additional items that may be billed under this service or requirements of the written recommendation (see the [HCBS-AMH Billing Guidelines](#) for specific components).

2 Assisted Living Services

Assisted living services foster recovery and independence by providing personal care, homemaker, and chore services; medication oversight; and therapeutic, social, and recreational programming provided in a home-like environment in a licensed assisted living facility. 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 persons or agencies may also furnish care directly or under arrangement with the community setting, but the services provided by other entities supplement, rather than supplant, that provided by the community setting.

Only persons 18 and older may reside in a setting in which supervised living services or assisted living services are provided.

Participants shall have the freedom and support to control their own schedules and activities; access at any time to food including access to a kitchen/kitchenette and/or living room; be able to have visitors at any time of their choosing; the freedom to furnish and decorate units; and access at any time to the common, shared areas, including kitchens, living rooms, and activity centers. Assisted living services shall not be provided in a setting where the participants would not have a reasonable expectation of privacy.

Assisted living services are furnished to participants who reside in their own living units, which may include dually occupied units when both occupants consent to the arrangement, contain bedrooms and toilet facilities, and may or may not include kitchenette and/or living rooms. The assisted living setting shall have a central dining room, living room or parlor, and common activity center(s), which may also serve as living rooms or dining rooms.

Participants in assisted living settings where units do not have a private kitchen/kitchenette and/or living room or parlor, shall have full access to a shared kitchen with cooking facilities and comfortable seating in the shared areas for private visits with family and friends.

Assisted living services are inclusive of assisting participants in acquiring, retaining, and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor, mobility, personal adjustment, relationship development, use of community resources, and adaptive skills necessary to reside successfully in home and community-based settings. As needed, this service may also include assistance in promoting positive social interactions, as well as services to instruct participants in accessing and using community resources. These resources include transportation, translation, and communication assistance related to the IRP goals and services to assist the participant in shopping, and other necessary activities of community and civic life, including self-advocacy. Assistance with ADLs and instrumental activities of daily

living (IADLs) are included.

The following standards apply to HCBS-AMH participants:

- Participants have a right to privacy;
- Participant rooms may be locked at the discretion of the participant, with keys available only to appropriate staff or landlords, as identified on the IRP;
- Each living unit is separate and distinct from each other;
- Participants retain the right to assume risk, tempered only by their ability to assume responsibility for that risk;
- Service provision shall foster the independence of each participant;
- Routines of service delivery shall be person-driven; and
- Any variations or modifications from the standards shall be documented in the IRP using the modification form (See Section 7700-Deviations from Service Standards for more information).

It is recommended that assisted living homes have an unexpired Narcan administration kit and housing staff be trained on Narcan administration prior to participants moving into home. See Appendix A for a link to training and how to order Narcan kits free of charge.

Residential services are provided to persons in settings licensed or certified by the State of Texas or designated representative using [Form 8201](#), HCBS-AMH Recovery Manager Settings Check | Texas Health and Human Services. Residential services are necessary, as specified in the IRP of the participant, to enable the participant to remain integrated in the community and ensure the health, welfare, and safety of the participant, in accordance with 42 CFR §441.710.

3 Community Psychiatric Supports and Treatment

CPST address specific needs of a participant with evidence-based and evidence informed psychotherapeutic practices designed specifically to meet those needs. Examples include:

- Cognitive adaptation training (CAT);
- Cognitive behavioral therapy (CBT);
- Cognitive processing therapy (CPT); and
- • Dialectical behaviortherapy (DBT).

CPST is provided face-to-face with the participant physically present; however, family or other persons significant to the participant may also be involved (see the [HCBSAMH Billing Guidelines](#) for specific components).

See Section 13100 Telehealth Delivery of Services for more information on using audio-visual and audio-only delivery for this service.

4 Employment Services

Employment services shall follow evidence-based or evidence-informed practices approved by HHSC (See Section 14000-Provider Training and Resources for allowable protocols and required trainings). Providers shall document that services are not available from a program funded under Section 110 of the Rehabilitation Act of 1973, relating to vocational rehabilitation services or the Persons with Disabilities Education Act (20 U.S.C. 1401 et seq.) relating to special education.

Employment services shall:

- Focus on the strengths and preferences of a participant;
- Promote recovery and wellness by enabling participants to engage in work that is meaningful to them and be compensated at a level equal to or greater than persons without SMI or other disabilities, i.e. Competitive employment;
- Include systematic job development based on the interests of the participant, i.e. developing relationships with local employers by making systematic contacts;
- Not be for job placements paying below minimum wage;
- Be delivered in a manner that supports and respects the communication needs of the participant, to include translation services and assistance with, and use of, communication devices; and
- not supplant existing resources, such as state vocational rehabilitation programs available to the participant.

Employment services shall be used for a participant to gain work-related experience considered crucial for job placement, e.g., unpaid internship, only if such experience is vital to the participant to achieve their vocational goal. Employment services shall be individualized and extended, as needed, to assist the participant in attaining and maintaining meaningful work.

Services shall be 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. In addition, services shall 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:

- Payments that are passed through to the participant;
- Payments for supervision, training, support, and adaptations typically available to other workers without disabilities filling similar positions in the business;
- Incentive payments made to an employer to encourage hiring the participant; or
- Payments used to defray the expenses associated with starting up or operating a business.

Services shall be coordinated within the context of the IRP, which delineates how employment services are intended to achieve the identified goals and objectives of the participant.

Documentation of employment services shall be made available to HHSC and to the RM for continuous monitoring. At a minimum, the RM shall monitor this service on a quarterly basis to assess if objectives and outcomes are met. Progress, or lack thereof, shall be detailed on the IRP.

See Section 13100 Telehealth Delivery of Services for more information on using audio-visual and audio-only delivery for this service.

A. Supported Employment

Supported employment includes adaptations, assistance, and training essential for participants to sustain paid employment at or above the minimum wages and benefits provided to non-disabled workers performing similar jobs. Supported employment is only billable for participants who are currently employed (see the [HCBS-AMH Billing Guidelines](#) for specific components).

B. Employment Assistance

Employment assistance helps participants in locating and maintaining paid employment in the community; including activities on behalf of a participant to assist in maintaining their continuous employment. Employment assistance is only billable for participants not currently employed (see the [HCBS-AMH Billing Guidelines](#) for specific components).

5 Flexible Funds

Flexible funds are monies that are used for supports that augment existing program services and are documented on the IRP. Flexible funds exist to reduce symptomatology and maintain quality of life and community integration. These funds shall be used on a temporary basis with prior authorization from HHSC. HHSC reserves the right to discontinue flexible funds with a 30-day notice. All services provided with flexible funds shall be identified on the IRP for review and prior approval by HHSC.

Flexible funds are reserved for indigent persons and shall only be used in accordance with the following guidelines:

- Enhanced observation needs, i.e. enhanced supervised living;
- Temporary psychiatric hospitalization;
- Medication related expenses;
 - Upon request, providers must provide documentation that all other local and community resources have been exhausted, including but not limited to, city, county, or other state medical/medication programs, discount medication programs, and assistance available through healthcare.gov; and
- Room and board.

HHSC shall review requests for flexible funds before approving to ensure the indicated service does not fall within the scope of the HCBS-AMH service array (see the [HCBSAMH Billing Guidelines](#) for specific components).

6 Home Delivered Meals

Home delivered meals services provide a nutritionally sound meal that is delivered to the home of the participant. Each meal shall provide a minimum of one-third of the current recommended dietary allowance for the participant, as adopted by the United States Department of Agriculture; however, the meals shall not constitute a full nutritional regimen.

The service is coordinated within the context of the IRP. The participant has met needs-based criteria for home delivered meals if they:

- Are unable to prepare meals on a regular basis without assistance;
- Do not have access to alternate resources for the provision of the meal provided by this service; and
- Do not have natural supports who are available, willing, and able to provide meal preparation services.

The provider shall comply, during all stages of food service operation, with applicable federal, state, and local regulations, codes, and licenser requirements relating to fire, health, sanitation, safety, building, and other provisions relating to the public health, safety, and welfare of meal patrons.

Foods shall be prepared, served, and transported:

- With the least possible manual contact;
- With suitable utensils;
- On surfaces that have been cleaned, rinsed, and sanitized to prevent cross contamination prior to use; and
- In disposable, sealed containers.

Meals may be hot, cold, frozen, dried, or canned with a satisfactory storage life.

Providers shall demonstrate that menu standards are developed to sustain and improve the health of the participant through the provision of safe and nutritious meals that are approved by a dietician.

All providers shall have a safety plan to ensure participants receive meals during emergencies, weather-related conditions, and natural disasters. Plans may include shelf-stable emergency meal packages, four-wheel drive vehicles, and volunteer arrangements with other community resources.

The RM shall be notified if a meal is not delivered to a participant for any reason. Notification shall be made prior to the scheduled meal and no longer than four hours after the meal was to be received by the participant. An occurrence of a non-delivered meal shall be updated in progress notes.

Providers shall deliver in-person, whereby a paid staff or volunteer delivers the meal to the home of the participant. To the extent possible, staff or volunteers shall report any changes in the condition of the participant, or any other concerns, to the RM of the participant. (see the [HCBS-AMH Billing Guidelines](#) for specific components).

7 Host Home/Companion Care

Host home/companion care is provided in a private residence that meets HCBS-AMH requirements and by a host home or companion care provider who lives in the residence. Type and frequency of supervision is determined individually and is based on the level of need of the participant.

In a host home arrangement, the host home provider owns or leases the residence; whereas, 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 participant. The service is inclusive of assisting participants in acquiring, retaining, and improving skills, such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive, necessary to reside successfully in home and community-based settings. As needed, this service may also include assistance in promoting positive social interactions, as well as services to instruct participants in accessing and using community resources. These resources may include transportation, translation, and communication assistance related to the goals of the IRP, as well as services to assist the participant in shopping and other necessary activities of community and civic life to include self-advocacy. Assistance with ADLs and IADLs is included.

No more than three HCBS-AMH participants may live in the host home/companion care arrangement. A family member, court-appointed guardian, or LAR is eligible to provide this service if they meet the necessary provider requirements. The spouse of the participant is not eligible to provide host/home companion care services. A family member, court appointed guardian, or LAR who provides host/home companion care services is not eligible to receive HCBS-AMH respite services (See Section 13000 Provision of Services for more information).

The following standards apply to HCBS-AMH participants:

- Participants have a right to privacy;
- Participant rooms may be locked at the discretion of the participant, with keys available only to appropriate staff or landlords, as identified on the IRP;
- Each living unit is separate and distinct from each other;
- Participants retain the right to assume risk, tempered only by their ability to assume responsibility for that risk;
- Service provision shall foster the independence of each participant;
- Routines of service delivery shall be person-driven; and
- Any variations or modifications from the standards shall be documented in the IRP using the modification form (See Section 11700-Deviations from

Service Standards).

Residential services are necessary, as specified in the IRP of a participant, to enable the participant to remain integrated in the community and ensure the health, welfare, and safety of the participant, in accordance with 42 CFR §441.710. (see the [HCBSAMH Billing Guidelines](#) for specific components).

8 Minor Home Modifications

All minor home modifications shall be provided in accordance with applicable state or local building codes. The PA shall 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.

Minor home modifications shall be necessary to address specific functional limitations, as documented in the IRP, and shall be previously approved by HHSC. Items costing over \$1000.00 shall be recommended in writing by a services provider qualified to assess the need for the specific adaptive aid and be previously approved by HHSC (see the [HCBS-AMH Billing Guidelines](#) for specific components).

9 Nursing

Nursing services shall be provided only after benefits available through Medicare, Medicaid, or other third-party resources have been exhausted or are not applicable, including home health benefits. Nursing 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 other state plan nursing services (See [HCBS-AMH Billing Guidelines](#) for billable components). Nursing services provide treatment and monitoring of health care procedures prescribed by a physician or medical practitioner, or as required by standards of professional practice or state law to be performed by licensed nursing personnel.

Nursing providers shall comply with all nursing delegations in accordance with 22 TAC, Part 11, Chapter 225, to include Delegation Criteria §225.9 and tasks that may be delegated §225.10. These criteria shall be met prior to the delegation of nursing tasks to unlicensed persons by a registered nurse and apply to all instances of delegation by the registered nurse.

Nursing services shall be coordinated within the context of the IRP which delineates how nursing services are intended to achieve the identified goals and objectives of the participant.

The registered nurse shall provide monitoring, supervision and take active steps to ensure that participants have needed medications and receive necessary

medical and psychiatric care. (see the [HCBS-AMH Billing Guidelines](#) for specific components).

See Section 13100 Telehealth Delivery of Services for more information on using audio-visual and audio-only delivery for this service.

10 Peer Support

Peer support services are recovery-focused services provided by CPSs who are in recovery from mental health, SUDs, or both. Peer support services promote development of skills for coping with symptoms of SMI and SUDs, which includes the identification and development of natural supports and strengths.

CPSs use their own experiences with mental health challenges, SUDs, or another cooccurring disorder, such as a chronic health condition, to help participants reach their goals.

Peer support services include:

- Helping participants make new friends and begin to build alternative social networks;
- Promoting coping skills;
- Facilitating the use of natural resources and supports;
- Enhancing recovery-oriented attributes, such as hope and self-efficacy;
- Assisting participants with tasks, such as setting recovery goals, developing recovery action plans and solving problems directly related to recovery, including finding housing; finding new uses of spare time and improving one's job skills;
- Assisting with issues that arise in connection with collateral problems, such as having a criminal justice record or coexisting physical or mental challenges;
- Helping participants navigate the formal treatment system, advocating for their access and gaining admittance, as well as facilitating discharge planning, typically in collaboration with treatment staff;
- Encouraging participation in mutual aid groups in the community;
- Facilitating participation in educational opportunities; and
- Developing links to resources that address specialized needs, such as agencies providing services related to HIV infection or aids, mental health disorders, chronic and acute health problems, parenting young children, and problems stemming from involvement with the criminal justice system.

Peer support services shall be coordinated within the context of the IRP, which delineates how peer support services are intended to achieve the identified goals and objectives of the participant. Peer support services are intended to assist participants in achieving and maintaining long-term recovery and are not intended to supplant or substitute for natural supports (see the [HCBS-AMH Billing Guidelines](#) for specific components).

See Section 13100 Telehealth Delivery of Services for more information on using audio-visual and audio-only delivery for this service.

11 HCBS-AMH Psychosocial Rehabilitation

Provision of HCBS-AMH psychosocial rehabilitation (PSR) services shall be intended to achieve the identified goals or objectives as set forth in the participant's IRP (See HCBS-AMH Billing Guidelines for billable components). PSR services consist of rehabilitative skill building, personal development of environmental and recovery supports considered essential in improving the functioning of the participant, learning skills to promote the individual's self-access to necessary services, and creating environments that promote recovery and support the emotional and functional improvement of the participant.

The service activities of PSR include:

- Providing skills support in the participant's self-articulation of personal goals and objectives;
- Assisting the participant in the development of skills to self-manage or prevent crisis situations;
- Individualized interventions in living, learning, working, and other social environments, which shall have as objectives: ◀ Identifying, with the participant, strengths that may aid in achieving recovery, as well as barriers that impede the development of skills necessary for functioning in work, with peers, and with family and friends;
- Supporting skills development to build natural supports including support and assistance with defining what wellness means to the participant to assist in recovery-based goal setting and attainment;
- ▶ Assisting in the development of interpersonal, community coping, and functional skills that may include adaptation to home, adaptation to work, adaptation to healthy social environments, and learning and practicing skills such as personal financial management, medication self-monitoring, and symptom self-monitoring;

- Assisting in the acquisition of skills for the participant to self-recognize emotional triggers and to self-manage behaviors related to the behavioral health issue;
- Assisting with personal development, work performance, and functioning in social and family environments through teaching skills and strategies to reduce the effect of behavioral health symptoms;
- Assisting in enhancing social and coping skills that reduce life stresses resulting from the participant's mental illness and/or addiction;
- Assisting the participant in gaining access to necessary rehabilitative, medical, social, and other services and supports;
- Assisting the participant and other supporting natural resources with illness understanding and self-management, including medication self-monitoring; and
- Identifying, with the participant and named natural supporters, indicators related to substance related disorder relapse and the development of skills and strategies to prevent relapse.

PSR is provided to promote stability and build towards functioning in the daily environment of the participant. Stability is measured by a decrease in the number of hospitalizations and frequency and duration of crisis episodes; and by an increase and/or stable participation in community and/or work activities. Supports based on the needs of the participant are used to promote recovery while understanding the effects of the mental illness and/or substance use and to promote functioning.

Skills include:

- Illness/recovery management;
- Self-care;
- ADLs;
- IADLs; and
- Additional services that assist the participant in reintegrating into the community. The modality used for the provision of PSR shall be approved by HHSC. A variety of evidence-based practices may be used as appropriate to the needs, interests, and goals of the participant. Approved protocols include:
 - CAT;
 - Illness Management and Recovery; and
 - Seeking Safety.

See Section 13100 Telehealth Delivery of Services for more information on using audio-visual and audio-only delivery for this service.

12 Recovery Management

Recovery management services include assisting beneficiaries in gaining access to needed Medicaid state plan and HCBS-AMH services, as well as medical, social, educational, and other resources, regardless of funding source (See HCBS-AMH Billing Guidelines for billable components). The role of RMs in the provision of recovery management services is to coordinate and monitor the provision of HCBS-AMH services and link to and advocate for access to needed services (See Sections 5200 Roles and Responsibilities of the Recovery Management Entity and 5210-Roles and Responsibilities of the Recovery Manager for more information). This can include transporting a participant for activities related to goals listed on the IRP.

See Section 13100 Telehealth Delivery of Services for more information on using audio-visual and audio-only delivery for this service.

It is recommended that RMs have an unexpired Narcan administration kit available and easily accessible when meeting with participants in the community in case of participant overdose. See Appendix A for information on how to administer Narcan and how to order kits free of charge. (see the [HCBS-AMH Billing Guidelines](#) for specific components)

Types of Recovery Management Services

Recovery Management Transitional Fee - provided for the first 90 days of enrollment to a participant who is residing in a state hospital at the time of enrollment.

Recovery Management Transitional Day Rate - provided after 90 days of enrollment but less than 180 days after enrollment to a participant who is residing in a state hospital at the time of enrollment.

HCBS-AMH Recovery Management Services– Regular RM service.

A. Recovery Management Conversion Services

Recovery management conversion services are provided prior to enrollment of an individual in the program from a nursing home, or another home and community based services program. The RM shall work with the individual's team and MCO service coordinator, or case manager (as applicable) to ensure a smooth transition into HCBS-AMH. Additionally, for those individuals residing in a nursing facility, the RM shall work with nursing facility staff, MCOs, and community providers to help the individual discharge from these institutions and move into the community. During this time, an IRP is completed so that services begin immediately on the first day of HCBS-AMH enrollment. (see the [HCBS-AMH Billing Guidelines](#) for specific components).

13 Respite Care

Respite care is provided for the planned or emergency short-term relief for natural, unpaid caregivers. Respite care is provided intermittently when the natural caregiver is temporarily unavailable to provide supports.

Other services indicated on the IRP may be provided during the period of respite, if not duplicative of, or integral to, services that can be reimbursable as respite or otherwise excluded by the HCBS-AMH Billing Guidelines. In-home respite services must comply with electronic visit verification requirements. For the latest information, go to [Electronic Visit Verification](#).

The PA shall ensure respite care is provided in accordance with the IRP of the participant.

In-home respite shall be provided in the home or place of residence of the participant or in the home of a family member or friend. Out-of-home respite can be provided in the following locations:

- Adult foster care home;
- 24-hour residential habilitation home;
- Licensed assisted living facilities; and • Licensed nursing facilities.

The number of individuals in a respite setting shall be in accordance with associated licensure (if applicable) or other standards and account for the individualized needs of every individual. (see the [HCBS-AMH Billing Guidelines](#) for specific components).

14 Substance Use Disorder

SUD services are specialized to meet the needs of participants who have experienced substance use issues.

SUD services shall be addressed on the IRP when substance use issues are indicated on the Nursing Assessment (See Section 21370 Required Health and Nursing Documentation) and/or the most recent UA (ANSA). If the participant does not wish to receive SUD services, the RM shall document that services were discussed with the participant and note that the RM will continue to monitor for future need. SUD services assist the participant in achieving specific recovery goals and objectives identified in the IRP and in preventing relapse. SUD services are provided using a team approach with other services, such as peer support.

Participants shall exhaust other state plan SUD benefits before choosing the program SUD benefit, unless other state plan benefits are not appropriate to meet the needs, limitations, and recovery goals of the participant, as determined by the independent evaluation, e.g., severe cognitive or social functioning limitations or a mental disability.

SUD services shall follow evidence-based or evidence-informed treatment modalities approved by HHSC and shall only be used when other state plan SUD services are exhausted or not appropriate. SUD services may include the following:

- Assessment;
- Outpatient group counseling; and
- Individual counseling.

SUD services follow evidence-based or evidence-informed treatment modalities approved by HHSC which may include:

- Motivational interviewing;
- Individual, group, and family counseling;
- Psychoeducation;
- Medication management;
- Harm reduction; and • Relapse prevention.

SUD services may be provided in a group setting if identified as clinically appropriate by the PCRCP participants and in accordance with the participant's approved IRP. (see the [HCBS-AMH Billing Guidelines](#) for specific components).

See Section 13100 Telehealth Delivery of Services for more information on using audio-visual and audio-only delivery for this service.

A. Substance Use Disorder Assessment

An integrated assessment shall be conducted to consider relevant past and current medical, psychiatric, and substance use information, including (see the [HCBS-AMH Billing Guidelines](#) for specific components):

- Information from the participant and LAR (if applicable) on the behalf of the participant regarding the strengths, needs, natural supports, and responsiveness to previous treatment of the participant, as well as preferences for, and objections to, specific treatments;
- Needs and desire of the participant for family member involvement in treatment and services if the participant is an adult without an LAR; and
- Recommendations and conclusions regarding treatment needs and eligibility for services for participants.

15 Supervised Living

Supervised living services provide residential assistance, as needed, by persons who live in the residence in which the PA holds a property interest and that meet HCBSAMH certification standards. Providers of this service are not required to be awake during normal sleeping hours but shall be present in the residence and able to respond to the needs of the participant during normal sleeping hours. Provider agencies must ensure all supervised living settings always have a ratio of no more than four residents for every one staff in each home. The required ratio of 4:1 includes everyone in the household, including residents who are not enrolled in the HCBS-AMH program. (see the [HCBS-AMH Billing Guidelines](#) for specific components).

It is recommended that all supervised living homes have an unexpired Narcan administration kit and housing staff be trained on Narcan administration prior to participants moving into home. See Appendix A for link to training and how to order Narcan kits free of charge.

Only persons 18 and older may reside in a setting in which supervised living services or assisted living services are provided:

Supervised living services are inclusive of assisting participants in acquiring, retaining and improving skills, such as communication, independent living skills

(medication administration and self-administration of medication, household management, cooking and nutrition, budgeting and shopping to include the capacity to possess and store their own money in a manner that is secure, use of transportation, healthy living, employment related skills, and social and interpersonal skills development to include interventions identified in the IPR), personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside successfully in home and community-based settings. As needed, this service may also include assistance in promoting positive social interactions, as well as services to instruct participants in accessing and using community resources. These resources include transportation, translation, and communication assistance related to the IRP goals and services to assist the participant in shopping and other necessary activities of community and civic life, including self-advocacy. Assistance with ADLs and IADLs is included.

The following standards apply to HCBS-AMH participants:

- Participants have a right to privacy;
- Participant rooms may be locked at the discretion of the participant, with keys available only to appropriate staff or landlords, as identified on the IRP;
- Each living unit is separate and distinct from each other;
- Participants retain the right to assume risk, tempered only by their ability to assume responsibility for that risk;
- Service provision shall foster the independence of each participant;
- Routines of service delivery shall be person-driven;
- Staff shall be available in the residence 24 hours a day, 7 days a week; and Any variations or modifications from the standards shall be documented in the IRP using the modification form (See Section 11700-Deviations from Services Standard for more information).

16 Supported Home Living

Supported home living services are provided to participants residing in their own home or in their family residence. The service includes activities that facilitate inclusion of the participant 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.

Supported home living services provided to participants residing with family members is designed to support, rather than supplant, the family and natural supports.

Supported home living services are inclusive of assisting participants in acquiring,

retaining, and improving skills, such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside successfully in home and community-based settings. As needed, this service may also include assistance in promoting positive social interactions, as well as services to instruct participants in accessing and using community resources. These resources may include transportation, translation and communication assistance related to the IRP goals and services to assist the participant in shopping and other necessary activities of community and civic life, including self-advocacy. Assistance with ADLs and IADLs is included.

The following standards apply to HCBS-AMH participants:

- Participants have a right to privacy;
- Participant rooms may be locked at the discretion of the participant, with keys available only to appropriate staff or landlords, as identified on the IRP;
- Each living unit is separate and distinct from each other;
- Participants retain the right to assume risk, tempered only by their ability to assume responsibility for that risk;
- Service provision shall foster the independence of each participant;
- Routines of service delivery shall be person-driven; and
- Any variations or modifications from the standards shall be documented in the IRP using the modification form (See Section 11700-Deviations from Service Standards for more information).

Residential services are necessary, as specified in the IRP of the participant, to enable the participant to remain integrated in the community and ensure the health, welfare, and safety of the participant, in accordance with 42 CFR §441.710. Supported Home Living must comply with electronic visit verification protocols. For the latest information, go to [Electronic Visit Verification](#).

Residential services are provided to persons in settings licensed or certified by the State of Texas or designated representative using HHS Form 8201, [HCBS-AMH Recovery Manager Settings Check](#) | Texas Health and Human Services.

Residential services are necessary, as specified in the IRP of the participant, to enable the participant to remain integrated in the community and ensure the health, welfare and safety of the participant, in accordance with 42 CFR §441.710. (see the [HCBS-AMH Billing Guidelines](#) for specific components).

17 Transition Assistance

Transition Assistance Services 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;
- Services necessary for the health and welfare of a participant, 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).

18 Transportation

Program transportation services are for non-emergency transportation that enables participants to gain access to services, activities, and resources. The service does not duplicate transportation provided as part of other program services or under the state plan medical transportation benefit.

Transportation is not billable for medical appointments that can be covered by the Medicaid transportation benefit, travel to and from a day habilitation service facility, or transportation required to meet a participant's ADL. The service shall be provided in support of the recovery goals of the participant, as identified in the IRP, and in accordance with HCBS-AMH policies, procedures, and billing guidelines (see the [HCBS-AMH Billing Guidelines](#) for specific components).

Transportation of participants shall be provided in accordance with applicable state laws, and providers transporting participants shall have a valid Texas driver license and proof of automobile insurance (See Section 13300-Description of Provider Qualifications for more information). Transportation is not billable for Rideshares.

13300 Description of Provider Qualifications

Providers shall ensure all employed or subcontracted direct service staff meet necessary credentialing and licensure requirements, as listed below, and complete initial and periodic trainings, as indicated in section 14100 Training Requirements. In addition, providers shall ensure residential settings meet relevant state and local requirements, and transportation of participants is provided in accordance with applicable state laws.

1 Adaptive Aids

PAs shall employ or contract with adaptive aid providers. Adaptive aid providers and their employees shall comply with all applicable laws and regulations for the provision of adaptive aids.

2 Assisted Living

Direct service providers of assisted living services shall meet and comply with the following qualifications and requirements:

- Be at least 18 years of age;
- Have a high school diploma, Certificate of High School Equivalency (General Equivalency Diploma [GED] credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including the ability to provide the required services as needed by the participant to be served as demonstrated through a written competency-based assessment; 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 participant(s) to be served;
- Assist with tasks delegated by an RN in accordance with state law;
- Maintain a valid Texas driver license and proof of automobile insurance; and
- Pass a fingerprint-based criminal background check and applicable HHSC registry checks.

3 Community Psychiatric Supports and Treatment

Direct service providers of CPST shall meet and comply with the following qualifications and requirements:

- Be at least 18 years of age;
- Be a Licensed Practitioner of the Healing Arts;
- Be trained, credentialed, and demonstrate competence in the specialized evidence-based practice in use; and
- Pass a fingerprint-based criminal background check and applicable HHSC registry checks.

If a direct service provider does not have competence in the specialized psychotherapy, the provider may provide psychotherapy under the supervision of a fully licensed clinician who meets the criteria to be a Licensed Practitioner of the Healing Arts and meets the supervisor requirements as outlined by the evidence based practice. Clinical licensure candidates (providers holding a current Licensed

Master Social Worker, Licensed Professional Counselor-Associate, Licensed Marriage and Family Therapist – Associate) may provide CPST services under the clinical supervision of a Texas Behavioral Health Executive Council- approved supervisor, in accordance with applicable licensing standards and rules of practice (§781.302; §681.91; §801.42).

4 Employment Services

Direct service providers of employment services shall meet and comply with the following qualifications and requirements:

- Be 18 years of age or older;
- Meet one of the following:
 - Have a bachelor’s degree in rehabilitation, business, marketing, or a related human services field, and one year of paid or unpaid experience providing employment services to individuals with disabilities;
 - Have an associate degree in rehabilitation, business, marketing, or a related human services field, and two years of paid or unpaid experience providing employment services to individuals with disabilities; or
 - Have a high school diploma or Certificate of High School Equivalency (GED credentials) and three years of paid or unpaid experience providing employment services to individuals with disabilities; and
- Pass a fingerprint-based criminal background check and applicable HHSC registry checks.

5 Home Delivered Meals

PAs shall employ or contract with home delivered meal providers. Home delivered meal providers shall follow procedures and maintain facilities that comply with all applicable state and local laws and regulations related to fire, health, sanitation, and safety, as well as food preparation, handling, and serving activities.

All staff and volunteers involved in food preparation shall be trained in:

- Portion control;
- FDA food code practices for sanitary handling of food;
- Texas food safety requirements; and
- Agency safety policies and procedures.

All staff and volunteers having direct contact with a participant shall be trained in:

- Protecting confidentiality;
- How to report concerns, such as change of condition, self-neglect, and abuse, to appropriate staff for follow-up; and
- When to report to the RM any persons considered high risk as a result of the nutrition risk assessment.

6 Host/Home Companion Care

Direct service providers of host/home companion care services shall meet and comply with the following qualifications and requirements:

- Be at least 18 years of age;
- Have a high school diploma, Certificate of High School Equivalency (GED credentials), or documentation of a proficiency evaluation of experience and competence to perform job tasks including the ability to provide the required services as needed by the participant to be served, as demonstrated through a written competency-based assessment;
- 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 participant(s) to be served;
- Assist with tasks delegated by an RN in accordance with state law;
- Maintain a valid Texas driver license and proof of automobile insurance (if transporting a participant); and
- Pass a fingerprint-based criminal background check and applicable HHSC registry checks.

7 Minor Home Modifications

Direct service providers of minor home modifications shall meet and comply with applicable laws and regulations for the provision of the approved minor home modification and ensure qualified building contractors provide modifications in accordance with applicable state and local building codes and other regulations. Requirements include:

- Type of allowed modifications;
- Time frames for completion;
- Specifications for modifications;
- Inspections of modifications; and
- Follow-up on the completion of modifications.

8 Nursing

Direct service providers of nursing services shall meet and comply with the following qualifications and requirements:

- Be 18 years of age or older;
- Maintain an RN license or licensed vocational nurse license under the supervision of an appropriate Clinical Supervisor RN who is registered to practice in the state or otherwise authorized to practice in Texas under the Nurse Licensure Compact; and
- Pass a fingerprint-based criminal background check and applicable HHSC registry checks.

9 Peer Support

Direct service providers of peer support services shall meet and comply with the following qualifications and requirements:

- Be 18 years of age or older;
- Be recognized under an HHSC-approved process for peer specialists;
- Maintain an HHSC approved certification for mental health or SUD peer specialists;
- Have lived experience;
- Have a high school diploma or GED;
- Be willing to appropriately share their own recovery story with recipients;
- Be able to demonstrate current self-directed recovery; and
- Pass a fingerprint-based criminal background check and applicable HHSC registry checks.

10 HCBS-AMH Psychosocial Rehabilitation Services

Direct service providers of PSR services shall meet and comply with the following qualifications and requirements:

- Be 18 years of age or older;

- Be qualified and demonstrate competency and fidelity to the evidence-based practices used;
- Be supervised by a licensed clinician trained and certified in the evidence-based practice;
- Have a bachelor’s degree in psychology or a related field;
- Have the level of education and experience required by the evidence-based modality employed;
- Have HHSC-approved training or certification in the evidence-based practice; and
- Pass a fingerprint-based criminal background check and applicable HHSC registry checks.

11 Recovery Management

Direct service providers of recovery management services shall meet and comply with the following qualifications and requirements:

- Be 18 years of age or older;
- Have at least two years of experience working with individuals with SMI;
- Have a master’s degree in a human services or related field;
 - The requirement to have a master’s degree may be waived if HHSC determines that waiver is necessary to provide access to care for Medicaid recipients
 - ◇ To request a waiver please submit an email request to MHContracts@hhsc.state.tx.us and HCBS-AMH-RM-IRP-PA@hhs.texas.gov and include “RM Requirements Waiver Request” in the subject line. A completed Form 8200 – Recovery Manager Education Requirement Waiver Request shall be included in the email request. This form can be found at <https://www.hhs.texas.gov/providers/behavioral-health-services-providers/home-community-based-services-adult-mental-health>
- Demonstrate knowledge of issues affecting individuals with SMI and community-based interventions and resources for this population; and
- Pass a fingerprint-based criminal background check and applicable HHSC registry checks.

Direct service providers of recovery management services cannot be:

- Related by blood or marriage to the participant;
- Financially or legally responsible for the participant;
- Empowered to make financial or health-related decisions on behalf of the participant; or
- Direct service providers of other HCBS-AMH services for the participant, or those who have interest in or are employed by an HCBS-AMH provider on the IRP, except when the provider is the only willing and qualified entity in a geographic area whom the participant chooses to provide the service.

12 Respite Care

Direct service providers of respite care services shall meet the following qualifications and requirements:

- Be 18 years of age or older;
- Be familiar with person-specific competencies;
- Be trained in CPR and first aid;
- Maintain a valid Texas driver license and proof of automobile insurance (if transporting a participant); and
- Pass a fingerprint-based criminal background check and applicable HHSC registry checks.

13 Substance Use Disorder

Direct service providers of SUD services shall meet the following qualifications and requirements:

- Be 18 years of age or older;
- Be a Licensed Chemical Dependency Counselor for the provision of SUD services, as defined by HHSC (SUD treatment programs shall be licensed by HHSC as Chemical Dependency Treatment Centers);
- Be licensed, or appropriately credentialed, to provide services and act within the scope of the licensure or credentialing; and
- Pass a fingerprint-based criminal background check and applicable HHSC registry checks.

14 Supervised Living

Direct services providers of supervised living services shall meet and comply with the following qualifications and requirements:

- Be 18 years of age or older;
- Have a high school diploma, Certificate of High School Equivalency (GED credentials), or documentation of a proficiency evaluation of experience and competence to perform job tasks including the ability to provide the required services as needed by the participant to be served, as demonstrated through a written competency-based assessment;
- 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 participant(s) to be served;
- Assist with tasks delegated by an RN in accordance with state law;
- Maintain a valid Texas driver license and proof of automobile insurance (if transporting a participant); and
- Pass a fingerprint-based criminal background check and applicable HHSC registry checks.

15 Supported Home Living

Direct service providers of supported home living services shall meet and comply with the following qualifications and requirements:

- Be 18 years of age or older;
- Have a high school diploma, Certificate of High School Equivalency (GED credentials), or documentation of a proficiency evaluation of experience and competence to perform job tasks including the ability to provide the required services as needed by the participant to be served, as demonstrated through a written competency-based assessment;
- 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 participant to be served;
- Assist with tasks delegated by an RN in accordance with state law;

- Maintain a valid Texas driver license and proof of automobile insurance (if transporting a participant); and
- Pass a fingerprint-based criminal background check and applicable HHSC registry checks.

16 Transition Assistance

Direct service providers of transition assistance services shall meet and comply with the following qualifications and requirements:

- Be 18 years of age or older;
- Demonstrate knowledge or have experience in managing transitions to home and community-based settings;
- Demonstrate knowledge of, and history in, successfully serving individuals who require home and community-based services; and
- Pass a fingerprint-based criminal background check and applicable HHSC registry checks.

17 Transportation

Direct service providers of transportation services shall meet and comply with the following qualifications and requirements:

- Be 18 years of age or older;
- Maintain a valid Texas driver license and proof of automobile insurance; and
- Pass a fingerprint-based criminal background check and applicable HHSC registry checks.

13400 Responsibility of the Recovery Manager in Service Provision

RMs shall assist participants in gaining access to needed HCBS-AMH services, as well as medical, social, educational, and other resources, regardless of funding source. RMs shall coordinate services, including coordinating HCBS-AMH services; coordinating with the MCO providing other Medicaid services; and coordinating with third parties providing services. RMs shall monitor the provision of services

included in the IRP to ensure the needs, preferences, health, and welfare of the participant are promoted.

RMs shall:

- Coordinate and lead the development of the IRP using a PCRP approach, which supports the participant;
- Monitor, on a quarterly basis, to determine if the objectives and outcomes of employment services are met;
- Assist the participant in directing and making informed choices according to their needs and preferences;
- Provide supporting documentation to be considered by HHSC in the independent evaluation and reevaluations;
- Support the participant in the process to:
 - ➤ Identify services and providers, brokers to obtain and integrate services, facilitate and advocate to resolve issues that impede access to needed services;
 - ➤ Develop and pursue resources to support recovery goals, including non-HCBS-AMH, Medicaid, Medicare and/or private insurance or other community resources; and
 - ➤ Assist in identifying and developing natural supports, e.g., family, friends and other community members, and resources to promote their recovery;
- Inform participants of fair hearing rights;
- Assist participants with fair hearing requests when needed and upon request;
- Assist participants with retaining HCBS-AMH and Medicaid eligibility;
- Educate and inform participants about services, the IRP process, recovery resources, rights, and responsibilities;
- Actively coordinate with other persons and/or entities essential to the physical and/or behavioral services for the participant, including the individual's MCO, to ensure other services are integrated and support the recovery goals, health and welfare of the participant;

- Monitor health, welfare, and safety through regular contacts, e.g., visits with the participant, paid and unpaid supports and natural supports, at a frequency that is supportive and not intrusive to the participant;
- Respond to and assess emergency situations and incidents and assure that appropriate actions are taken to protect the health, welfare, and safety of participants;
- Review provider service documentation and monitor the progress of participants;
- Initiate IDT 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);
- Through the recovery plan monitoring process, solicit input from the participant, lar (if applicable), and/or family, as appropriate, related to satisfaction with services;
- Arrange for modifications in services and service delivery, as necessary;
- Advocate for continuity of services, system flexibility and integration, proper utilization of facilities and resources, accessibility, and beneficiary rights; and
- Participate in any HHSC-identified activities related to quality oversight and provide reporting, as required by HHSC.

13410 Developing, Monitoring, Reviewing, and Updating the Individual Recovery Plan

13411 Developing the Individual Recovery Plan

RMs shall facilitate the creation of the initial IRP within 14 calendar days of enrollment and submit to HHSC for review and approval (See Section 11000- Individual Recovery Plan for more information).

13412 Monitoring the Individual Recovery Plan

RMs shall monitor IRPs through:

- Contacting the IDT members identified on the IRP;
- Reviewing provider service documentation;
- Monitoring of the participant's progress toward recovery goals;
- Initiating IDT discussions or meetings when services are not achieving desired outcomes;

- Soliciting input from the participant or LAR (if applicable) related to satisfaction with services;
- Arranging for modifications in services and service delivery, as necessary;
- Advocating for continuity of services, system flexibility and integration, proper utilization of facilities and resources, accessibility, and beneficiary rights; and
- Participating in any HHSC-identified activities related to quality oversight and provide reporting as required by HHSC.

13413 Reviewing and Updating the Individual Recovery Plan

RMs shall convene an IDT meeting to review HCBS-AMH services on the IRP at least every 90 calendar days from the date of the last IRP for the first year of enrollment, and every 180 calendar days for all subsequent years of enrollment.

RMs shall initiate updates to the IRP in coordination with IDT members. Modifications to quantity and/or type of services listed on the IRP of a participant may occur.

Reasons for this to occur include:

- Quantity and/or type of services specified in the most recent approved IRP are no longer clinically appropriate for the participant;
- Quantity and/or type of services are adjusted to meet the current treatment needs of the participant, as identified by the IDT members;
- Participant transfers to a different RME or PA entity (See Section 15100 Transfer for more information);
- Participant's place of residence changes to an institutional setting for a period more than 30 days and services are suspended (See Section 15200-Suspension for more information);
- Participant is disenrolled from the program; or (See Section 15300-Disenrollment for more information); and
- Participant has an imminent health or safety risk.

13420 Service Coordination

13421 Coordination with Managed Care Organizations

RMEs shall provide and obtain updates from the MCO during weekly conference calls. The RM shall work closely to coordinate services with the MCO. The RM shall work closely with the participant's assigned MCO coordinator for provision of services, access to benefits, and ensuring non-duplication of services (See 24000 Non-Duplication of Services and 5000-Program Roles and Responsibilities for more information).

13422 Coordination with the Provider Agency

After the participant selects the PA, the RM shall notify the selected PA and coordinate participation on the development of the initial IRP. The RM shall ensure HCBS-AMH services are initiated within seven business days of authorization of the IRP.

Throughout the duration of services RM duties shall include:

- Continuing contact with HCBS-AMH providers to ensure the coordination and provision of services;
- Coordination and facilitation of IDT meetings with the participant, LAR (if applicable), and HCBS-AMH providers;
- Assisting with conflict resolution between the participant and HCBS-AMH providers; and
- Conducting outreach to participants after missed scheduled appointments with providers within 24 hours;
 - Upon notification by the PA that the participant is not attending scheduled services, the RM shall schedule and facilitate an IDT meeting with the participant and LAR (if applicable) and other providers, as identified by the participant, within seven business days of this notification to attempt to re-engage the participant in services. The IDT meeting shall address access barriers and issues and concerns with current provider(s) and the IRP shall be updated accordingly to reflect any change in services (if the participant chooses to remain in services, additional updates to the IRP may be required).

13423 Coordination with HHSC to Obtain Authorization for Recovery Management Conversion Services

Pre-authorization is approval by HCBS-AMH staff for a provider to bill for recovery management services prior to the enrollment of an individual into the program from a nursing home or another home and community-based services program. Preauthorization of recovery management services allow the RM to work with the participant's current team to ensure a smooth transition into the HCBS-AMH program. Additionally, for those individuals residing in a nursing facility, the RM works with nursing facility staff, MCOs, and community providers to help the individual discharge from these institutions and move into the community (See Section 13200-Description of Service Provision for more information on Recovery Management Conversion Services). [Form 3036 Preauthorization Request of Conversion Services](#) may be accessed on the HCBS-AMH webpage.

13430 Frequency of Recovery Management Service Provision

13431 Recovery Management Prior to Discharge from a State Hospital

During Recovery Management Facility Discharge services (HCBS-AMH service provided prior to discharge from the state hospital), the RM shall meet with the participant at a minimum of one time every two weeks for RM Facility Discharge Services. RMs providing Recovery Management Facility Discharge Services to participants in state hospitals at a distance greater than 100 miles from the RM's office building shall provide a minimum of one in-person visit every two months prior to the person discharging from the state hospital. The RM shall meet face-to-face, or using telehealth through audio/visual medium if approved by HHSC, with the participant within 14 calendar days prior to the anticipated date of discharge. The RM is permitted to coordinate and monitor services via teleconference in addition to the required face-to-face contacts. The RM shall coordinate and assist the participant with building rapport, addressing pre-discharge planning, and identify a transition plan back into the community.

13432 Recovery Management Following Discharge from a State Hospital

RMs shall attempt to meet with the participant for the provision of recovery management at an intensive level, i.e. a minimum of three times per week, during the first three months of a participant's discharge to the community from the state hospital. The RM shall provide at least one of these encounters in the residence of the participant and document in the progress note if the participant declines to meet with the RM.

After three months of recovery management at an intensive level, the RM shall convene a meeting with the participant, LAR (if applicable), the participant's supports, and HCBS-AMH providers to discuss the necessary level of recovery management. If appropriate, the RM may reduce recovery management

encounters to a minimum of one weekly home visit. This reduction in visits shall be reflected on the IRP.

13433 Recovery Management at an Intensive Level

The RM shall provide recovery management services at an intensive level, i.e. a minimum of three times per week, during crisis situations, potential discharge from the program, and/or transfer of services.

13500 Provider Agency and Recovery Management Entity Service Area Change Request Process

For all expansion or service area change requests please submit Form 8206 to the HCBS AMH Services mailbox and include the applicable PA or RME Liaison. All requests will be reviewed by HHSC within 5 business days and are subject to HHSC approval or denial.

Before an expansion request can be considered, the PA or RME must have had their current contract for at least 6-months.

HHSC may use additional criteria to determine if a provider is granted an expansion or service area change such as previous contract actions, recoupment, etc.

14000 Provider Training and Resources

RMEs and PAs shall implement and maintain a plan for initial and periodic training of staff members and service providers. Initial and periodic training shall ensure direct service providers are qualified to deliver services, as required by the current needs and characteristics of the participant to whom services are delivered and knowledgeable of acts that constitute ANE of a participant and methods to prevent the occurrence of ANE.

To ensure the safety and security of program participants, PAs will deliver periodic training, as needed, to ensure service providers are qualified to provide program services, in accordance with state and federal laws and regulations.

All direct service staff shall be trained on program philosophy, policies, and procedures to include identifying, preventing, and reporting critical incidents and ANE, and in the safe use of personal restraint, if applicable.

Training certificates shall not follow a staff member if they choose to move their employment to another HCBS-AMH provider. Staff members must retake all trainings. RMEs and PAs shall employ direct service staff who meet or exceed the minimum skills and training required to provide the assigned program service, and to meet the primary objective of protecting and promoting the health, safety, and well-being of program participants.

At any time, RMEs and PAs may identify training or technical assistance needs to HHSC by contacting HCBS-AMH staff. RMEs, PAs, or HHSC may identify issues and suggest potential remedies.

All RME and PA direct service staff shall attend and satisfactorily complete the relevant program specific training prior to the provision of program services or within designated timeframes. RMEs and PAs shall submit to HHSC training-related information via quarterly reports and shall maintain training documentation in personnel files.

14100 Training Requirements

1 Assisted Living

Required Trainings:

- ANE (prior to service provision and renewed annually)
- Ask About Suicide (ASK) (prior to service provision)
- Co-occurring psychiatric and substance use disorder (COPSD) (prior to

- service provision and renewed annually)
- Critical incident reporting (prior to service provision and renewed annually)
- PCRP (in-person or virtual) (within three months of service provision)
- PCRP (self-pace online course) (prior to service provision)
- Opioid overdose prevention (prior to service provision and renewed annually)
- Restrictive interventions, including physical restraint (prior to service provision and renewed annually)

Recommended Trainings:

- Harm reduction
- Motivational Interviewing, I and II
- Trauma-informed care
- Narcan administration (prior to service provision)

2 Community Psychiatric Supports and Treatment

Required Trainings

- ANE (prior to service provision and renewed annually)
- ASK (prior to service provision)
- COPSD (prior to service provision and renewed annually)
- Critical incident reporting (prior to service provision and renewed annually)
- Harm reduction (within three months of service provision)
- Illness Management and Recovery (within three months of service provision)
- PCRP (in-Person or virtual) (within three months of service provision)
- PCRP (self-paced online course) (prior to service provision)
- Opioid overdose prevention (prior to service provision and renewed annually)
- Restrictive interventions, including physical restraint (prior to service provision and renewed annually)
- Seeking Safety (within three months of service provision)
- Competency in at least one of the following (initial training prior to service provision and competency within one year of service provision):

- CBT;
- CBTp or
- DBT.

Recommended Trainings

- CBTp (if provider already holds a competency in DBT or CBT)
- Cognitive processing therapy
- Motivational Interviewing, I and II
- Narcan administration
- Trauma-informed care

3 Employment Services

Required Trainings

- ANE (prior to service provision and renewed annually)
- ASK (prior to service provision)
- COPSD (prior to service provision and renewed annually)
- Critical incident reporting (prior to service provision and renewed annually)
- Individual placement and support - supported employment (prior to service provision)
- PCR (in-person or virtual) within three months of service provision
- PCR (self-paced online course) (prior to service provision)
- Opioid overdose prevention (prior to service provision and renewed annually)
- Restrictive interventions, including physical restraint training (prior to service provision and renewed annually)

Recommended Trainings

- Motivational Interviewing, I and II
- Narcan administration
- Trauma-informed care

4 HostHome/Companion Care

Required Trainings

- ANE (prior to service provision and renewed annually)
- ASK (prior to service provision)

- COPSD (prior to service provision and renewed annually)
- Critical incident reporting (prior to service provision and renewed annually)
- PCRCP (in-person or virtual) within three months of service provision)
- PCRCP (self-paced online course) (prior to service provision) Opioid overdose prevention (prior to service provision and renewed annually)
- Restrictive interventions, including physical restraint training (prior to service provision and renewed annually)

Recommended Trainings

- Harm reduction
- Motivational Interviewing, I and II
- Trauma-informed care
- Narcan administration (prior to service provision)

5 Nursing Services

Required Trainings

- ANE (prior to service provision and renewed annually)
- ASK (prior to service provision)
- COPSD (prior to service provision and renewed annually)
- Critical incident reporting (prior to service provision and renewed annually)
- HCBS-AMH Program Training Nursing Services Best Practices (prior to service provision and renewed annually)
- PCRCP (in-person or virtual) within three months of service provision)
- PCRCP (self-paced online course) (prior to service provision)

- Opioid overdose prevention (prior to service provision and renewed annually)
- Restrictive interventions, including physical restraint training (prior to service provision and renewed annually)

Recommended Trainings

- Harm reduction
- Narcan administration
- Trauma-informed care

6 Peer Support Services

Required Trainings

- ANE (prior to service provision and renewed annually)
- ASK (prior to service provision)
- COPSD (prior to service provision and renewed annually)
- Critical incident reporting (prior to service provision and renewed annually)
- PCRP (in-person or virtual) within three months of service provision)
- PCRP (self-paced online course) (prior to service provision)
- Opioid overdose prevention (prior to service provision and renewed annually)
- Peer support specialist certification (prior to service provision)
- Restrictive interventions, including physical restraint training (prior to service provision and renewed annually)

Recommended Trainings

- Illness Management and Recovery
- Narcan administration
- Peer Specialist Whole Health and Resiliency
- Trauma-informed care

7 Psychosocial Rehabilitation

Required Trainings

- ANE (prior to service provision and renewed annually)
- ASK (prior to service provision)
- COPSD (prior to service provision and renewed annually)
- Critical incident reporting (prior to service provision and renewed annually)

- PCRP (in-person or virtual) within three months of service provision)
- PCRP (self-paced online course) (prior to service provision)
- Opioid overdose prevention (prior to service provision and renewed annually)
- One of the following (prior to service provision if provider does not already hold competency in an evidence-based practice (EBP):
 - CAT;
 - Illness Management and Recovery; or
 - Seeking Safety.
- Restrictive interventions, including physical restraint training (prior to service provision and renewed annually)

Recommended Trainings

- Harm reduction
- Illness Management and Recovery
- Motivational Interviewing, I and II
- Narcan administration
- Trauma-informed care

8 Recovery Management Services

Required Trainings

- ANE (prior to service provision and renewed annually)
- ANSA (prior to service provision and renewed annually)
- ASK (prior to service provision)
- COPSD (prior to service provision and renewed annually)
- Critical incident reporting (prior to service provision and renewed annually)
- HCBS-AMH Program Training Nursing Services Best Practices (prior to service provision and renewed annually)
- PCRP (in-person or virtual 2-days training) (within three months of service provision)
- PCRP (self-paced online course) (prior to service provision)
- Opioid overdose prevention (prior to service provision and renewed annually)
- Restrictive interventions, including physical restraint training (prior to service provision and renewed annually)
- Supplemental security income (SSI) (prior to service provision)

Recommended Trainings

- Certified Application Counselor Training (required if the participant is utilizing the Health Exchange)
- County Indigent Health Care Program Training Course
- Harm reduction
- Illness Management and Recovery
- Motivational Interviewing, I and II
- SSI/SSDI Outreach, Access, and Recovery Training
- Supportive Housing for Direct Service Providers
- Trauma-informed care
- Narcan administration (prior to service provision)

9 Respite Care

Required Trainings

- ANE Training (prior to service provision and renewed annually)
- ASK (prior to service provision)
- Critical Incident Reporting (prior to service provision and renewed annually)
- COPSD (prior to service provision and renewed annually)
- EVV
- PCRP (in-person or virtual) within three months of service provision)
- PCRP (self-paced online course) (prior to service provision)
- Opioid Overdose Prevention (prior to service provision and renewed annually)
Restrictive Interventions, including physical restraint training (prior to service provision and renewed annually)

Recommended Trainings

- Harm reduction
- Narcan administration
- Trauma-informed care

10 Substance Use Disorder

Required Trainings

- ANE Training (prior to service provision and renewed annually)
- ASK (prior to service provision)
- COPSD (prior to service provision and renewed annually)
- Critical Incident Reporting (prior to service provision and renewed annually)
- Harm reduction (within three months of service provision)
- Motivational Interviewing
 - Motivational Interviewing I (within three months of service provision)
 - Motivational Interviewing II and III (within one year of service provision)
- PCRP (in-person or virtual) within three months of service provision)
- PCRP (self-paced online course) (prior to service provision)
- Opioid Overdose Prevention (prior to service provision and renewed annually)
- Restrictive Interventions, including physical restraint training (prior to service provision and renewed annually)

Recommended Trainings

- CBTp
- Illness Management and Recovery
- Narcan administration
- Seeking Safety
- Trauma-informed care

11 Supervised Living

Required Trainings

- ANE Training (prior to service provision and renewed annually)
- ASK (prior to service provision)
- COPSD (prior to service provision and renewed annually)
- Critical Incident Reporting (prior to service provision and renewed annually)
- PCRP (in-person or virtual) within three months of service provision)
- PCRP (self-paced online course) (prior to service provision)
- Opioid Overdose Prevention (prior to service provision and renewed annually)

- Restrictive Interventions, including physical restraint training (prior to service provision and renewed annually)

Recommended Trainings

- Harm reduction
- Motivational Interviewing, I and II
- Trauma-informed care
- Narcan administration (prior to service provision)

12 Supported Home Living

Required Trainings

- ANE Training (prior to service provision and renewed annually)
- ASK (prior to service provision)
- COPSD (prior to service provision and renewed annually)
- Critical Incident Reporting (prior to service provision and renewed annually)
- EVV
- PCRCP (in-person or virtual) within three months of service provision)
- PCRCP (self-paced online course) (prior to service provision)
- Opioid Overdose Prevention (prior to service provision and renewed annually) • Restrictive Interventions, including physical restraint training (prior to service provision and renewed annually)

Recommended Trainings

- Harm reduction
- Motivational Interviewing, I and II
- Trauma-informed care
- Narcan administration (prior to service provision)

Many of the aforementioned trainings are available online or in-person at [Texas Centralized Training Infrastructure for Evidence Based Practices \(CTI-EBP\)](#). RMEs and PAs shall pass the HCBS-AMH Open Enrollment Application desk and on-site reviews prior to accessing trainings via CTI-EBP.

All required trainings shall be completed within the time frames specified. Recovery Managers are required to complete the 2-days PCRCP training (in-person or virtually within 3 months of service provisions); whereas, the PA's are required to complete the 1.5 days PCRCP training (in-person or virtually within 3 months of service provisions). Trainings that are not available through CTI-EBP may be accessed by

other means. Some trainings are the responsibility of the contracted RME or PA. The web-based trainings produce a certificate upon completion of the training that shall be made available in personnel records for review by HHSC at desk and annual on-site reviews. The need for training and technical assistance may be identified through results of HHSC monitoring, technical assistance contacts, and the use of quality indicators.

Please refer to Appendix A for appropriate training and resources websites.

15000 Transfer, Suspension, and Disenrollment

15100 Transfer

A participant may transfer from a provider, i.e. RME, PA, or both, to another available provider at any time and for any reason. Transfers are reviewed and approved/not approved by HHSC at the program’s discretion. In the event a participant is transferred to a new provider, one of the following reasons shall be cited.

Reason	Justification
Access to services	Participant is not receiving services identified on the IRP.
Allegations of ANE	Participant or others involved in the care of the participant have reported allegations of ANE. A CIR with relevant details will need to be submitted along with the transfer request.
Dissatisfaction with current provider(s)	Participant is not satisfied with the current provider(s).
Individual choice	Participant desires a new provider(s) for reasons other than those listed above.
Issues with staff and/or residents	Participant has continued issues with staff or residents of the current provider unable to be resolved.
Participant relocation	Participant relocates to a county within Texas that is served by the program but not by the current provider(s).
Provider agreement termination	The HCBS-AMH provider agreement is terminated between the provider(s) and HHSC.

15110 HHSC Designated Transfer

There may be times where it is necessary for HHSC to request a participant select a new RME or PA or designate a new RME or PA on behalf of the participant. Situations where HHSC may designate a new provider(s) may include:

- HCBS-AMH contract is terminated;
- The health, safety, or welfare is at risk; or
- Participant is currently unable to be located or is incarcerated or hospitalized.

If HHSC must designate a new provider, HHSC will send out a notification to the current RME, PA, LMHA, MCO (as applicable), and the new designated provider(s) regarding the transfer. The current RME or HHSC shall ensure the participant understands they are able to select the provider(s) of their choice at the initial meeting and assist the participant in selecting a new provider(s), if desired.

15120 Standard Provider Transfer Process

A participant has the right to select a new provider, i.e. RM, PA or both, at any time during their enrollment in the program. Standard transfer requests must be submitted by the RME. The LMHA/LBHA and state hospital may also submit a provider transfer request as needed in situations where the RM is unable to complete the request or the participant does not wish to have the RM involved in the transfer process.

The RME shall complete and submit the Provider Selection Update Form (PSUF) in CMBHS and include a hard-copy of the form signed by the participant and/or LAR. The form should be saved in Ready for Review status in order for HHSC to review the request. If a LMHA/LBHA representative or state hospital social worker needs to submit a PSUF, they shall complete a PDF version to be emailed directly to the [HCBS-AMH Referral and Enrollment Liaison](#). Once HHSC receives the request, the referral and enrollment liaison shall review for approval. If the request is denied, the referral and enrollment liaison shall notify the requestor, i.e. RME, LMHA or state hospital, and provide guidance on any outstanding, unresolved issues related to the request and mail out a denial notification to the participant.

If the request is approved, the referral and enrollment liaison shall send an approval notification with the effective date of transfer to the:

- Current and new provider(s);
- LMHA/LBHA point of contact;
- Medicaid Managed Care Organization (MCO) point(s) of contact (if applicable);
- State hospital social worker (if applicable); and

- HCBS-AMH Recovery Manager Liaison.

Upon receipt of the approval notification the:

- HCBS-AMH Recovery Manager Liaison shall reply to the email with a copy of the current approved IRP attached;
- Previous provider shall, within three business days, send to the current provider(s) via secure email all documentation, including the initial enrollment packet, progress notes, and any additional documentation that will assist in continuity of care and service planning for the participant;
- Current provider(s) shall provide services according to the IRP for the next 14 business days; and
- Current RME shall schedule an IDT meeting to review and update the IRP for submission to HHSC for review and approval within 14 business days of the effective date of the transfer.

15130 Additional Requirements for Court Supervised Participants

The following additional requirements apply to participants under court supervision, i.e., incompetent to stand trial, Chapter 46B of the Texas CCP; not guilty by reason of insanity, Chapter 46C of the Texas CCP; or probation/parole:

- If the transfer includes a relocation to a new residence, the RME shall submit (with the aforementioned forms) documented communication from the LMHA/LBHA, probation or parole department, or court of jurisdiction that the presiding judge has approved the change in residence.
- Except in cases of an immediate danger to the health, safety, or welfare of participants, the RME or PA shall not relocate participants to another residence unless or until the request is approved by the presiding judge.
- In cases of an immediate danger, the RME, PA, or both shall submit notification via email to the HCBS-AMH Manager, the general HCBS-AMH services inbox, and presiding judge by close of business of the next business day.

15200 Suspension

In the event a participant is suspended from the program, one of the following reasons shall be cited.

Reason	Justification
Incarceration	Participant is incarcerated for a period more than 30 days.
Medical hospitalization	Participant is hospitalized in an inpatient medical hospital for a physical health need for a period more than 30 days.
Psychiatric hospitalization	Participant is hospitalized in an inpatient psychiatric facility for a period more than 30 days.
Resides in nursing home	Participant is in a nursing home for a period more than 30 days.
Temporary move out of service area	Participant temporarily moves out of the service region for more than 30 days to a region where program services are not available (move shall not exceed 180 days; if more than 180 days, individual should be disenrolled). RME must have current address for participant, otherwise the suspension reason is Unable to Locate.
Unable to locate	Participant is unable to be located after 30 consecutive days (attempts to locate individual by the recovery manager shall be documented weekly during the 30-day timeframe; participant may be placed on suspension for up to 180 days before disenrollment from program).
Voluntary	Participant chooses to be placed on suspension (participant may be placed on suspension for up to 180 days before disenrollment from the program).
Enrolled in another HCS Medicaid Program	Participant must be placed on suspension once it's discovered they've been enrolled in another Medicaid program. During the suspension period, the participant, their RM, and their MCO shall meet to determine in which program the participant would like to remain.
Non-Engagement in Services	Participant is not missing and in the community, but has refused to engage with services for 30 consecutive days.

15210 Suspension Procedure

If a participant needs to be placed on suspension for any reason, the RM shall submit the suspension request and suspension reason in CMBHS through the participant's HCBS-AMH Clinical Eligibility form. The HCBS-AMH Referral and Enrollment Liaison shall review the suspension request and either approve or deny. HHSC may request supporting documentation, such as progress notes documenting outreach attempts or hospital nursing home admission records, to make a determination. If denied, HHSC shall provide additional guidance to the RM, PA, or state hospital on next steps.

If approved, HHSC shall issue a Suspension Notification letter to the RM, PA, LMHA/LBHA, and MCO (as applicable) and mail a copy of the letter to the individual and LAR (if applicable). The letter shall include:

- Determination of suspension of services;
- Date and reason for suspension of services;
- Duration of suspension of services; and
- Medicaid fair hearing process.

All PA services shall be suspended effective the approved suspension date, as determined by HHSC. Recovery management services shall continue in order that the RM remain in contact with the individual or continue to attempt contact throughout the suspension period. The schedule for completing update IRPs shall remain the same during the suspension period. If an update IRP is required while an individual is on suspension, the RM shall complete and submit an update IRP that includes recovery management services and only urgent PA services (such as nursing and/or residential services) to HHSC for review and approval. Signatures of the participant and PA shall not be required on an update IRP that occurs during a suspension period. A participant may be placed in suspended status for up to 180 days, with the option of an additional 30-day extension (See Section 15230-Extension of Suspended Services for more information).

15220 Recovery Management Entity and Provider Agency Responsibilities during Suspension

At least one time each month during the suspension the RM shall check in with the participant for continued care coordination and planning. All check ins and engagement attempts shall be documented in progress notes. If the participant is unable to be located, the RM shall do the following at least one time each month:

- Check all local inpatient facilities, and city and county jails;
- Conduct outreach to the emergency contact of the participant;
- Conduct outreach to the LMHA/LBHA; and

- Attempt a home visit to the last known address of the participant.

The PA shall contact the RME with any updated information about the participant that is received. If a participant who is on suspension contacts the PA or unexpectedly returns to a home of a PA during a weekend or time outside of regular business hours, the PA shall immediately notify the RME of the participant's return. The PA and RM shall document the specific date of the participant's return, and the RME shall immediately send notification of the enrollment status of the participant to HHSC for review.

15230 Extension of Suspended Services

An individual shall be placed in suspended status for up to 180 days, with the option of a 30-day extension with HHSC approval. Approval of the 30-day extension may occur if reasons or conditions demonstrate clear and convincing evidence the participant can resume services within 30 days past the 180-day suspension period. Reasons and conditions may include:

- Discharge date of the participant from an institution shall occur within the 30-day time period;
- Participant is temporarily living or traveling out of state but plans to return to the service area within the 30-day extension period; or
- Additional time is needed to arrange housing and support for the participant upon their return to the community.

To request an extension, the RM shall send a request to the HCBS-AMH Enrollment and Referral Liaison outlining the request with supporting documents, as applicable, via encrypted email with "Extension of Suspended Services" in the subject line

15240 Suspension to Enrollment Status Change

If the participant needs to be placed back into enrolled status, the RME shall request re-enrollment through the participant's HCBS-AMH Clinical Eligibility form in CMBHS. Once the request is reviewed and approved by HHSC, a re-enrollment notification email will be sent out to all relevant parties and include a re-enrollment notification letter to be sent to the participant. . The RM shall convene an IDT meeting to complete an update IRP within 14 days of the re-enrollment of the participant. If possible, the IDT meeting to update the IRP should happen prior to an individual discharging from a hospital, nursing home, or city or county jail to ensure continuity of services immediately upon return to the community.

15250 Suspension to Disenrollment Status Change

If the participant needs to be disenrolled after being placed on suspension for 180 days, the RME shall follow the disenrollment procedure (See Section 15300

Disenrollment for more information). Please note, a disenrollment request can occur prior to any suspension requests if there is supportive documentation showing the participant has been away from services for 180 consecutive days.

15300 Disenrollment

In the event a participant is disenrolled from the program, one of the following reasons shall be cited.

Reason	Justification
Court order	Participant ordered by court not to participate in the program or to disenroll from program
Death	Participant is deceased.
Does not meet financial eligibility	Participant no longer meets financial eligibility criteria for the program and will not meet the requirements in the future.
Enrollment in another HCBS waiver program	Participant enrolls in another HCBS waiver program and chooses to remain in new waiver and disenroll from program.
Higher clinical need	Participant needs a higher level of medical care than what the program can provide, e.g., nursing home level of care.
Incarceration	Participant is incarcerated in a criminal justice institution for a period of more than 180 days and does not receive an extension on suspension of their services.
Medical hospitalization	Participant is hospitalized in a medical facility for a period more than 180 days and does not receive an extension on suspension of their services.
No clinical need	Participant does not meet the needs-based clinical criteria.
Non-engagement	Participant declines to participate in the recovery planning process for 180 consecutive days.
Participant-defined successful completion of program	Participant requests to disenroll from the program due to successful completion of program

Psychiatric hospitalization	Participant is hospitalized in a psychiatric facility for a period more than 180 days and does not receive an extension on suspension of their services.
Relocation out of service area	Participant permanently relocates out of state or to a service area where program services are not available. RME must have a current address for participant, otherwise the reason is Unable to Locate.
Services no longer available	Program services are no longer available due to no program providers available in the service area of the participant, and the participant chooses not to relocate to another service region with available program services.
Unable to locate	Participant is unable to be located (participant shall be placed on suspension prior to being disenrolled and efforts to locate shall be documented in progress notes; see section 12200-Suspension for more information).
Voluntary	The participant requests disenrollment from the program.

15310 Disenrollment Procedure

The RME and PA shall not discontinue services to a participant of the program unless documented efforts have been made with the participant or LAR (if applicable) to resolve the situation.

When it is determined that a participant needs to be disenrolled from the program for any reason, all efforts should be made by the RM to convene an IDT meeting to complete the disenrollment process. The IDT meeting should be scheduled and facilitated within five business days of the requested disenrollment by the participant or LAR (if applicable) or within five business days of the determination to disenroll the participant.

15311 Participant Involved in Disenrollment

When a participant is still engaged and willing to participate in the disenrollment process, the RM shall do the following:

- Schedule and facilitate an IDT meeting with the participant, LAR (if applicable), and other IDT members of the participant's choosing, within five business days of the disenrollment request. The IDT meeting shall address:
 - Reason(s) for disenrollment;

- Discussion of pros and cons of remaining and disenrolling from the program, to include review of progress and successes;
 - Discussion of possible changes to current services that would meet the needs of the participant without disenrolling from program, as applicable (if the participant decides to remain in the program, an updated IRP shall be created to reflect requested changes and submitted to HHSC for review); and
 - Development of a transition plan that includes the effective date of disenrollment to ensure continuity of care upon disenrollment from the program, e.g., Communication with LMHA/LBHA case worker of disenrollment, living arrangements, medication management (the RM and PA shall obtain releases of information, as applicable, for alternative community resources).
- Document all items listed above in a progress note.
 - Assist the participant in connecting with, and making referrals to, community resources, as discussed in the IDT meeting.
 - Submit the disenrollment request through the participant's HCBS-AMH Clinical Eligibility form and IDT progress note to HHSC within five business days of the IDT meeting.

Upon receipt, HHSC shall make a determination within five business days. If disenrollment is not approved, HHSC shall contact the RM to discuss further and request additional steps. If approved, HHSC shall send a Notification of Disenrollment letter to participant, RM, PA, LMHA/LBHA, and MCO, as applicable. The letter shall include:

- Notification of disenrollment from HCBS-AMH services and effective date of disenrollment (date the request is approved);
- Re-enrollment process and Medicaid fair hearing process; and ● Contact information of LMHA/LBHA.

15312 Participant Not Involved in Disenrollment

When a participant is not currently involved in the program at time of determination to disenroll, e.g. refuses to engage, unable to locate, moved out of service area, documented efforts shall be made by both the RM and PA that show attempts were made to reengage the participant before initiating the disenrollment process. Once it is determined the participant should be disenrolled, the following occurs:

- The RM submits a disenrollment request in the CMBHS system through the participant's HCBS-AMH Clinical Eligibility form along with supporting progress notes within three business days of determination to disenroll.
- HHSC reviews and makes a determination request within five business days of receipt of request. If disenrollment is not approved, HHSC shall contact the RM to discuss further and request additional steps. If approved, HHSC shall send a Notification of Disenrollment letter to participant, RM, PA, LMHA/LBHA, and MCO, as applicable. The letter shall include:
 - Notification of disenrollment from HCBS-AMH services and effective date of disenrollment (date the request is approved);
 - Reason for disenrollment;
 - Re-enrollment process and Medicaid fair hearing process; and
 - Contact information of LMHA/LBHA.

16000 Settings Requirements

16100 General Settings Requirements

Program services are provided in home and community-based settings, including individual homes, apartments, adult foster homes, assisted living facilities, small community-based residences, and public community settings such as libraries, recreation centers, day activity centers, retail centers, and parks. Home and community-based settings shall meet certain requirements, as dictated by local, state, and federal licensure or certification standards. In accordance with 42 CFR §441.710, home and community-based settings shall:

- Be integrated in and supports 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 persons not enrolled in the Program;
- Be selected by the participant from among setting options, including non-disability specific settings, with an option for a private unit in a residential setting;
- Be identified based on the needs and preferences of the participant and, for residential settings, resources available for room and board and documented in the IRP;

- Ensure the rights of privacy, dignity, and respect of the participant, as well as the freedom from coercion and restraint;
- Optimize, but not regiment, the initiative, autonomy, and independence of the participant in making life choices, including daily activities, physical environment, and with whom to interact; and
- Facilitate individual choice regarding services and supports, and who provides them.

Residential settings include homes or apartments owned by the participant or their family; homes or apartments leased by the participant from non-HCBS provider sources; homes owned or leased by an HCBS-AMH PA and certified by the state; or assisted living facilities licensed by the state under 26 TAC, Part 1, Chapter 553, Licensing Standards for Assisted Living Facilities.

All non-residential services must be provided in settings that comply with HCBS settings requirements. HHSC reviews ongoing compliance with settings requirements for HCBS-AMH services through the quality improvement process to ensure that nonresidential 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.

HHSC or its designee shall perform an onsite HCBS setting review prior to rendered services and on a biennial basis to ensure all settings meet the 42 CFR §441.710, and do not have the quality of an institutional setting.

HCBS setting requirements apply to provider offices if the participant is receiving services in a provider office. The program settings checklist shall be performed by HHSC, the RME, or both.

Program services shall:

- Be physically accessible to the participant;
- Be furnished in integrated settings and in a way that fosters the independence of each participant and the realization of the benefits of community living, including opportunities to seek employment, and work in competitive integrated settings;
- Be person-driven to the maximum extent possible, treat each participant with dignity and respect, promote participant inclusion in community activities, and use natural supports and typical community services available and accessible to the same degree as persons not receiving program services; and

- Promote social interaction and participation in leisure activities and improve and maintain daily living and functional living skills.

Home and community-based settings do not include:

- A nursing facility;
- An institution for mental diseases;
- An intermediate care facility for individuals with intellectual disabilities;
- A hospital providing long-term care services; or
- Any other locations that have qualities of an institutional setting.

In addition, participants shall not receive Program Services if residing in any of the following settings:

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

On the RME Quarterly Report the RME must provide attestation by the RM that the setting where the participant resides meets HCBS-AMH settings requirements listed above and that the setting was chosen by the participant.

16200 Provider-Owned and Operated Housing

In addition to the qualities specified above in Section 16100, a provider-owned or controlled residential setting shall meet the following conditions:

- The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the participant, and the participant has, at a minimum, the same responsibilities and 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, a residency agreement or other form of written agreement shall be in place for each participant which provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
- Each participant has privacy in their sleeping or living unit and:
 - Units shall have entrance doors lockable by the participant with only appropriate staff having keys to doors if this modification is documented on

the IRP;

☞ Individuals sharing units have a choice of roommates in that setting; and

☞ Participants have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

- Participants shall have the freedom and support to control their own schedules and activities.
- Participants shall have access to food at any time.
- Participants shall have visitors of their choosing at any time.
- The setting is physically accessible to the participant.
- The setting must have a visitor sign-in sheet in the home and require all visitors, including service providers, to sign-in upon entering the home and sign-out upon exiting the home.

Only persons 18 and older may reside in a setting in which supervised living services or assisted living services are provided:

Any modification of the additional conditions specified above shall be supported by a specific assessed need and justified in the IRP according to the following requirements:

- Identify a specific and individualized assessed need.
- Document the positive interventions and supports used prior to any IRP modifications.
- Document less intrusive methods that were attempted but unsuccessful.
- Include a clear description of the condition that is directly proportionate to the specific assessed need. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
- Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- Include the informed consent of the participant.
- Include an assurance that interventions and supports will cause no harm to the participant.

17000 Utilization Management

17100 HHSC Functions

HHSC shall monitor service utilization data in coordination with the approved IRP, as well as all service encounter claims. HHSC shall conduct UM functions and develop quality indicators.

To maintain the integrity of program services and cost within the state appropriations, HHSC shall monitor IRPs and utilization of services by participants. The total cost of program services shall not exceed a maximum amount set by HHSC based on the amount of monies available to the program, as authorized in appropriation by the legislature. When program costs get close to the maximum amount, as authorized in appropriations by the legislature, HHSC may submit an amendment to the Centers for Medicare & Medicaid Services (CMS) to amend the program state plan amendment, requesting changes to the needs-based criteria.

HHSC shall monitor RMEs and PAs on the performance of program activities and conduct regular data verification via desk reviews. The process shall include comparing the scope, frequency, duration, and amount of authorized services reported on the IRP with services reported on the provider invoice. Billable services are subject to prior approval by HHSC and may be subject to periodic reviews to ensure fidelity with evidence-based practice.

HHSC shall conduct an on-going process of real time and retrospective analyses of the non-Medicaid and Medicaid utilization data.

17200 Utilization Management Guidelines

Across the program population served, some participants may require more or less intense provision of services or use services at a higher or lower rate per month. If service utilization is high need, supporting documentation is submitted to HHSC for review prior to the authorization of service(s).

As necessary, HHSC shall coordinate with the RME or PA in question to request additional documentation of delivered services and amounts of services that meet the level of need as defined in the UM Guidelines. When notified by HHSC that a requested service needs additional justification, the RME or PA shall provide required documents to HHSC within five business days (See Section 11000-Individual Recovery Plan for more information).

17300 Provider UM Functions

The PA shall not modify, discontinue, or refuse services to a participant. If the participant refuses, or desires to discontinue or modify, a service, this information shall be documented and discussed with the participant or LAR (if applicable) and the RM. Due to the limited availability of resources in certain service areas, it may not

always be possible to locate the full array of program services. In such cases, a provider shall demonstrate a Good Faith Effort in locating providers through outreach and networking (See Section 8310-Good Faith Effort Exception for more information).

17310 Recovery Management Entity Functions

The RME shall perform UM activities to include monitoring service utilization for compliance with the approved IRP for each participant. RMEs shall monitor the frequency and duration of recovery management services provided to ensure the service is supportive of the participant, focused on participant needs, and not intrusive to the participant. The RME shall monitor the documentation created by the RM to ensure the documentation supports the recovery management service provided and substantiates the frequency and duration of the service. HHSC shall assist the RME in UM activities by requesting monthly encounter data and requesting additional supporting documentation for review. This HHSC-level review shall be used to provide feedback and technical assistance to the RME as needed.

The RME shall participate collaboratively in ongoing quality improvement and assurance activities, to include an internal process for ongoing supervision of staff and service and documentation review.

RMEs are required to repay any identified overpayment. Encounters are linked to paid claims and any identified invalid services or unsubstantiated claims are expected to be repaid by the RME. The RME shall participate collaboratively in ongoing quality improvement and assurance activities (See Section 17000-Utilization Management for more information).

17320 Provider Agency Functions

The PA shall monitor service utilization for compliance with the approved IRP for each participant to include the frequency and duration of services provided to ensure the participant receives the services identified on the IRP. The PA shall monitor the documentation created by the providers to ensure the documentation supports the services provided and substantiates the frequency and duration of each service. HHSC shall assist the PA in UM activities by requesting monthly encounter data and requesting additional supporting documentation for review. This HHSC-level review shall be used to provide feedback and technical assistance to the PA, as needed.

The PA shall participate collaboratively in ongoing quality improvement and assurance activities, to include an internal process for ongoing supervision of staff and service and documentation review.

PAs shall be required to repay any identified overpayment. Encounters are linked to paid claims and any identified invalid services or unsubstantiated claims are expected to be repaid by the PA. The PA shall participate collaboratively in ongoing quality improvement and assurance activities (See Section 14000-Utilization Management for more information).

17400 Minimum Amount of Services

To demonstrate need for participation in the program, a participant shall require the provision of at least one HCBS-AMH service, as documented in the IRP.

17500 Reduction in Services

During an individual's participation in the program, the intensity of services provided by the RM and direct service providers may change. If a reduction in services is clinically indicated, the RM shall:

- Convene an IDT meeting with the participant, LAR (if applicable), and PA to review a possible reduction in services;
- Complete an update IRP that reflects which Program service(s) shall be reduced and the reason(s) for the reduction in service(s) with concurrence by the participant or LAR (if applicable);
- Submit the update IRP to HHSC for approval within three business days (See Section 11000-Individual Recovery Plan for more information); and
- If approved, notify the participant or LAR (if applicable), as well as the PA via the Determination Letter provided by HHSC.

18000 Maintenance of Records, Documentation, and Reporting

18100 Provider Maintenance of Records

RMEs and PAs shall ensure records are:

- Organized and divided into sections according to a consistent standard, allowing for ease of location and referencing;
- In sequential and date order;
- Complete and maintained in one location;
- Fastened together to avoid loss or misplacement, i.e. No loose papers; and
- Retained, according to the provider agreement, until one of the following occurs (whichever is the latest):
 - Seven years from the date one of the following events occurs: transfer, death, or disenrollment; or
 - Until any audit exception or litigation involving the records is resolved.

RMEs and PAs shall store clinical records in a “double locked” manner, i.e. in a locked filing cabinet located within a locked office. If records must be transported, RMEs and PAs shall maintain the “double locked” and safeguarding requirements, i.e. transported in a locked box in a locked vehicle trunk and not left in an unattended vehicle. In addition, Electronic Health Records shall be stored in a password-protected computer located in a locked room.

The exchange or sharing of confidential information, particularly PHI or other sensitive personal information shall be done in compliance with HIPAA. All parties involved with the Program, to include HHSC staff, RME, PA, and direct service staff shall maintain and protect the confidential information to the extent required by law (See Section 4700-Confidentiality for more information).

RMEs and PAs shall allow HHSC staff access to, or provide, all clinical records and any additional information that may be used to substantiate claims upon request of HHSC. RMEs and PAs shall also ensure participants have access to their clinical record in accordance with Texas Health and Safety Code, §611.0045.

18200 HHSC Maintenance of Records

HHSC shall maintain:

- Records documenting the audit trail of adjudicated claims, including supporting documentation for a minimum period of seven years, as required in 45 CFR §92.42;
- Determination letters;
- Consents;
- Enrollment documents;
- Assessments;
- Criminal history and registry checks, licensures, and certifications for persons providing program services in a state hospital to a participant; and
- Evidence of guardianship, power of attorney (POA), or LAR.

18300 Recovery Management Entity Maintenance of Records

The RME shall maintain original forms provided to the participant or LAR (if applicable) in the clinical record of the participant and provide copies to the participant, LAR, or both. Also, RMEs shall maintain supporting documentation, such as assessment data and medical, psychiatric and criminal records, to be used as a guide in the independent recovery process.

The RME shall maintain in the clinical record of each participant:

- Demographic and contact information for the participant;
- Enrollment documents;
- Consent forms;
- IRPs;
- Safety Plans and ANE Prevention Plans;
- Guardianship, POA, or LAR documentation;
- Progress notes for all recovery management services provided to the participant;

- CIRs; and
- Other program documentation.

18400 Provider Agency Maintenance of Records

The PA shall maintain in the clinical record of each participant:

- Demographic and contact information for the participant;
- Enrollment documents;
- IRPs;
- Safety Plans and ANE Prevention Plans;
- Guardianship, POA, or LAR documentation;
- Respite Provider form;
- Transportation log;
- Progress notes for all Program services, including housing services provided to the participant;
- CIRs;
- Lease agreements;
- MARs;
- Evidence of annual physical exams;
- Nursing assessments;
- Lab results; and
- Other program documentation.

In addition, key documents relating to the health, welfare and safety of participants shall be maintained at their residence, e.g., demographic information, IRPs to include safety and ANE prevention plans, consents, physician orders, MARs, and lease agreements.

18500 Documentation Requirements

RMEs and PAs shall keep accurate and adequate records that document program services provided to the participant. Upon request, the RMEs and Pas must make available to HHSC any documents, papers, and phone records that are directly pertinent to the goods or services being provided to participants in the HCBS-AMH Waiver program. Examples includes but are not limited to: invoices; service authorizations; sign-in sheets; insurance certificates; any documentation required under the entity's contract; and the HHSC Standard Procurement Terms and Conditions, and/or HCBS-AMH Waiver standards. Documentation of services shall meet service claim or billing requirements (See HCBS-AMH Billing Guidelines for additional documentation requirements).

18510 Documentation of Provider Choice

RMEs and PAs shall include documentation regarding provider choice in the clinical record of a participant. Documentation of provider choice includes:

- A completed HCBS-AMH Provider Selection Form signed by the participant or LAR (if applicable);
- Final selection of an HCBS-AMH RME and PA; and
- Selection of RME and/or PA direct service personnel to provide Program services (participant's or LARs (if applicable) right to choose service providers extends to the specific direct service personnel that provide Program services).

18520 Progress Notes

Progress notes are required for all services provided to a participant. HHSC may request progress note documentation at any time to verify reimbursed services are provided in accordance with the requirements of the Program. Please see HCBS-AMH Billing Guidelines Section 2800 for Documentation of Service Provision Requirements.

18530 Frequency of Documentation

The documentation mentioned above shall be completed within two business days after each contact that occurs to provide mental health community services. For more information on documentation requirements (See Section 3800-Documentation of Service Provision in the HCBS-AMH Billing Guidelines for more information).

18540 Retention

Documentation shall be retained in compliance with applicable federal and state laws, rules, and regulations.

18550 Error Correction

Providers shall not use correction tape or fluid, or scribble over to correct errors. Instead, providers shall draw a single line through the error, initial and enter correct material (no edits are allowed after submission to HHSC). Service providers shall be the original author of progress notes. Reviewers or supervisors shall not edit original authors but may supply an addendum with dated signature. Last, only universal acronyms and abbreviations shall be used.

18560 Documentation Specific to Certain Services

In addition to the general documentation requirements identified in section 18520, certain Program services have documentation requirements (See HCBS-AMH Billing Guidelines for more information).

18600 Reporting

18610 Service Reporting

The encounter system and invoice system are linked together in an Excel workbook that is titled "[HCBS-AMH Encounter Invoice](#)" Template. The template can be downloaded at the HCBS-AMH website (See Rate Information section for more information). Providers shall have prior approval by HHSC to submit the template via a method other than encrypted email.

Providers will be required to complete encounters and invoicing using the CMBHS system once mandated by Program. The CMBHS process will replace the manual process stated above for all encounters and the invoicing process for all Medicaid billed services. Non-Medicaid billed invoices will still be completed using the manual Excel process and submission.

HHSC shall receive all Program invoices directly from the RME and PA. HHSC shall conduct quality checks on invoices for accuracy and completeness and review the amounts against the approved IRP. HHSC may collect any information from the provider by accessing other data sources, such as the Texas Medicaid and Healthcare Partnership or requesting records from the RME or PA (See HCBS-AMH Billing Guidelines for the "[HCBS-AMH Encounter Invoice](#)" Template and detailed instructions).

RMEs and PAs shall respond to all information, to include ad hoc report requests, from HHSC within five business days.

18620 Quarterly and Annual Reports

RMEs and PAs shall submit, via email to the HCBS-AMH QM mailbox, quarterly and annual reports using the [HCBS-AMH Quarterly and Annual Report Templates](#). The Annual Reports are due by September 30th of each state fiscal year. The Quarterly

Reports are due no later than 20 business dates following the close of each quarter. The Quarterly Reporting Periods are as follows:

1. September 1st – November 30th
2. December 1st – February 28th
3. March 1st – May 31st
4. June 1st – August 31st

Along with the quarterly reports, RMEs and PAs shall submit initial (prior to hire), and annually thereafter, copies of fingerprint based criminal history checks for all direct contact employees to include subcontractors and their employees and applicable service providers. RMEs and PAs may be required to provide updated criminal history reports as requested by HHSC. Failure to submit both quarterly and annual reports, and initial and annual fingerprint based criminal history checks may result in a breach of contract leading to contract action up to and including contract termination.

18630 Critical Incidents

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.

18631 Critical Incidents Examples

Examples of critical incidents include but are not limited to the following:

- Abuse, Neglect, and Exploitation (ANE) of a participant (See Section 18640- Abuse, Neglect, and Exploitation for more information);
- Allegations against participant rights (federal and state laws and regulations protect participants applying for or receiving benefits from discrimination based on race, color, national origin, sex, age, religion, disability, political beliefs, and sexual orientation);
- Behavioral health emergencies or psychiatric hospitalizations necessitating assessment and treatment by emergency medical services, mobile crisis outreach team, or an emergency room, and crisis facilities, as well as those requiring inpatient care at acute care hospitals, and public and private inpatient psychiatric facilities;
- Medical emergencies or hospitalizations such as physical injuries, illnesses or medical complications necessitating assessment and treatment by emergency medical services, urgent care facilities, or an emergency room as well as those requiring inpatient care due to serious illness or injury after an accident or after surgery;
- Self-abuse, self-harm, or self-neglect, including suicidal behavior, self-inflicted injuries, refusing medications, refusing to eat, or neglecting personal hygiene;

- Legal or justice system involvement refers to any alleged illegal activity committed by the participant, involving law enforcement, such as arrests, incarceration, parole violation, criminal court appearances/charges, illegal drug use and shoplifting;
- Restraint refers to a situation involving a participant who is behaving in a violent or self-destructive manner and in which preventive, less restrictive measures 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 self or others (see section 21200-use of restrictive interventions for more information);
- Medication errors, including non-adherence, wrong dosage, wrong medication, wrong timing, missed dose, irregular administration, errors involving documentation, storage, prescription, and failure to refill medications on time;
- Incidents caused by the participant, such as verbal and/or physical abuse, sexual assault, or threats, or actual physical assault against staff or other members;
- Contraband, such as weapons or illicit drugs;
- Participant departure, specifically when they cannot be located or in the case of elopement, requires that a missing person report to be filed with the law enforcement within 72 hours of the departure;
- Eviction from primary residence;
- Property destruction, damage, or fire setting and arson;
- Environmental emergencies, such living facility impacted by power outage, floods or other natural calamities, or disruption of utility services;
- Death of a participant (the death of the participant served by the HCBS-AMH program is to be reported within one working day); and
- Extended nursing home placement.

18632 Critical Incident Immediate Actions by Providers and Caregivers

In the event of a critical incident, providers and caregivers shall immediately:

- Call 911 or local law enforcement for emergencies or life-threatening situations that require immediate attention;
- Take all necessary actions to ensure health, safety, and welfare of the participant, families, and the public;
- Seek all necessary care and assistance from medical or emergency personnel as appropriate; and
- Take immediate action to resolve critical incidents, when feasible, and to report

them to the appropriate state and/or local law enforcement agencies.

18633 Critical Incidents Reporting

The HCBS-AMH contracted Recovery Management Entity and Provider Agency with the relevant information of the incident can submit CIR. But it is essential for them to collaborate closely to streamline the CIR submission process and avoid duplicating incident reports. Failure to coordinate and submitting reports separately may result in multiple CIRs for the same incident. Therefore, HHSC recommends the RME to take the lead in promptly submitting the CIR, while the PA is responsible for ensuring incident information is shared with RME for timely submission to HHSC. Additionally, RME shall share incident information with PA within 24 hours of critical incident report. However, if the RME fails to submit the CIR, it becomes PA's responsibility to ensure that CIR is submitted to HHSC within the required timeframe. In such instances and when complete incident information is not yet available, the provider can submit the CIR with the available information to meet the CIR submission deadline. Any additional details that become available subsequently can be included as updates to the initial report.

RMEs and PAs shall implement procedures that ensure the reporting of all critical incidents to HHSC, according to the following guidelines:

- All critical incidents shall be reported online using the CIR template in CMBHS within 72 hours of incident information. Although, RME is required to take the lead in submitting CIR, both RME and PA are equally responsible to ensure that critical incident reports are submitted within specified timeframe. The provider agency is also responsible to ensure that incident information and updates if any, are shared with RME for timely CIR submission. In the infrequent event when CIR cannot be entered in CMBHS system for technical issues, the same shall be submitted within 72 hours of incident information via a secure email using [CIR form](#) to the [HCBS-AMH Critical Incident Reports](#) mailbox with "participant initial - CIR - date of incident" (*JD - CIR - 01-25-22*) in the subject line.
- CIR forms shall include:
 - Participant's demographic information;
 - Date, time, and location of incident;
 - Name(s) of staff making the report, witnesses, and associated contact information;
 - Incident type (if multiple incident types are involved, the most serious incident type shall be checked in the incident report as primary and details of the other types shall be included in the CIR narrative);
 - Detailed description of the incident, i.e. Who, what, when and where, and immediate actions taken and, when indicated, detailed description of

hospitalization or legal system involvement; and

➤ Department of Family and Protective Services (DFPS) intake number and the date of registering ANE complaint, if applicable (all suspected cases of ANE must be reported immediately to DFPS).

- If the incident has not resolved by the time of initial reporting, the provider shall submit updates within 72 hours and periodically thereafter to address any developments that may have occurred during that period. Incidents requiring updates include but are not limited to, a participant's admission or discharge from hospital, their release following an arrest, their return after departing, and medication error, or upon receipt of final ANE investigative report from DFPS;
- The RME and PA, when submitting the CIR to HHSC, must promptly share incident details among each other within 24 hours of the incident report. Additionally, the RME is responsible for ensuring that the incident details, including any updates, are conveyed to the LAR or the participant's family in a timely fashion;
- Critical incidents reported by telephone shall also be submitted electronically, immediately following the telephonic report.
- RMEs shall contact the PA, participant, and LAR (if applicable) or participant's family to share follow-up on the incident and update the crisis and safety plan, as needed (if psychiatric hospitalization or other institutionalization occurs, the RME shall submit an update IRP to HHSC within 30 days of discharge from the institution (See Section 11000-Individual Recovery Plan for more information));
- If a participant is disenrolled due to extended hospitalization, incarceration, or departure, the RME is required to revise the initial incident report to facilitate closure of the case;
- As a follow-up to ANE incidents reported to DFPS, RMEs and PAs shall submit the final investigation report to HHSC within 72 hours of receipt from DFPS.

18634 Critical Incidents Training

Critical incident training for RME and PA direct service staff is provided by the HCBS-AMH RME and PA. HHSC will check training curriculum to ensure content is comprehensive and meets requirements.

The required critical incident training for all staff, volunteers, interns, and direct service providers shall include:

- Critical incident reporting (required at hire and renewed annually);
- Abuse, Neglect, and Exploitation (required at hire and renewed annually);
- Restraint (required at hire and renewed annually) See Section 21200-Use of

- Restrictive Interventions for more information; and
- De-escalation and Behavior Management (recommended training)

These trainings are available at [Centralized Training Infrastructure \(CTI\)](#).

18635 Critical Incidents Reports Review, Oversight and Tracking

The RME and PA shall ensure that all incidents are reported, reviewed, and tracked for resolution. This may include reviewing the incident details and precipitating factors and establishing corrective actions, if needed, to minimize recurrence of similar incidents in future. The details of the review shall be shared with HHSC within five business days.

HHSC shall reach out to reporting entities in case more information, documents, or updates are required. The information requested will help HHSC keep track of reported incidents and ensure appropriate resolution.

HHSC shall oversee the reporting of, and response to, critical incidents as part of the contract oversight process. When reviews of the RME and PA occur, CIRs are reviewed.

The RME and PA shall cooperate with and assist HHSC, as well as any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud or ANE. In addition, RMEs and PAs shall comply with all applicable federal and state ANE, and other, reporting laws. It is the responsibility of the RME and PA to understand and comply with professional and legal requirements within the State of Texas.

18640 Abuse, Neglect, and Exploitation

The RME and PA shall ensure, by all possible means, that program participants are free from abuse, neglect, and exploitation. Allegations of ANE by others, including service providers, may include following areas:

- Abuse, including physical abuse, verbal/emotional abuse, and sexual abuse;
- Neglect; and
- Exploitation.

The RME and PA shall immediately report cases of suspected ANE to the appropriate investigative authority. Specifically, they shall report any suspected ANE to DFPS immediately, but no later than one hour, after having knowledge or suspicion that an individual has been, or is being, abused, neglected, or exploited. This reporting should be done by calling the DFPS Abuse Hotline toll-free telephone number, at 1-800-252-5400 or online at [Texas Abuse Hotline](#).

HHSC recommends that the RME takes the lead in submitting ANE incident reports, However, it is essential to emphasize that both the RME and PA share equal responsibility in ensuring that ANE incident reports are submitted within specified timeframe. Furthermore, the PA has the responsibility to immediately share any incidents of alleged abuse, neglect, or exploitation with RME to ensure timely reporting of such incidents to state agencies including DFPS and HHSC as mandated by relevant regulations. 18641 Abuse, Neglect, and Exploitation Training Policy

The RME and PA shall develop, implement, and enforce a written ANE policy to ensure all employees and service providers demonstrate a thorough understanding of the relevant elements of reporting, investigating, and preventing ANE prior to contact with participants and annually thereafter. The relevant elements of reporting, investigating, and preventing ANE include:

- Knowledge of and training on following:
 - ▶ Acts that constitute ANE;
 - ▶ Signs and symptoms of ANE;
 - ▶ Methods to prevent ANE; and
 - ▶ Safe management of verbally and physically aggressive behavior before contact with participants and annually thereafter;
- Reporting of ANE to DFPS and HCBS-AMH in compliance with state rules and HCBS-AMH policies;
- Taking necessary measures to secure the safety of the alleged victim(s) involved in the allegation, which include:
 - ▶ Ensuring immediate and on-going medical and psychological attention is provided to the alleged victim(s), as necessary; and
 - ▶ Separating the alleged victim(s) from the alleged perpetrator(s) until a APS investigation is completed; and
- Disciplinary consequences for:
 - ▶ Committing ANE;
 - ▶ Failing to report ANE; and
 - ▶ Failing to cooperate with an investigation.

Please refer to Section 14000-Provider Training and Resources for ANE and other training opportunities.

18642 Abuse, Neglect, and Exploitation Reporting Process

The direct service providers associated with the RME and PA shall be aware of following aspects when reporting ANE:

- Call 9-1-1 or your local law enforcement agency immediately if there is an emergency or life-threatening situation.
- Report suspected ANE to the DFPS Statewide Intake immediately, but not later than one hour, after having knowledge or suspicion that an individual has been, or is being, abused, neglected, or exploited. Do not use the DFPS Abuse Hotline website to report urgent or emergency situations; instead, call the toll-free number if the situation is urgent and needs to be investigated within 24 hours (See Section 18640-Abuse, Neglect, and Exploitation).
- Protect the alleged victim(s) and other residents by separating the alleged victim(s) from the alleged perpetrator(s) once the report of an allegation of ANE to DFPS is complete and until an investigation has been completed ([25TAC §414.554](#)).
- Report the information immediately to DFPS whenever a person has cause to believe that an elderly or disabled person is in a state of ANE (See Texas Human Resources Code, §48.051 relating to Report).
- Notify suspected ANE to supervisor to include RME and PA.
- Report suspected ANE to HCBS-AMH as a critical incident by submitting an online CIR in CMBHS (the CIR shall be submitted within 72 hours of an alleged ANE incident or its notification and shall include DFPS ANE intake number and the date of reporting to DFPS).
- The provider shall submit a follow-up update within 72 hours of the initial CIR to reconfirm the safety of the participant and address outcomes that may have occurred during that timeframe.
- The provider is required to share the final ANE investigation report with HCBS-AMH, either as an update to a previously submitted CIR for the same incident within 72 hours of receiving the report from APS or HHSC PI or if the incident was not reported previously, they must submit it as a new CIR.

Reports regarding alleged sexual exploitation committed by an HCBS-AMH service provider are also registered with the law enforcement and prosecuting attorney in the county in which the alleged sexual exploitation occurred and any state licensing board that has responsibility for

the mental health services provider's licensing in accordance with the [Texas Civil Practice and Remedies Code, §81.006](#). It is important to register sexual exploitation complaints with DFPS and HCBS-AMH as required for any other ANE allegation.

The most important aspect of preventing the continuation of ANE is reporting suspicions as they arise. When making the decision of whether to report suspected ANE, it is not the responsibility of the RME or PA to confirm ANE is taking place. A suspicion is all that is required. The responsibility of investigating, confirming, and legally addressing ANE is owned by the State of Texas. Responsibility of healthcare workers is to make a report as soon as there is a suspicion that any form of ANE is taking place.

It is also a legal requirement for the RME and PA to report allegations of ANE to the DFPS Statewide Intake immediately (25 TAC §414.554). Anyone who fails to immediately report suspected ANE, without sufficient justification, may be held liable for a misdemeanor or felony as specified in [Texas Human Resources Code, §48.052](#). On the other hand, a person who reports ANE in good faith is immune from civil or criminal liability and DFPS keeps the name of the person making the report confidential.

Complaints related to a provider extorting money from participants receiving program services or misuse of food stamps shall be reported by calling the Office of Inspector General (OIG), Texas Health and Human Services toll-free line at 1-800-436-6184 or by submitting a referral online at [OIG](#). It is also important to register exploitation complaints with DFPS and HCBS-AMH.

Suspected misuse of Social Security benefits like SSI by a representative payee or by a program service provider shall be registered with OIG, SSA via telephone at 1-800269-0271, or online at [OIG Fraud Hotline](#).

18643 Abuse, Neglect, and Exploitation Reporting by LMHAs/LBHAs

The policies and procedures concerning critical incident reporting, including ANE, remain the same as described in Sections 18630-Critical Incidents and 18640-Abuse, Neglect, and Exploitation. If the alleged perpetrator is an employee or agent of an LMHA/LBHA, or the perpetrator is unknown and the victim is a program participant, then the Administrator of the HCBS-AMH Provider, or their designee, shall ensure that an ANE report is filed with DFPS immediately for investigation. The provider shall also ensure an online CIR indicating alleged ANE is submitted to HCBS-AMH. The CIR shall be submitted within 72 hours of notification of the incident.

18644 Abuse, Neglect, and Exploitation and HHSC Provider Investigations

DFPS and HHSC Provider Investigations (PI) are the only authority to investigate ANE complaints for HCBS-AMH participants. The reports are initially registered with the DFPS abuse hotline and subsequently referred to HHSC PI or Adult Protective Services (APS) for investigation. APS and HHSC PI conduct these investigations pursuant to Texas Human Resources Code, Chapter 48, as amended by S.B. 1880, as well as Texas Family Code §261.404, as amended by S.B. 1880.

Typically, HHSC Provider Investigations handle the investigation of all allegations of abuse, neglect, or exploitation within the HCBS-AMH program. However, there are certain circumstances where APS is responsible for conducting the investigation. These circumstances include cases where:

- The alleged perpetrator is neither an employee nor an agent of a licensed provider/contractor offering services to the individual, and if they are a family member, caretaker, or have a significant ongoing relationship with the participant beyond a contractual one.
- The participant is alleged to be engaging in "self-neglect" or is unable to provide themselves with the necessary goods and services to prevent harm.

RMEs and PAs shall cooperate with the investigators to ensure APS and HHSC PI can complete a thorough investigation. RMEs and PAs shall retain reporting documentation on site and make it available for inspection by HHSC when requested.

All contacts related to reporting of suspected ANE shall be documented by all direct service staff. This documentation, at a minimum, shall include date of contact, the name of service provider and provider agency, the name of participant the report is being made on behalf of, a brief synopsis of allegations, the name of the DFPS employee taking the report, the ANE intake number and the date of reporting to DFPS.

APS and HHSC PI releases the report of investigation findings to the provider and any other entity required by law. The provider is required to share the final ANE investigation report with HCBS-AMH, either as an update to previously submitted CIR for the same incident within 72 hours upon receipt of the report from APS and HHSC PI or if the incident was not reported previously, they may submit a new CIR.

Furthermore, HCBS-AMH routinely shares the profile data of its participants for matching with the DFPS ANE database on monthly basis. The information is used to cross-reference ANE investigation findings and dispositions for corresponding participants. HHSC, irrespective of the investigation findings, shall review each incident report. In some cases, HHSC may seek a comprehensive internal investigation conducted by PA and RME. This investigation will also encompass the measures undertaken for administrative purposes and how they aim to prevent or minimize such incidents in future. If deemed essential, HHSC may also request a

final investigation report from HHSC PI.

PA and RME shall not change a confirmed finding made by APS or HHSC PI investigator; however, providers may request a review of the finding, or the methodology used to conduct the investigation.

In addition to investigating ANE complaints against non-providers, DFPS also investigates reports of alleged ANE of persons receiving services from certain providers including older adults, disabled persons, and children.

HHSC PI on the other hand, investigates claims of abuse, neglect, or exploitation by the following providers:

- Facilities:
 - ▶ State-operated facilities
 - ▶ Intermediate care facilities for individuals with intellectual disabilities
 - ▶ Health and Human Services Commission-operated community services
- People who contract with an HHS agency to provide inpatient mental health services;
- Community centers, LMHA, or local intellectual and developmental disability authorities;
- People who contract with an HHS agency or managed care organization to provide home and community-based services;
- People who contract with a managed care organization to provide behavioral health services;
- Managed care organizations;
- Officers, employees, agents, contractors or subcontractors of the people or organizations listed above;
- Employees, agents, case managers or service coordinators of a Consumer Directed Services employer;

HHSC PI also investigates abuse, neglect or exploitation involving:

- People living in a Home and Community-Based Services group home, even if they do not get services under the program from the provider.

When DFPS receives ANE reports concerning an individual in a facility licensed by another state agency, DFPS shall forward the report to the appropriate agency for investigation. DFPS shall investigate reports of ANE when there is not already an authorized entity to conduct such an investigation. Specific contact information for each type of facility is listed below.

Entity	Phone Number
HHSC (regulates hospitals, public and private psychiatric hospitals, nursing homes, assisted living facilities, private Intermediate Care Facilities for Individuals with Mental Retardation, adult day care complaints, and other medical facility complaints)	1-888-973-0022
Nursing home information	1-800-252-8016
Texas Council on Family Violence – domestic violence hotline	1-800-799-7233 (1-800-799-SAFE) 1-800-787-3224 (TDD)
DFPS-APS Abuse Hotline for Facility Investigations	1-800-647-7418 or online at Texas Abuse Hotline *
DFPS-APS Abuse Hotline/Statewide Intake	1-800-252-5400 or online at Texas Abuse Hotline *

*Providers shall not use the DFPS Abuse Hotline website to report urgent or emergency situations. Instead, providers shall call the toll-free number if the situation is urgent and needs to be investigated within 24 hours.

18645 Reporting Fraud, Waste, or Abuse

HCBS-AMH contracted provider shall report suspected fraud, waste, or abuse to the [HHS Inspector General](#) or the Texas State Auditor's Office. HHS Inspector General takes reports of suspected fraud, waste, or abuse of HHS benefit by recipients or HHSC providers. Call the Integrity Line at 800-436-6184 or use the online Fraud Reporting Form Inspector General - Report Waste, Abuse & Fraud (state.tx.us).

Please provide as much information as possible:

- If you think someone is getting state benefits they are not entitled to receive, provide their date of birth, Social Security number, phone number and address.
- If you suspect a provider of wrongdoing, provide the name and address of the clinic, office, or business they work for.
- Submit any other information you think might be helpful to an investigator.

To report fraud, waste, or abuse regarding the expenditure of other state funds, contact the Texas State Auditor's Office <https://sao.fraud.texas.gov/ReportFraud/>. The State Auditor's Office investigates allegations of illegal acts and improprieties involving any entity that receives funds from the state.

HCBS-AMH will report all allegations of potential misuse or misappropriation of state resources to the HCBS-AMH Manager who will submit the report using the fraud hotline webpage [Texas State Auditor's Office - Report Fraud](#).

18700 Reporting Emergencies

In an emergency, call 9-1-1 or local law enforcement. For non-life-threatening behavioral health emergencies, call the [LMHA/LBHA Local Crisis Hotline](#).

All HCBS-AMH residences shall have emergency contact information readily available including each participant's IRP and safety plan.

18800 Personnel Records

18810 Minimum Standards

The RME and PA shall retain a confidential personnel record for each direct service staff, and PAs are ultimately responsible for verifying that direct service staff of subcontracted providers meet stated qualifications, fingerprint-based criminal history, and registry checks. At a minimum, personnel records shall include:

- Hire date;
- Annual fingerprint-based criminal history checks;
- Documentation of three personnel reference checks;
- Completion of HHSC required training;

- Completion of training required for competence of the service delivered;
- Certification records for employees and subcontractors;
- Certification or registration with the state and federal government, as required by applicable state and federal laws;
- Current copy of professional licensure, certification, or registration with the state and federal government, as required by applicable state and federal laws;
- Educational history; and
 - An applicant with a foreign degree must submit an official transcript and certified translation when applying to be a provider in the HCBS-AMH program. If applicable, the official transcript must be translated to English by the issuing institution, a translator that is certified by the American Translators Association, a reputable foreign translator or translation service, or a U.S. college or university official.
 - An applicant with a foreign degree must have the degree evaluated to determine if it is comparable to the degree required for the position. Foreign degree evaluations must be sent directly to the HHSC.
 - Foreign degree evaluations must be conducted by a foreign degree evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or the Association of International Credential Evaluators, Inc. (AICE).
- Work history to include experience working with individuals diagnosed with a SMI.

The RME and PA shall allow HHSC staff access to personnel records when conducting QM reviews, invoicing verifications, and for other requests.

18820 Credentialing for Service Provision Within the State Hospitals

The services identified below are allowable inside the state hospital and require completion of the fingerprinting procedure by all direct service staff providing HCBSAMH services inside a state hospital.

Service	Fingerprinting Required	Degree/License/Certification
Recovery management	Yes	Master's degree (or waiver approved by HHSC)
Psychiatric supports and treatment	Yes	License
Substance use disorder services	Yes	Degree or license

Service	Fingerprinting Required	Degree/License/Certification
HCBS-psychosocial rehabilitation services	Yes	Bachelor's degree or license
Peer support	Yes	Certification

The RME and PA shall maintain personnel records of direct service staff providing services (See Section 18800-Personnel Records for more information). Also, the RME and PA shall provide the following to the [HCBS-AMH RM and PA](#) mailbox, via secure email with "HCBS-AMH Provider Credentialing" in the subject line, for direct service staff providing services in the state hospital:

- Each direct service provider's name and state hospital(s) in which each direct service provider provides services;
- Completion of fingerprinting procedures, as described by HHSC policy; and
- As applicable, proof of degree, license, or certification for each direct service provider providing HCBS-AMH services inside a state hospital.

RMEs and PAs shall send notification to the [HCBS-AMH RM and PA](#) mailbox, via secure email, identifying any changes or updates to HCBS-AMH direct service staff who are authorized to work in a state hospital. The HCBS-AMH direct service providers shall not provide Program services to any participant inside a state hospital until the credentialing process is complete.

19000 Benefits, Entitlements, and Financial Resources

19100 Medicaid Eligibility Determination

Eligibility determinations for Medicaid are performed as described under the Texas Medicaid state plan. HHSC shall make 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 state plan shall be made by HHSC or, for individuals qualifying for SS), by the agency or agencies administering the supplemental security income program. Individuals approved for SSI benefits shall receive Medicaid without an additional application process.

HHSC may confirm Medicaid eligibility at any time to determine continued HCBS-AMH program enrollment. Please see the [HCBS-AMH Medicaid Plans](#) list for a list of eligible Medicaid plans.

19110 Social Security Administration Prerelease

Program

Through the interagency agreement with the SSA, state hospitals shall use the SSA prerelease program. This expedited application process is for individuals who have never received Social Security benefits or whose Social Security benefits have been reduced, suspended, or terminated because of institutionalization and who are being discharged from a public or private institution. If an individual is currently residing in a state hospital at the time of application to the program, the state hospital social worker shall assist the individual with the SSI application process through the SSA Prerelease program.

An application filed before release allows the SSA to make a determination based on what the situation will be after the institution releases the individual. This allows the eligible individual to receive SSI or Social Security payments shortly after re-entering the community. In addition, this process confirms whether the individual is eligible for SSI and if so, they are determined Medicaid eligible to meet program financial eligibility criteria.

19120 Medicaid Application for Non-SSI Eligible Individuals in a State Hospital

If, through the prerelease program process it is determined the individual residing in the state hospital is not eligible for SSI, the individual shall complete a Medicaid application to HHSC Medicaid Eligibility. This process involves an investigation of the applicant's financial status and proof of citizenship and ends with a decision of approval or denial. Once the individual is determined Medicaid eligible by HHSC Medicaid Eligibility, and program staff confirm the individual will have an accepted type of assistance, the state hospital social worker shall submit the program application along with documentation showing the individual is Medicaid eligible.

19130 Community Applications for Medicaid Benefits

Individuals currently residing in the community who are interested in applying for the Program must have active Medicaid at the time of application. If an individual wanting to apply to the program does not currently have Medicaid, the individual may work with their referring entity to apply for SSI benefits to the SSA or a Medicaid application to HHSC Medicaid Eligibility. Once Medicaid is active, the individual may apply for the program.

19140 Recovery Manager's Role in Obtaining and Maintaining Benefits

When applicable, it is the responsibility of the RM to coordinate with the state hospital social worker to ensure the Social Security prerelease application process is completed. The RM shall monitor the status of the individual's benefits and provide

guidance and assistance to help the individual obtain and maintain benefits throughout the individual's enrollment in the program.

The RM shall assist with Medicaid applications, renewals, and appeals to ensure eligible Medicaid is obtained and retained for all HCBS-AMH participants. i The RM shall assist participants with follow up to any questions, inquiries or requests for additional documents requested by Medicaid or the SSA office. The RM shall assist the participant with retaining HCBS-AMH Medicaid eligibility status at all times and reactivating Medicaid benefits if benefits have been suspended or terminated.

Failure to obtain an eligible form of Medicaid and maintain Medicaid eligibility status may result in the participant's disenrollment from the HCBS-AMH program.

19200 Medicaid Eligibility Resources

19210 SSI Application and Resources

The SSA website includes information about applying for [disability benefits](#).

Individuals may also be eligible for expedited approval of Social Security and Medicaid benefits if they have been diagnosed with a disorder that is listed as a [Compassionate Allowance Condition](#).

If an individual is denied SSI benefits, please go to the SSA website for information on the process for [Hearings and Appeals](#).

Failure to obtain an eligible form of Medicaid and maintain Medicaid eligibility status may result in the participant's disenrollment from the HCBS-AMH program .

19220 Medicaid Application and Resources

[Your Texas Benefits](#) includes information on the application and submission process. Following are tips to submitting a complete application.

- Complete application in terms of income and resources of the individual applying for Medicaid.
- Provide the diagnosis review.
- Provide the most recent physician signed medical treatment records with diagnosis (records from the most recent 12 months is preferable).
- Provide a copy of the individual's birth certificate.
- Provide a front and back copy of the individual's private insurance card and include policy values.
- List all resources, for example bank accounts, financial verification, i.e. three consecutive monthly bank statements dated to first of month of application

date, complete with ending balance and account holder names.

Information from other sources may also help show the extent to which an individual's impairment(s) affects their ability to function in a work setting. Other sources include public and private agencies, non-medical sources, such as social workers and employers, and other practitioners, such as naturopaths, chiropractors, and audiologists.

19221 Medicaid Appeal Process

Denial of Medicaid eligibility may be appealed through a request to HHSC Medicaid Eligibility staff. If an individual, referring entity, or their authorized representative does not agree with HHSC's decision concerning eligibility for any Medicaid for the Elderly and Persons with Disabilities, they may request a fair hearing within 90 days of the eligibility determination. Reasons for dissatisfaction may include:

- Denial of benefits;
- • Reduction of benefits; or
- • Co-payment amounts.

An individual or their authorized representative may request a fair hearing by:

- Calling 2-1-1;
- Contacting any local HHSC office;
- Submitting a written request via fax to 1-877-447-2839; or
- Submitting a written request via mail to:

↪ HHSC, PO Box 15100, Midland, TX 79711-990710.

19222 Additional Resources if Medicaid Eligibility is Denied

Following is a list of application options in the situation the current status of Medicaid eligibility is denied, no record of eligibility, or record is showing a future eligibility end date.

- H1010E-Application for Assistance located at [Texas Works Application](#): This is an integrated application for requesting additional programs and services outside the scope of Medicaid Aged and Disabled, i.e. Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families.
- Qualified Income Trust: If an individual's income exceeds the program financial eligibility requirements (150 percent of the federal poverty level), then an option is available for the individual to set-up a [Qualified Income Trust](#) to meet the financial requirements. It is the responsibility of the individual and LAR (if applicable) to set up a Qualified Income Trust.

19300 Dual Eligibility

Individuals are eligible for program services if they are receiving both Medicaid and Medicare, referred to as dual eligibility, and have an accepted Medicaid Type. Refer to the “Home and Community Based Services- Adult Mental Health Medicaid Plan- Types of Assistance” resource document found on the general HCBS-AMH webpage. In cases of dual eligibility, program services shall be covered under Medicaid and acute care services shall be billed to Medicare.

19400 STAR+PLUS

STAR+PLUS is a Medicaid managed care program of HHSC in which individuals are automatically enrolled if they have a physical or mental disability and are eligible to receive SSI or Medicaid because of low income. Medicaid STAR+PLUS eligible individuals are provided information on MCO choices and have 15 calendar days after an enrollment packet is mailed to them to select their STAR+PLUS MCO. If no selection is made within the specified timeframe then, by default, the individual shall be enrolled into a STAR+PLUS MCO. STAR+PLUS enrollees can change to a different STAR+PLUS MCO within the first 90 days after initial enrollment into an MCO, and annually thereafter. Under certain circumstances, enrollees may change STAR+PLUS MCO after that 90-day timeframe.

STAR+PLUS plans offer:

- Traditional Medicaid benefits;
- Primary care provider;
- Community-based long-term services and supports;
- Mental health rehabilitative and mental health targeted case management services;
- Service coordination;
- No limit on prescription medicines; and
- Extra services offered by the health plan.

Dual eligible individuals are enrolled in long-term services and supports through STAR+PLUS and basic medical services through Medicare.

19500 Federal Insurance Exchange

If an individual’s income is more than 100 percent of the federal poverty level, the individual may purchase a private health insurance plan in the Marketplace and may be eligible for premium subsidies based on their household size and income.

Individuals may visit the [Texas Health Insurance Exchange Marketplace](#) or call 1-800318-2596 for assistance in comparing plans, applying, and enrolling for coverage.

19600 Texas Supplemental Nutrition Assistance Program

[Supplemental Nutrition Assistance Program](#), commonly known as food stamp benefits, is a government-operated program to assist individuals and families with food costs. [Supplemental Nutrition Assistance Program](#) benefits allow individuals and families to purchase food items at an authorized retail store.

19700 Texas Department of Home and Community Affairs Programs

The [Texas Department of Home and Community Affairs](#) offers many community and energy assistance programs, including rental assistance, home buyer assistance, and home energy costs.

19800 County Indigent Health Care Program

For information on County Indigent Health Care Program (CIHCP) training and services available, see Section 11000-Provider Training and Resources.

20000 Quality Management

The RME, PA, and HHSC shall perform local Quality Management (QM) reviews. The RME and PA shall participate collaboratively with HHSC in ongoing quality improvement and assurance activities. HHSC, the RME, or the PA may identify issues and suggest potential remedies.

The foremost responsibility of any service system is to ensure the health, welfare, and safety of program participants. Within Texas' mental health service delivery system, protocols are in place to ensure health and welfare standards are continuously met and that Medicaid services, including those funded through the program, are implemented in accordance with Medicaid statute and program requirements and standards. Components of the HHSC QM system include:

- Continuous monitoring and improving of the quality and effectiveness of services delivered to participants;
- Evaluating and improving participant satisfaction;
- Reviewing IRPs;
- Routine review of each program provider;
- Service utilization and billing analysis;
- Clinical outcomes analysis;

- Review and investigation of health and safety complaints by protective agencies;
- Training and technical assistance;
- Review and follow-up on CIRs;
- Collection and analysis of critical incident data to identify trends and initiate quality improvement strategies;
- Enhanced continuity and coordination among behavioral health care providers and between behavioral health care and physical health care providers; and
- Setting requirements.

20100 HHSC Responsibilities

HHSC is responsible for the oversight of the RMEs and PAs. HHSC shall conduct quarterly desk reviews in compliance with the functions delegated in the approved HCBS-AMH Provider Agreement and State Plan Amendment. HHSC may conduct Quality Management (QM) reviews as desk or onsite reviews scheduled at least biennially. These reviews examine provider policies, procedures, and operation of the functions delegated in the approved HCBS-AMH application. These reviews also monitor HCBS-AMH Provider compliance with requirements for finger-printed criminal history and registry checks. Program staff annually aggregate the data and report to CMS.

HHSC shall monitor provider activity and use data to assess provider performance related to quality initiatives and specific performance measures. HHSC shall conduct reviews of each provider organization on a regularly scheduled cycle or as needed based on indicators of service delivery issues, such as complaints, grievances, or critical incidents. HHSC shall review a sample of the provider organization's participant records, personnel records, encounter data, policies, and procedures to ensure the organization's compliance with HHSC standards and program requirements, and to ensure the provider is providing adequate oversight and is responsive to findings.

Quality monitoring activities includes desk and onsite reviews, participant record reviews and provider credential and training records, tracking of and response to critical incidents, coordination of care, and timely access to services. Participant record reviews include:

- IRPs, including safety and ANE plans;
- Progress notes of the participant's progress toward goals, as well as strengths and limitations in achieving goals and objectives; and
- Referrals to preventative and self-help care, as well as interventions to prevent incarceration or hospitalization.

HHSC shall monitor data on a regular basis to identify trends or issues that may require training, policy clarification, process improvement or program action. HHSC may require a corrective action plan with specific actions and timelines. Failure to respond to program requirements may result in withholding payment or contractual action, to include contract termination.

HHSC shall review each sampled participant's record to verify that demographic, clinical, and financial eligibility has been met and that any applicable service limitations have not been exceeded.

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

HHSC shall review IRPs in relation to practice and conduct periodic onsite 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 settings shall meet state licensure or program certification requirements that may pertain to each setting.

HHSC shall include medication management review as part of the annual review of contracted RMEs and PAs. HHSC shall monitor the performance of providers administering medications to the participant and enforce requirements through annual assessment and review of critical incidents.

HHSC shall oversee providers to ensure individual choice and independence is not compromised. HHSC shall also review and approve IRPs for participants before the provision of services.

Annually, HHSC shall review contractors who complete evaluations, reevaluations, assessments, and IRPs to ensure the contractors do not have an interest in or are under the control of a provider on the IRP. In addition, HHSC shall 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.

In addition to scheduled reviews, HHSC may conduct intermittent reviews if a pattern of unresolved complaints, critical incidents, past performance of an RME or PA, or other findings warrant more frequent review.

HHSC shall conduct reviews of reported service encounters to verify the validity of the service. Encounters are linked to paid claims and any identified invalid services are

expected to be repaid by the RME or PA. These data verification reviews include IRPs, demographic, clinical, and financial eligibility, and server credentials, as well as service documentation.

HHSC shall identify noncompliance and document the findings in the report after every QM review for RME and PA's.

DFPS shall provide HHSC copies of each investigation of ANE allegations involving a program participant. Regardless of the investigation findings, HHSC shall review each investigative report.

HHSC shall develop, implement, and monitor compliance with rules, policies, procedures, and other guidance governing the program.

HHSC may conduct interviews with program participants to verify the participants' satisfaction and delivery of services.

The HHSC QM Plan delineates specific indicators related to each performance measure. Data from these reviews are reported to CMS via these indicators and associated reports. HHSC shall coordinate with leadership to discuss findings and trends and, when necessary, develop and monitor remediation plans.

HHSC shall conduct surveys and monitor RMEs and PAs for compliance with licensing and certification requirements. When harmful or non-compliant practices are identified, corrective action shall be taken to bring the facility back into compliance. HHSC shall analyze data regarding each quality assurance measure through reports presented at Quality Review Team meetings, and when potentially harmful practices are identified, develop remediation or improvement plans, as needed.

20200 Recovery Management Entity and Provider Agency Responsibilities

RMEs and PAs shall allow representatives of HHSC, DFPS, the Office of the Attorney General–Medicaid Fraud Unit, and the United States Department of Health and Human Services full and free access to records related to Program services, direct service staff, participants, and all locations where PA direct service staff or subcontractors and RME RMs perform activities related to the Program. On an ongoing basis, RMEs and PAs shall verify that this access is achieved, maintained, and documented, and HHSC shall conduct reviews to verify these requirements continue to be met after the provider and HHSC enter into an agreement.

HHSC, RMEs, and PAs shall collaborate on identifying, developing, and implementing UM, quality assurance, and improvement activities specific to the Program. RMEs and PAs shall be specifically responsible for the following QM activities:

- Informing HHSC of concerns or known issues with RMEs and PAs and

implementation of services identified in IRPs of participants.

Implementing QM operating practices for Program services and activities, such as monitoring that the required contacts occur, modifying each IRP as necessary and ensuring documentation generated by providers are compliant with requirements.

20210 Quality Improvement Processes and Management of Risk to Participants, Staff, and Others

RMEs and PAs shall ensure quality improvement processes and management of risk to participants, staff, and others are a priority by ensuring:

- There is a well-defined quality improvement plan for assessing and improving organizational quality. Providers shall demonstrate how:
 - Issues are identified;
 - Solutions are implemented;
 - New or additional issues are identified and managed on an ongoing basis;
 - Internal structures minimize risks for individuals and staff;
 - Processes used for assessing and improving organizational quality are identified; and
 - The quality improvement plan is reviewed and updated, at a minimum, annually and that the review is documented.
- Indicators of performance are in place for assessing and improving organizational quality. Providers shall demonstrate:
 - The indicators of performance established for each issue;
 - The method of routine data collection;
 - The method of routine measurement;
 - The method of routine evaluation;
 - Target goals/expectations for each indicator; and
 - Outcome measurements determined and reviewed for each indicator on a quarterly basis.
- A percentage of participant records are reviewed quarterly to include records of participant who are considered "at risk." Evidence of QM record reviews shall be kept for a period of at least two years. Record reviews shall include verification that:
 - Records are organized, complete, accurate, and timely;

- Services are delivered in accordance with IRPs;
- Participants have choices;
- Documentation of service delivery includes participants' responses to services and progress toward IRP goals;
- Participants have health care services;
- Critical incidents are reported and strategies to reduce reoccurrence are followed;
- Medication administration and management issues follow policy; and
- Nursing and physician treatment plans of care are followed.

All HCBS-AMH PA contracted entities must complete and submit the HCBS-AMH Subcontracting Attestation Form ([link here](#)) for each subcontractor as part of the HCBS-AMH biennial QM review, or as requested by HHSC. PA contracted entities must attest that all subcontractors are in compliance with all requirements outlined in the contract and held to the same standards as the HHSC contract.

At a minimum, Provider Agencies must attest that all minimum requirements below are met:

- Annual fingerprint-based criminal history checks;
- Documentation of three personnel reference checks;
- Completion of HHSC required training;
- Completion of training required for competence of the service delivered;
- Certification records for employees and subcontractors;
- Certification or registration with the state and federal government, as required by applicable state and federal laws;
- Current copy of professional licensure, certification, or registration with the state and federal government, as required by applicable state and federal laws;
- Educational history; and
- Work history to include experience working with individuals diagnosed with a SMI.
- Sub-contractor is held to the same standards as the HHSC contract.

21000 Health and Safety

21100 Suicide Prevention and Intervention Protocol

Information on policies and procedures associated with suicide prevention and intervention, as well as information on available trainings, may be accessed at [Texas Suicide Prevention](#). For additional information on training requirements for suicide prevention and intervention, see section 14000-Provider Training and Resources.

21200 Use of Restrictive Interventions

RMEs and PAs shall comply with 25 TAC Chapter 415, Subchapter F regarding Interventions in Mental Health Services. Per 25 TAC §415.254, except as provided by this subchapter, the use of restraint or seclusion is prohibited while delivering Program services. TAC §415.253 defines restraint as “the use of any personal restraint or mechanical restraint that immobilizes or reduces the ability of the person to move his or her arms, legs, body, or head freely.” Restraint shall only be used as a last resort after less restrictive measures have been found ineffective or are judged unlikely to protect the participant or others from harm. The intervention shall be used for the shortest period possible and terminated as soon as the participant demonstrates the release behaviors specified by the ordering physician. A participant held in restraint shall be under continuous, direct observation. The PA and RME shall ensure adequate breathing and circulation during restraint. An acceptable hold is one that engages one or more limbs close to the body to limit or prevent movement.

Informed consent regarding the potential use of restrictive intervention is required of participants. Also, the potential use of a restrictive intervention shall be included on the Safety Plan and Modification section of the participant’s IRP to include the participant’s statement of understanding of their rights and how to report ANE (See 7700-Deviations from Service Standards and 11100-Individual Recovery Plan Requirements for more information).

Direct staff shall:

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

The use of restrictive interventions by personal restraint is permissible on the property of the provider or for transportation of a participant only if implemented:

- In accordance with state law regarding interventions in mental health services 25 TAC, Chapter 415, Subchapter F, regarding Interventions in Mental Health Services;
- When less restrictive interventions, such as those listed in the safety plan, are determined ineffective to protect other individuals, the participant, staff members, or others from harm;
- In accordance with, and using only those safe and appropriate techniques as determined by, the written policies or procedures and training program of the provider;
- 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 effective to protect other individuals, the participant, staff members, or others from harm; and
- Is discontinued at the earliest possible time.

The PA and RME shall consider information that could contraindicate or otherwise affect the use of personal restraint, including information obtained during the UA or intake. This information includes:

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

21210 Documentation and Reporting of Restrictive Interventions

The PA and RME shall document the use of personal restraint as a critical incident and follow the procedures for CIRs. Unauthorized use of restrictive interventions is discovered by record review and through complaints.

The PA and RME shall record the following information in the clinical record within 24 hours of a restrictive intervention:

- The circumstances leading to the use of personal restraint.
- The specific behavior necessitating the restraint and the behavior required for release.
- The less restrictive interventions that were tried before restraint was implemented.
- The name(s) of the direct service staff who implemented the restraint.
- The date and time the restraint was implemented and ended.
- The response of the participant.

The PA or RME shall notify the LAR each time restraint is used according to the following:

- Except as provided by 42 CFR, Part 2, a staff member shall notify as soon as possible but no later than 12 hours following the initiation of the restrictive intervention.
- Except in cases in which the participant has consented to have one or more specified family members informed regarding their care, and the family member or members have agreed to be informed, the RME or PA shall inform the family member or members of the restraint or seclusion episode within the time frame determined by prior agreement between the participant and specified family member(s).
- The date and time of notification and the name of the staff member providing the notification shall be documented in the clinical record of the participant, and the documentation shall include any unsuccessful attempts, the phone number called and the name(s) of person(s) with whom the staff member spoke.
- As permitted by Texas Health and Safety Code, §611.0045(b), a professional may deny the LAR of a participant access to any portion of the participant's record if the provider determines the disclosure of such portion would be harmful to the physical, mental, or emotional health of the participant.

The RM shall convene the IDT of the participant 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 participant more than two times during any 30-day period.
- When two or more separate episodes of restrictive interventions of any duration have occurred within the same 12-hour period.

HHSC shall oversee the use of restrictive interventions, including the use of personal restraints, with program participants through annual risk assessments. Unauthorized use of restraint is discovered by record review, site reviews, and through complaints. The use of restrictive interventions is reported as critical incidents and managed as part of the contract oversight process by HHSC.

21220 Prohibited Restrictive Interventions

The use of personal restraints is prohibited except in a behavioral health emergency. PAs are prohibited from using chemical restraints, mechanical restraints, or seclusion. Other forms of interventions that restrict participant movement, participant access to other persons, locations, or activities, restrict participant rights, or employ other aversive methods to modify behavior are not allowed.

A behavioral emergency is a situation which involves a participant behaving in a violent or self-destructive manner where preventive, de-escalating, or verbal techniques have been determined ineffective, deeming it immediately necessary to restrain the participant to prevent:

- Imminent probable death or substantial bodily harm to the participant because the participant is attempting to commit suicide or inflict serious bodily harm; or
- Imminent physical harm to others because of acts the participant commits.

Restrictive interventions shall not be used:

- As a means of discipline, retaliation, punishment, or coercion;
- For the convenience of staff members or other persons;
- As a substitute for effective treatment or habilitation; or
- Unless it is necessary to intervene to prevent imminent probable death or substantial bodily harm to the participant or imminent physical harm to another, and less restrictive methods have been tried and failed.

PAs and RMEs shall not use more force than is necessary to prevent imminent harm and shall ensure the safety, well-being, and dignity of participants who are personally restrained, including attention for personal needs.

Additionally, per 25 TAC §415.255, personal restraints that do any of the following are prohibited:

- Obstruct the airway of the participant, including a procedure that places anything in, on, or over the mouth or nose of the participant;
- Impair the breathing of the participant, including applying pressure to their torso or neck;
- Restrict circulation;

- Secure a participant to a stationary object while the participant is in a standing position;
- Causes pain to restrict a participant's movement (pressure points or joint locks);
- Inhibit, reduce, or hinder the ability of the participant to communicate;
- Is a protective or supportive device that is not easily removable by the participant without a staff member's assistance; and
- Function as a protective device for wound healing after a wound has healed.

Per 25 TAC §415.255, a prone or supine hold shall not be used during a personal restraint. Should a participant become prone or supine during a restraint, then any provider involved in administering the restraint shall immediately transition the participant to a side lying or other appropriate position.

21230 Training Requirements Regarding Restrictive Interventions

PAs and RMEs shall ensure direct service staff are informed of their roles and responsibilities and are trained and demonstrate competence accordingly. The training program shall:

- Target the specific needs of the Program target population;
- Be tailored to the competency levels of the staff members being trained;
- Emphasize the importance of reducing and preventing the use of restraint and seclusion;
- Be evaluated annually to ensure the training program, as planned and implemented, complies with the requirement of this section and 25 TAC, Chapter 415, Subchapter F;
- Incorporate evidence-based best practices; and
- Provide information about declarations for mental health treatment, including:
 - The right of participants to execute declarations for mental health treatment; and
 - The duty of direct service staff to act in accordance with declarations for mental health treatment to the fullest extent possible.

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

- 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 or seclusion and the behavior of staff members can affect the behavior of an individual, 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 nonphysical interventions, such as clinical timeout and quiet time.
- Recognizing, and appropriately responding to, signs of physical distress in individuals who are restrained, 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 application, and use of personal restraint as a last resort in a behavioral emergency; and
- Management of emergency medical conditions in accordance with the provider's policies and procedures and other applicable requirements for:
 - Obtaining emergency medical assistance; and
 - Obtaining training in and using techniques for cardiopulmonary respiration and removal of airway obstructions.

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

- Perform assessments of participants who are in restraint shall receive training, which shall include a demonstration of competence in:
 - Monitoring cardiac and respiratory status and interpreting their relevance to the physical safety of the participant in restraint or seclusion;

- Recognizing and responding to nutritional and hydration needs;
 - Checking circulation in, and range of motion of, the extremities;
 - Providing for hygiene and elimination;
 - Identifying and responding to physical and psychological status and comfort, including signs of distress;
 - Assisting participants in de-escalating, including through identification and removal of stimuli, that meet the criteria for a behavioral emergency if known;
 - Recognizing when continuation of restraint or seclusion is no longer justified by a behavioral emergency; and
 - Recognizing when to contact emergency medical services to evaluate and/or treat a participant for an emergency medical condition.
- Conduct evaluations of persons, including face-to-face evaluations pursuant to 25 TAC §415.260(c) relating to Initiation of Restraint in a Behavioral Emergency of individuals who are in restraint, shall receive training, which shall include a demonstration of competence in:
 - Identifying restraints that are permitted by the provider and by applicable law;
 - Identifying stimuli that trigger behaviors;
 - Identifying medical contraindications to restraint;
 - Recognizing psychological factors to be considered when using restraint and seclusion, 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 an RN, participants 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 persons 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.

21300 Medication Safety and Management

21310 Medication Management General Standards

The program has identified the PA as responsible for ensuring all services are available and provided based on a participant's needs and goals, in accordance with their IRPs and allowing as much autonomy as possible in keeping with person centered principles. The PAs shall monitor medication regimens, which means verifying that medications are taken as prescribed, ensuring proper medication storage, and medication reconciliation, administration, documentation, and reporting of medication errors. The PA shall assure that an employed or subcontracted RN provides unlicensed personnel with delegated authority to administer medications, or oversight of participants who self-administer medications, training and a competency assessment for medication administration and monitoring. Before assuming their duties, unlicensed personnel should have knowledge of each medication, for what it is prescribed, and any adverse reactions.

PAs shall monitor participant medication regimens for participants who cannot self-administer and/or require oversight of self-administration of medications (See 11700 Deviations from Service Standards for more information). An RN authorizes an unlicensed person to perform tasks of nursing care in selected situations and indicates that authorization in writing. The delegation process includes nursing assessment of a participant, evaluation of the ability of the unlicensed persons, teaching the task, ensuring competency, ongoing supervision of the unlicensed persons, and reevaluating the task at regular intervals. The PAs, through the RN, as applicable shall:

- At least annually, assure that nursing staff are qualified under their scope of practice.
- Comply with 22 TAC, Chapter 225 when delegating nursing tasks to unlicensed personnel.
- Assure that staff delegated the authority to administer medications or oversight of participants who self-administer medications receive instruction in medication administration and monitoring from an RN with delegation authority. Staff delegated to administer medications are competent and have knowledge of each medication, for what it is prescribed, and the adverse reactions side effects before assuming their duties and as indicated by changes in the condition of the participant or medication regimen.

Monitor unlicensed personnel who have been delegated the administration of

medications or oversight of participants who self-administer medications.

- If applicable, the lar shall sign an authorization for the pa to administer each medication according to label directions.
- Medications shall be in the original container labeled with the expiration date and the full name of the participant.
- Administer the medication according to the label directions or as amended by a physician. Physician orders shall be readily available to verify accuracy ofmars.
- Administer the medication only to the participant for whom it is intended.
- Not administer the medication after its expiration date.
- If applicable provide non-prescription medications if the pa obtains lar consent prior to administration of the medication. Consent may be given over the phone and documented as such by the pa.
- At least quarterly, or more frequently if indicated by the condition of the participant, medication regimen or changes to the regimen, review mars to ensure that medications are correctly administered.
- Inform the participant of the likely impact of refusing treatment, medications, or dietary restrictions. The PA must document refusals and inform the IDT.

21320 Self-Administration of Medications

Participants are encouraged to self-administer their medications to the degree that they are willing and able. The participant may be able to safely self-administer medications independently, or independently with ancillary aid provided to the individual according the participant's self-administered medication regimen. Per 22 TAC §225.4(3), ancillary aid covers activities such as reminding an individual to take a medication at the prescribed time, opening and closing a medication container, pouring a predetermined quantity of liquid to be ingested, returning a medication to the proper storage area, and assisting in reordering medications from a pharmacy. Progress on medication adherence should be documented in the participant's IRP.

In the comprehensive nursing assessment, the nurse should work with the participant to assess their knowledge and ability to self-administer medications. If the RN assesses that the participant needs assistance in medication administration but the participant wants to self-administer, every effort should be made to develop a plan for supporting the participant in the choice to self-administer.

The IRP should reflect this individualized plan under nursing services.

21330 Medication Errors

All medication errors shall be reported to HHSC as critical incidents using the CIR template in CMBHS within 72 hours of incident information..

PA direct service staff responsible for medication administration shall record and report medication errors to HHSC. PAs shall record the following as applicable:

- Medication given to the wrong person;
- Giving the person the wrong medication;
- Giving the incorrect dosage;
- Failing to give the medication at the correct time;
- Failing to use the correct route;
- Discrepancy in the medication count; or
- Failing to accurately document the administration of the medication.

21340 Medication Administration Records

The PA is responsible for monitoring a participant's use of medications. Monitoring the use of medications means verifying that the medications are taken as prescribed. A licensed nurse is required to monitor the use of medications for participants who are unable to safely administer their own medications. Medication administration by an unlicensed paid staff is documented on a MAR. MARs should not be altered or signed prior to the administration of medications. A MAR is signed by putting the staff's initials on the MAR, which verifies that the medication was administered. You should not use check marks or white out on a MAR.

All medication records must be kept for seven years in accordance with 22 TAC §165.1(b) or other applicable statutes, rules, and regulations governing medical information.

The PA or authorized designee must document the following on the MAR when medication is administered or assistance is provided with self-administered medication:

- Full name of the person to whom the medication is given;
- Date of birth;
- Allergies;
Name of the medication;
- Date, time, route, and dose of medication given;
- Full name and initials of direct service staff administering the medication; and
- Outcome of medication administration (i.e. person refused or medication discontinued)

21350 Storing Medications

If the PA is responsible for storing the medications of the participant, the provider

shall store medications as follows:

- in locked storage;
- In a manner that does not contaminate food;
- Refrigerate if required; and
- Kept separate from food.

Authorized staff may pick up or transport medications pre-packaged (by the pharmacy) from one program site to another.

Authorized staff may transport prescribed medications to or from the person's home if authorized by the person and/or LAR, including pill packs accurately labeled in advance by the client or pharmacy and pharmacy-labeled pill bottles.

Prescribed medications must be reconciled by a licensed nurse/designated staff upon receipt from the pharmacy or the client. Medications held at the site for the person to access or for staff to transport to the person's home must be inventoried and kept locked.

21360 Destruction of Medication and Empty Prescription Bottles

If the PA is responsible for storing the medications of the participant, the provider shall abide by TAC, Title 22, and Rule 303.1 regarding destruction of medication. Empty bottles contain PHI and must be disposed of appropriately.

21370 Required Health and Nursing Documentation

The Program requires the following documentation for each participant:

- **Nurse Health Screening – Form 3090:** This form is completed by an RN or LVN within 72 hours of enrollment and community placement to evaluate health and ensure prescribed medications or treatments are available and referrals and appointments to primary care physician or specialists are scheduled.
- **Comprehensive Nursing Assessment and Nursing Service Plan - Form 3091:** The RN comprehensive assessment as defined by the Board of Nursing: "Comprehensive Nursing Assessment is an extensive data collection (initial and ongoing) addressing anticipated changes in client conditions as well as emergent changes in an individual's health status; recognizing alterations to previous conditions; synthesizing the biological, psychological, spiritual and social aspects of the individual's condition; and using this broad and complete analysis to make independent decisions and nursing diagnoses; plan nursing

interventions, evaluate need for different interventions, and the need to communicate and consult with other health team members.” 22 TAC §217.11. This comprehensive assessment is for an individual with SMI and additional information may be required based on the individual’s condition, age, or other factors. It contains a delegation decision page to document the self-administration of medication decision based on the comprehensive assessment, and a section for the planning of nursing care. This form must be completed within 30 days of enrollment and placement in the community and reviewed annually or sooner if health status changes.

- **RN Delegation Worksheet - Form 8585:** This form is completed by the RN and attached to the comprehensive nursing assessment to guide RN delegation decisions for medication administration, other nursing tasks, and to guide RNs in planning care in an independent living environment for stable and predictable conditions. This worksheet synthesizes nursing tasks identified in 22 TAC §225 that guide the RN in practice options in addition to his/her professional judgment.
- **Nursing Supervision – Form 8588:** This form is used to document the continued competency of the unlicensed person performing the nursing task(s). The form is also completed for each individual and each staff performing delegated tasks on a frequency determined on the comprehensive nursing assessment and RN Delegation Worksheet.

Tracking of Delegated Tasks - Form 8509: This form is completed by the RN for each individual to document supervision and training of unlicensed personnel. A copy of this must be kept in the individual’s residential (home) record to demonstrate nurse training and supervision of unlicensed personnel. Frequency of monitoring and supervision is determined and documented on the comprehensive nursing assessment.

- **Medication Administration Record - Form 3092:** This form is a legal record of the medications administered to an individual by health care professionals or unlicensed personnel. The MAR is part of a participant’s permanent record in their medical chart. The health care professional or trained unlicensed personnel signs off on the MAR at the time that the medication is administered. The MAR is initialed for each dose administered and medication errors are documented on the MAR, progress notes, and a CIR are submitted to the state. Staff initials on the MAR indicate medications were administered. The MAR must include the full name of staff and their initials and additional information if participant refused, medication discontinued, or medication error.

21380 Screening for Tuberculosis

All employees must be screened for tuberculosis when hired and annually thereafter. Initial evaluation includes screening for the signs and symptoms of active tuberculosis and a Mantoux tuberculin skin test, chest x-ray, or Interferon Gamma Release Assay (IGRA) test performed within three months of the date of hire. It is preferable to have a Mantoux tuberculin skin test or lab test; however, at the physician's discretion a chest X-ray may be substituted for the Mantoux test. Annual screening may consist of one of any form of surveillance, including active symptom screening questionnaires, Mantoux tuberculin skin test, chest x-ray, or IGRA testing.

HCBS-AMH recommends that all persons receiving services have a documented baseline tuberculosis screening, which consists at a minimum of an evaluation for the evaluation of the symptoms of active tuberculosis, which include persistent cough greater than two weeks duration, bloody sputum, night sweats, weight loss, anorexia, and fever. Individuals who show signs of active tuberculosis should be referred to their primary care provider or the local health department for treatment. Additionally, a baseline laboratory test for latent tuberculosis infection, such as an IGRA, Mantoux skin test, or chest x-ray, should be sought for all persons receiving services, particularly those who are at highest risk. Further screening should be guided by exposure to active tuberculosis and clinical risk factors.

The highest risk groups include medically underserved populations; unhoused individuals; individuals with SUDs; foreign born persons from Asia, Africa, the Caribbean, and Latin America; the elderly; those with contacts to persons with tuberculosis; and residents of extended care facilities.

Those persons at a high risk of disease progression should also obtain baseline laboratory screening. These include persons with HIV infection, silicosis, a history of gastrectomy or jejunioileal bypass surgery, greater than 10 percent below normal body weight, chronic renal failure, diabetes mellitus, immunosuppressed due to medication, and some cancers.

22000 Consumer Rights

Individuals shall be notified of their rights prior to enrollment in the program. This shall be verified through completion of the Notification of Participant Rights Form. The Notification of Participant Rights Form:

- Informs the participant of the contact information for HHSC Office of Consumer Services and Rights Protection, DFPS, and the Office of the Ombudsman;
- Informs the person of his/her right to an administrative appeal or Medicaid Fair Hearing regarding the program;
- Informs the person of the process for reporting allegations of ANE and the tollfree number for DFPS; and

- Includes an attestation of acknowledgement of receipt of a copy of the Handbook of Consumer Rights, Mental Health Services, and the HCBS-AMH Participant Handbook outlining the conditions in which the right to request a Medicaid Fair Hearing apply.

RMES and PAs shall also give this information to the individual and LAR (if applicable) upon request and if/when a need is identified or believed to exist.

The name, telephone number, mailing address, and fax number of the Office of the Ombudsman-Behavioral Health Ombudsman shall be prominently posted in every area that is frequented by program participants. RMEs and PAs shall allow access to a telephone whenever a participant desires to contact the Office of Ombudsman.

The method used to communicate the information is 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 shall be documented on the Notification of Participant Rights Form bearing the date and signatures of the person enrolled in HCBS-AMH and/or LAR and the staff person who explained the rights. The Notification of Participant Rights Form shall be filed in the clinical record of the participant.

22100 Administrative Appeals and Medicaid Fair Hearings

The Medicaid Fair Hearing is described in 1 TAC, Chapter 357, Subchapter A (relating to Uniform Fair Hearing Rules). The HHSC Appeals Division is responsible for publishing fair hearing rules, receiving fair hearings appeal requests, conducting fair hearings, and issuing decisions. Administrative Appeals and Medicaid Fair Hearings are conducted as an informal proceeding by an impartial hearings officer.

RMEs and PAs shall implement procedures to give notice of the right to a timely and objective administrative appeal or Medicaid Fair Hearing process for all participants whose program services or benefits are denied, reduced, suspended, or terminated.

The RME or PA shall assist any participant with requesting an Administrative Hearing or Medicaid Fair Hearing and ensure the participant or LAR (if applicable) have all the necessary information to submit a request for an Administrative Appeal or Medicaid Fair Hearing. The procedures shall include ensuring all participant or LARs (if applicable) for program services are submitted to the HHSC via the IRP.

The Determination Letter shall also inform the participant of the right to continue to receive services while the Administrative Appeal or Medicaid Fair Hearing is pending and the actions the participant shall take for services to continue.

When HHSC receives a request for an Administrative Appeal or Medicaid Fair Hearing, HHSC shall notify the RME and PA of such request and the date and time of the Administrative Appeal or Medicaid Fair Hearing. The PA shall review the basis of its

decision to deny, terminate, reduce, or suspend services. The RME and/or PA shall be notified by HHSC of the requirement to attend the Fair Hearing as a witness and shall be provided a copy of the evidence packet submitted to the HHSC Appeals Division.

The PA shall continue services until the hearing officer makes a final decision, if notified by HHSC that the participant is entitled to continued services.

The RM shall assist the participant with the Administrative Appeal or Medicaid Fair Hearing process, if needed, including informing HHSC of any reasonable accommodations required and with the preparation and submission of documentation.

22110 Conditions for Requesting an Administrative Appeal and Medicaid Fair Hearing

The conditions under which the participant may request an Administrative Appeal or Medicaid Fair Hearing include:

- An individual is denied participation in the program;
- A participant is denied continued participation in the program;
- A participant's program services are denied, reduced, suspended, or terminated; or
- An individual's request for eligibility for the program is not acted upon with reasonable promptness.

22120 Requirements for Notification

The individual/participant is informed of the right to an Administrative Appeal or Medicaid Fair Hearing during enrollment through the Notification of Participant Rights Form, Handbook of Consumer Rights, and the Participant Handbook. Additional notifications occur for any reduction, termination, suspension, or denial of a service.

22130 Administrative Appeal and Medicaid Fair Hearing Process

22131 Requesting an Administrative Appeal or Medicaid Fair Hearing

The individual (appellant) has the right to appeal within 90 days from the date on the notice of agency action or the effective date of the agency action, whichever is later. Only the appellant or the appellant's authorized representative has the right to appeal action by an agency.

Requests for an Administrative Appeal or Medicaid Fair Hearing shall be made to the HHSC Office of Ombudsman—Behavioral Health Ombudsman. An authorized representative of the appellant may make the request for an Administrative Appeal or Medicaid Fair Hearing by completing the steps outlined in the Determination Letter or

by calling the Office of the Ombudsman–Behavioral Health Ombudsman.

Once an appeal is filed, only the appellant or the appellant’s representative may withdraw the request. The appellant shall make the request in writing to the hearings officer or the local office and give the reason for requesting to withdrawal.

Contact Information:

Office of the Ombudsman – Behavioral Health Ombudsman

P.O. Box 13247

Mail Code: H-700

Austin, Texas 78711

Fax: (512) 706-7337

Toll-Free Number: 1-800-252-8154 Relay

Texas: TTY 711

22132 Continuation of Benefits

During the appeal process, the appellant has the right to receive continued benefits under the program if required by state or federal regulation or statute. The appellant shall request continued benefits when requesting a Fair Hearing, if applicable. Individuals not currently enrolled may not request continued benefits.

The Determination Letter notice informs the participant of their right to continue to receive services while the hearing is pending and the actions the participant shall take for services to continue.

22133 Notification of Fair Hearing

The HHSC Office of Ombudsman-Behavioral Health Ombudsman receives and enters the formal request for a Fair Hearing into the Texas Integrated Eligibility Redesign System database, and HHSC provides notification of a scheduled hearing date no less than 14 days prior to the Fair Hearing.

22134 Decision by Fair Hearings Officer

The hearing officer will determine if the agency’s, or its designee’s, action is compliant with statutes, policies, or procedures and will issue a written decision. A decision by the Fair Hearings officer shall be made by 90 days from the date the appeal request is received. All Fair Hearings are conducted according to the rules in 1 TAC, Chapter 357, Subchapter A (relating to Uniform Fair Hearing Rules).

22200 Complaints

22210 HCBS-AMH Provider Agency and Recovery Management Entity Policy

RMEs and PAs shall be responsible for implementing a procedure that ensures the

reporting of a complaint against an agency or its personnel by a member or interested party.

RMEs and PAs shall ensure availability of their policies and procedures to staff, participants, LARs (if applicable), family members, or any other interested parties. RME and PA policies and procedures may be subject to review by HHSC.

22220 HHSC HCBS-AMH Program Provider Complaint Process

Provider complaints shall be submitted to [HCBS-AMH Complaints](#) via form 3089. The complaint form requires a signed attestation by the complainant that the information is accurate and complete.

Complaints submitted by providers may range from payment issues, participant solicitation, quality of care, continuity of care, ethics violation, or professionalism issues, but are not limited to these categories. Concerns that may affect the health, welfare, or safety of participants must be addressed immediately and brought to the attention of HHSC.

22230 Complaints Involving Allegations of Abuse, Neglect, and Exploitation

Complaints involving allegations of ANE are referred immediately to the DFPS which is the department with statutory responsibility for investigation of such allegations. (See Section 18640-Abuse, Neglect and Exploitation for more information).

22240 Complaints Involving Community Mental Health Center/Local Mental Health Authority

Complaints involving services provided by the LMHA/LBHA should be referred to the rights protection officer at the local authority and or the Office of Ombudsman Behavioral Health Ombudsman.

22250 HHS Office of the Ombudsman– Behavioral Health Ombudsman

The Ombudsman for Behavioral Health (OBH) is established by Texas Government Code §531.02251. The OBH serves as a neutral party to help individuals, including consumers who are uninsured or have public or private health benefit coverage, and behavioral health care providers navigate and resolve issues related to individual access to behavioral health care, including care for mental health conditions and substance use disorders. The OBH also identifies, tracks, and helps report potential violations of Texas Insurance Code Subchapter F of Chapter 1355.

OBH staff operate a toll-free phone line with TTY (telecommunication device for the

deaf) capabilities from 8:00 a.m.–5:00 p.m., Monday–Friday. Complaints may also be submitted via telephone, email, or written correspondence by mail or fax.

The OBH may be contacted if a provider or participant is having a problem with an HHSC program or service. The OBH can answer questions and help resolve a complaint about services with the state hospital, community mental health center, or HCBS-AMH program, to include assistance with access to health care through the health insurance plan, whether it is private plan or a public plan like Medicaid.

The OBH can help a participant access behavioral health services, connect to other resources, and assist the participant in understanding their rights. The OBH shall gather information from the participant or provider about concerns and ensure they involve the agency or program that oversees their services to resolve the concern. OBH staff shall follow up with the participant or LAR (if applicable) within five business days of the date of receipt of a contact, and then at least every 10 business days thereafter, until the contact is closed. If the participant provides consent, the OBH shall follow up with the health care provider of the participant.

The OBH's services include:

- Conducting independent reviews of complaints concerning agency policies or practices;
- Ensuring policies and practices are consistent with the goals of HHSC;
- Ensuring participants are treated fairly, respectfully, and with dignity;
- Making referrals to other agencies as appropriate; and
- Providing an impartial review of actions taken by the program or department.

The Office of the Ombudsman seeks a resolution and may use mediation if appropriate. If it is necessary for the Office of the Ombudsman to refer an issue to the appropriate department, the Office of the Ombudsman:

- Follows-up with the complainant to determine if a resolution has been achieved; and
- Refers complainant to other available known resources.

22300 Advanced Directives

Advance directives are legal documents that allow an individual to convey their decisions about end-of-life care ahead of time. They provide a way for an individual to communicate their wishes to family, friends, and health care professionals and to avoid confusion later.

Texas law allows an option for an individual's signature to be acknowledged by a notary instead of witness signatures and for digital or electronic signatures on the Directive to Physicians, Out-of-Hospital Do Not Resuscitate Order, and the

Medical Power of Attorney, if certain requirements are met. See Health and Safety Code Chapter 166, Subchapter A for details.

When applicable, the RME may assist the participant in accessing the following forms.

22310 Declaration for Mental Health Treatment

The Declaration for Mental Health Treatment is a legal document that allows an individual to make decisions about mental health treatment in advance. Specifically, the individual gives a declaration regarding three types of mental health treatment: psychoactive medication, convulsive therapy, and emergency mental health treatment. The instructions that an individual includes in the declaration are followed only if a court believes the individual is incapacitated to make treatment decisions.

Otherwise, the individual is considered able to give or withhold consent for the treatments.

To make a Declaration, the individual shall fill out a statutory form when they are competent. Competent means a judge has not said the individual cannot make medical decisions.

22320 Directives to Physicians, Family, or Surrogates

Directive to Physicians, Family or Surrogates communicates the wishes of an individual about medical treatment at some time in the future when they are unable to make their wishes known because of illness or injury.

22330 Medical Power of Attorney

Except to the extent stated otherwise, this document gives the person named as the individual's agent the authority to make all health care decisions for the individual in accordance with their wishes, including their religious and moral beliefs, when the individual is no longer capable of making them.

22340 Out-of-Hospital Do Not Resuscitate

This legal document instructs emergency medical personnel and other health care professionals to forgo resuscitation attempts and to permit the patient to have a natural death with peace and dignity. This order does not affect the provision of other emergency care, including comfort care.

22350 Statutory Durable Power of Attorney

Statutory Durable Power of Attorney is a legal form for designating an agent who is empowered to take certain actions regarding the property of an individual. It does not authorize anyone to make medical or other healthcare decisions for an individual.

23000 Managing Conflicts of Interest

23100 Conflict of Interest Standards

23110 Standards

RMEs and PAs shall establish clear and easily accessible means for participants to make complaints and/or appeals to the state for assistance regarding concerns about choice, quality, and outcomes. These processes shall be available in writing at each agency. Complaints can be made via phone or written communication. The complaint process is managed and reviewed independently by HHSC.

RMEs and PAs shall be transparent in their communications about agency decisions that directly affect the interests of the participant, including the process and criteria for the selection of subcontracted HCBS-AMH service providers.

RMEs and PAs shall regularly review relationships and agreements with direct service providers and/or RMs to ensure they are keeping with prevailing laws, agency policies, professional standards, and the best interests of the participants they serve.

Former employees of RMEs and PAs are to cease contact with participants once they have left employment. In the event a former RME or PA employee is employed by another RME or PA, the employee is prohibited from actively recruiting the participant to change agencies. HHSC will monitor these types of situations and intervene as necessary. This monitoring process may lead to disciplinary action for the new service provider if the employee is found to be recruiting participants to the new service provider.

Providers of HCBS-AMH services, except a host home/companion care provider shall not be related by blood or marriage to the participant or to any of the paid caregivers of the participant or to anyone financially responsible for the participant or empowered to make financial or health-related decisions on the behalf of the participant.

Agencies that are both an RME and PA shall have a clear administrative firewall that separates the two service entities. Supervision or administrative oversight of the PA or subcontractors by any recovery management staff is not allowed. As such, supervision or administrative oversight of recovery management staff by the PA or subcontractors is also not allowed (See Section 23000-Managing Conflicts of Interest for more information).

23120 Ensuring Individual Choice

The participant and LAR (if applicable) shall be presented with options of RMEs and PAs available in the community of choice of the participant at the time of enrollment by the referral source. Additionally, during IRP meetings the participant shall verify if they wish to continue assistance from the current RME and PA, or if they wish to choose an alternative.

The opportunity to choose among all qualified RMEs and PAs shall be documented on the Provider Selection Form. The selection of the RME and PA shall be documented in the IRP in addition to the Provider Selection Form.

Additional documentation may be required if the selected PA is also providing recovery management services to that participant (See Section 23000-Managing Conflicts of Interest for more information).

Participants, LARs (if applicable), and referral sources shall be able to research contracted RMEs and PAs by requesting the '**Home and Community-Based – Adult Mental Health Service Regions**' document from the [HCBS-AMH Enrollment and Referral Liaison](#). This document contains a list of RMEs and PAs by service region and includes websites and contact information for each provider.

23200 Administrative Firewall

23210 Agency Roles and Responsibilities

Agencies providing both RME and PA services to the same participant shall establish administrative separation between recovery management staff and PA direct service staff. These agencies shall have separate administrative structures which provide oversight over RME and PA service staff providing all HCBS-AMH services. This separate administrative structure shall ensure that recovery management decisions are not subject to influence or revision by those providing or administering other PA services. An individual may not select an agency that provides both recovery management and PA services if there are other RMEs and PAs in the service region. If there is more than one RME and PA in the service region, the individual is free to choose either of the RMEs or PAs, if they are not part of the same organization. If the RME or PA is a provider of last resort, the participant shall select a new RME or PA at the next IDT meeting. When a new RME or PA becomes available in the service area of a participant, the participant shall be provided information about the new RME or PA at the next IDT and can change RMEs or PAs at that time. It is the responsibility of the entity that is both the RME and PA to ensure that participants are only discussed with the selected entity. If a participant receives recovery management services and

PA services from the same entity, the RME staff are prohibited from discussing the participant with PA staff in the same agency. If a participant receives PA services but not recovery management services from the same entity, the PA staff are prohibited from discussing the participant with RME staff in the same agency.

RMs are prohibited from providing any services listed as PA services at any time. PA staff or subcontracted staff may not provide recovery management services.

23220 Agency Policies

Agencies providing both RME and PA services shall have clear agency policies that provide an additional layer of protection regarding conflict of interest. These policies outline staff's fiscal and ethical responsibilities regarding the interests of the agency and the individuals served. These policies shall include a process for disclosing conflicts to HHSC and a process for reviewing and acting upon those disclosures within seven business days. This includes:

- Changes in administrative structure;
- Changes in billing practices; and
- Responsible parties for submitting invoices for the agency.

To ensure individual choice is protected, HHSC may require additional documentation if the selected RME is also providing PA services to the same participant. This includes documentation that the recovery manager is not rewarded or penalized based on amount of services listed on an IRP.

24000 Non-Duplication of Services

HCBS-AMH Medicaid participants are enrolled in Medicaid managed care and are eligible to receive traditional Medicaid state plan services in addition to HCBS-AMH services. As a result, duplication of services can occur. This service duplication happens when a participant receives similar services from two different programs at the same time (e.g., TRR services through the LMHA/LBHA and HCBS-AMH).

24100 Role of the Recovery Manager in Non-Duplication of Medicaid Services

The RM shall identify the potential for service duplication and prevent the occurrence of duplication. The RM shall coordinate care, including the development of an IRP, with the LMHA/LBHA and MCO Service Coordinator of the participant and any additional providers designated by HHSC to ensure comprehensive, coordinated, and unduplicated services.

The RM shall certify that the participant has exhausted all applicable state plan resources before the following HCBS-AMH services are submitted on the IRP:

- Adaptive aids;
- Peer Specialist services;
- SUD services;
- Outpatient mental health treatment services; and • Mental health rehabilitation.

If the assessment indicates the participant needs a HCBS-AMH service in lieu of the state plan services, it shall be documented on the IRP.

A participant shall not receive more than one of the four residential services at the same time. The participant shall not receive individual counseling, psychotherapy, or CPST from more than one provider, regardless of funding source.

Additionally, the RM shall ensure HCBS-AMH services are not delivered at the same date and time as another service that is alike in nature and scope as that HCBS-AMH service, regardless of the funding source.

24200 Role of the Recovery Manager in Nonduplication of Services for Participants 18-21

HCBS-AMH Medicaid participants under age 21 shall be enrolled in STAR Kids or STAR Health (for foster children). STAR Kids is tailored to the needs of youth with disabilities. These programs provide benefits such as prescription drugs, hospital care, primary and specialty care, preventive care, personal care services, private duty nursing, and durable medical equipment and supplies. STAR Health provides a full range of Medicaid-covered medical and behavioral health services for children in DFPS conservatorship and young adults in DFPS paid placement.

Through STAR Kids and STAR Health, participants have access to traditional state plan services and additional benefits that may be duplicative of HCBS-AMH services. To avoid duplication of services for HCBS-AMH participants under 21 years of age in DFPS conservatorship, i.e. foster children, RMs shall ensure the following HCBS-AMH services are not delivered at the same date and time as another service that is alike in nature and scope as that HCBS-AMH service, regardless of the funding source:

- Residential services (if the participant is in a Foster Care Residential Placement, the participant may remain in their placement and receive HCBS-AMH services; and
- Respite.

Additionally, the RM shall certify that the participant has exhausted all applicable state plan resources before the following HCBS-AMH services are submitted on the IRP:

- Private duty nursing through Early and Periodic Screening, Diagnostic and

Treatment.

If the assessment indicates the participant needs a HCBS-AMH service in lieu of the state plan services, it shall be documented on the IRP.

25000 Contract Action for Non-Compliance

HCBS-AMH monitors services to ensure compliance with the Provider Manual, Provider Billing guidelines; State Plan Amendment (SPA), Texas Administrative Code 26, Chapter 307, Subchapter B, and HCBS-AMH Provider Contract. Failure to meet compliance will result in a remedy or sanction against the Contractor.

When HCBS-AMH identifies actions or inactions that constitute a breach of contract, contract actions will be required. Actions constituting breach of contract may include, but are not limited to, the following:

- Failure to properly provide the services and/or goods as specified in the HCBS-AMH Provider contract.
- Failure to comply with any provisions of the HCBS-AMH contract including failure to comply with all applicable statutes, rules or regulations.
- Failure to pay refunds or penalties owed to the department.

HCBS-AMH may impose remedy or sanctions. As a result of breach of contract, HCBS-AMH may require a corrective action plan (CAP); impose a participant referral hold or withhold payments; deny additional or future contracts with Contractor; demand repayment or recoupment when it has been verified that Contractor has been overpaid or did not have proper documentation for payment claims; reduce contract terms; and terminate the contract.

HCBS-AMH will notify Contractor in writing when a remedy or sanction is imposed, stating the nature of the remedies and sanction, the reasons for imposing them, the corrective actions, if any, that must be taken before the actions shall be removed and the time allowed for completing the corrective action.

The Contractor is required to submit a written response within 15 calendar days of receipt of notice to acknowledge the receipt of the notice.

25100 Corrective Action Plan

A Corrective Action Plan is required for any area on the QM tool that scores below 90%. The contractor must submit a written corrective action plan within 15 calendar days of the date of the notification. A corrective action plan must include the following:

- 1) Describe the non-compliance that HCBS-AMH identified from the monitoring or investigation resulting in the corrective action plan.
- 2) Describe the activities the contractor will perform to correct or prevent the non-compliance from reoccurring.
- 3) The name and title of the person responsible for performing the activities to correct or prevent non-compliance from reoccurring.
- 4) The schedule or frequency for monitoring compliance.

All corrections must be completed within 60 calendar days of the date of the

notification letter; however, HCBS-AMH has the discretion to require a different deadline based on the severity of the issue.

25200 Participant Referral Hold

HCBS-AMH may issue a Participant Referral Hold if there is noncompliance or insufficient corrective actions. A Participant Referral Hold is imposed for 90 calendar days.

Participant Referral Holds may also be requested by providers that are experiencing financial, personnel, or personal problems by submitting a formal request to HCBS AMH Enrollment and Referral mailbox at HCBS-AMH-EnrollmentandReferral@hhs.texas.gov .

25300 Demand for Payment or Recoupment

HCBS-AMH may identify overbilling during monitoring or an investigation. Recoupment may occur for all overbillings. HCBS-AMH may recommend a Remedy or Sanction against Contractor for any actions or inactions that constitute breach of contract for overbilling by sending the recoupment letter to the Contractor with a remittance form requesting total of the final disallowed costs. The contractor must work with the Contract Manager to repay the department.

25400 Terminate the Contract

HCBS-AMH may recommend a sanction against the contractor to terminate the contract for non-compliance with the Provider Manual, Provider Billing guidelines; State Plan Amendment (SPA), Texas Administrative Code 26, Chapter 307, Subchapter B, and HCBS-AMH Provider Contract.

HCBS-AMH will notify the Contractor in writing no less than thirty calendar days before the effective date of the termination. HCBS-AMH has the discretion to immediately terminate a Contract, when, termination is in the best interest of the State of Texas.

25500 Administrative Hearing Request

A Contractor may appeal a contract termination by submitting a request for an Administrative Hearing. HHSC will docket the request with the State Office of Administrative Hearings.

In accordance with Texas Administrative Code Title 1, §357.484, a request for hearing must be in writing, in the form of a petition or letter and must state the basis of your appeal. Your request must be received by HHSC within 15 days after the date you receive the Contract Termination notification letter. You must include a legible copy of the letter with your request. A request that is not submitted in accordance with 1 TAC §357.484 may be denied.

A request for hearing must be submitted to HHSC by mail or fax as follows:

By Mail:

Legal Services (W-615)

Office of General Counsel
Texas Health and Human Services Commission
P.O. Box 149030
Austin, TX 78714

By Fax:
(512)438-5759

List of Acronyms

Acronym	Term
ANE	Abuse Neglect or Exploitation
ADLs	Activities of Daily Living
ANSA/UA	Adult Needs and Strengths Assessment/Uniform Assessment
APS	Adult Protective Services
CMS	Centers for Medicare and Medicaid Services
CPS	Certified Peer Specialist
CFR.	Code of Federal Regulations
CMBHS	Clinical Management for Behavioral Health Services
CIR	Critical Incident Report/Reporting
DFPS	Department of Family and Protective Services
DSHS	Department of State Health Services
EDD	Emergency Department Diversion
FPL	Federal Poverty Level
HHSC	Health and Human Services Commission
HIPAA	Health Insurance Portability and Accountability Act
HCBS	Home and Community-Based Services
HCBS-AMH	Home and Community-Based Services-Adult Mental Health
IRP	Individual Recovery Plan
IADL	Instrumental Activities of Daily Living
IDT	Interdisciplinary Team
JD	Jail Diversion
LAR	Legally Authorized Representative
LTPH	Long-Term Psychiatric Hospitalization
LBHA	Local Behavioral Health Authority
LMHA	Local Mental Health Authority
MCO	Managed Care Organization
MAR	Medication Administration Record
MMIS	Medicaid Management Information System

MBOW	Mental Retardation and Behavioral Health Outpatient Data Warehouse
PA	Provider Agency
PI	Provider Investigations
PCRPP	Person-Centered Recovery Planning
PHI	Protected Health Information
QM	Quality Management
RME	Recovery Management Entity
RM	Recovery Manager
SMI	Serious Mental Illness
SSA	Social Security Administration
SPA	State Plan Amendment
TAC	Texas Administrative Code
TMHP	Texas Medicaid and Healthcare Partnership
TRR	Texas Resilience and Recovery
UM	Utilization Management

26000 Appendix A

<u>Training and Educational Resources</u>	Description
<u>ANSA</u>ⁱ	ANSA training and annual certification.
<u>ANE Online Training</u>ⁱ	Educates providers and service provider professionals on how to suspect/recognize ANE, report to DFPS, and ensure the safety and wellness of the participant.
<u>Ask About Suicide (ASK)</u>ⁱⁱ	Suicide prevention training.
<u>Cognitive Adaptation Training (CAT)</u>ⁱ	Teaches in-home environmental supports to help persons bypass problems in motivation and thinking to organize their home environments and live independently
<u>Certified Application Counselor</u>ⁱⁱⁱ	Provides an overview of the new health coverage options, applying for financial help with coverage, and enrolling in private health plans through the new health insurance marketplaces.
<u>Cognitive Behavioral Therapy (CBT)</u>ⁱ	Reviews the core principles of CBT and how to implement CBT practices in service provision.
<u>Cognitive Behavioral Therapy for Psychosis (CBTp)</u>ⁱ	Outlines how to utilize CBT when working with persons diagnosed with psychosis related disorders.
<u>Co-Occurring Psychiatric and Substance Use Disorder (COPSD)</u>ⁱ	Offers information on how to integrate mental health and substance use disorder services. The training stresses a multi viewpoint approach to recovery when working with persons with co-occurring disorders.
<u>County Indigent Health Care Program (CIHCP)</u>^{iv}	CIHCP Handbook and Forms and Instructions provide information on the services offered through the CIHCP and how to access them.

<p><u>Electronic Visit Verification (EVV)</u>^v</p>	<p>EVV is a computer-based system that verifies the occurrence of authorized personal attendant service visits by electronically documenting the precise time a service delivery visit begins and ends. The HHSC EVV Training Policy requires program providers to complete all required training before first using an EVV system and then annually.</p>
<p><u>Dialectical Behavioral Therapy (DBT)</u>ⁱ</p>	<p>Provides DBT skills to help a variety of clients enhance their capabilities to aid them in their recovery. This training teaches the core component of DBT, the evidence-based treatment for BPD and co-occurring disorders.</p>
<p><u>Harm Reduction</u>ⁱ</p>	<p>Introduces the concept of harm reduction and explores how it is used in a broader framework when working with persons diagnosed with a substance use disorder.</p>
<p><u>Illness Management and Recovery (IMR)</u>ⁱ</p>	<p>Offers a variety of different information, strategies, and skills on IMR to help persons make informed decisions in their treatment and become empowered in their own recovery.</p>
<p><u>Individual Placement and Support (Supported Employment)</u>ⁱ</p>	<p>Teaches providers how to support persons with a diagnosis of SMI in obtaining supported employment and competitive employment.</p>
<p><u>Motivational Interviewing</u>^vⁱ</p>	<p>Teaches the provider how to utilize motivational practices to help elicit change in the person.</p>
<p><u>Narcan Administration</u>^{vii}</p>	<p>Provides information and videos on how to administer Narcan to a person in case of overdose</p>
<p><u>Peer Support Specialist/Peer Specialist Advanced Practices/Peer Specialist Whole Health and Resiliency</u>^{viii}</p>	<p>Peer providers, who are currently in recovery, who help educate participants on how to use their recovery story to aid other persons in their own recovery journey.</p>
<p><u>Person Centered Recovery Planning (PCRP)</u>ⁱ</p>	<p>Provides a comprehensive approach to assessment and services which empower persons to be leaders in their own recovery.</p>

<u>Permanent Supportive Housing</u> ⁱ	Outlines the essential components of supportive housing in working with persons with mental illness.
<u>Opioid Overdose Prevention</u> ^j ^x	Provides information on overdose prevention. This training will be given through the provider entity.
Restrictive Interventions	Outlines the roles and responsibilities of providers in the use of restrictive interventions. Must be compliant with the requirement of this section and 25 TAC Chapter 415 Subchapter F. This training is administered by the provider entity in accordance with TAC regulations
<u>Seeking Safety</u> ⁱ	Shows how to implement Seeking Safety therapy to help persons who have Post Traumatic Stress Disorder (PTSD) and substance use.
<u>SSI/SSDI Outreach, Access, and Recovery</u> ^x	Educates providers on how to help persons with a disability and at risk of homelessness to apply for SSA benefits.
<u>Supplemental Security Income (SSI)</u> ^x ⁱ	Outlines SSI eligibility and application process.
Texas Medicaid Telecommunications Handbook ^x ⁱⁱ	This handbook contains information about Texas Medicaid fee-for-service benefits. Telemedicine and telehealth services must be provided in compliance with standards established by the respective licensing or certifying board of the professional providing the services
Texas Board of Nursing ^x ⁱⁱⁱ	The Texas Board of Nursing (BON or Board) is responsible for licensing, regulating, and monitoring the status of approximately 260,000 licensed registered nurses and 98,000 licensed vocational nurses.
Texas Medicaid Provider Procedures Manual ^x ⁱⁱⁱⁱ	This manual is a comprehensive guide for Texas Medicaid providers. It contains information about Texas Medicaid fee-for-service benefits, policies, and procedures including medical, dental, and children's services benefits.

- ⁱ <https://centralizedtraining.com/index.html> ⁱⁱ <http://www.texasuicideprevention.org/tr> ⁱⁱⁱ <https://marketplace.cms.gov/technical-assistance-resources/training-materials/training> ^{iv} <https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/county-indigent-health-care-program/cihcp-handbook-forms>
- ^v <https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification>
- ^{vi} <https://centralizedtraining.com/in-person-workshops.html> ^{vii} <https://keeplearning.uthscsa.edu/overdose-prevention-education-training/> ^{viii} <https://www.viahope.org/programs/peer-specialist-training-and-certification/> ^{ix} <https://www.hhs.gov/surgeongeneral/priorities/opioids-and-addiction/opioids-overdose-prevention/index.html>
- ^x <https://soarworks.prainc.com/course/ssissdi-outreach-access-and-recovery-soar-online-training>
- ^{xi} <https://www.benefits.gov/benefit/4412>
- ^{xii} https://www.tmhp.com/sites/default/files/file-library/resources/provider-manuals/tmppm/pdf-chapters/2023/2023-04-april/2_Telecommunication_Srvs.pdf
- ^{xiii} https://www.bon.texas.gov/faq_nursing_practice.asp.html#Telehealth
- ^{xiii} <https://www.tmhp.com/sites/default/files/file-library/resources/provider-manuals/tmppm/archives/2023-04-TMPPM.pdf>