



**TEXAS**  
Health and Human  
Services System

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# Home and Community-Based Services—Adult Mental Health

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Provider Manual

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## **Definitions:**

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

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| Activities of Daily Living (ADLs)                          | Routine daily activities. These activities include 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 individual in charge of an HCBS-AMH Provider Agency or HCBS-AMH Recovery Management Entity.  |
| 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.  |
| Assessor   | The person who conducts the uniform assessment to evaluate the individual's need for HCBS-AMH. Assessors must, at minimum, be a qualified mental health professional-community services as defined in Chapter 412, Subchapter G of this title (relating to Mental Health Community Services Standards).  |
| Capacity   | The total number of individuals to whom the HCBS-AMH provider is capable of providing HCBS-AMH services.   |
| Claims Administrator                                       | Contracted entity responsible for conducting certain Medicaid administrative activities on behalf of the single state Medicaid agency.   |
| 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 Abuse Services. Contracted HCBS-AMH Provider Agency Agencies and Recovery Management Entities shall utilize CMBHS as directed by HHSC.  |
| 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-psychotics.  |
| Community Mental Health Center (CMHC)                      | An entity established in accordance with the Texas Health and Safety Code, §534.001, as a community mental health center or a community mental health and mental retardation center.   |
| Court-Appointed Guardian                                   | A Guardian is given the legal authority by court order to care for the personal and property interests of another person, who is referred to as a ward of the state. A guardian who has been given responsibility by the court for both the personal well-being and financial interests of a person is known as a general guardian. An individual can have two separate court-appointed guardians. For example, the court can choose to appoint one individual as guardian of the person and a different individual as the guardian of the person's estate. Guardians differ from Legally Authorized Representatives, because the guardian is considered legally responsible for the person. |

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| Credentialing            | A process to review and approve a staff member's educational status, experience, licensure, and certification status (as applicable) to ensure that the staff member meets HHSC requirements for service provision. 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. Re-credentialing is the periodic process of reevaluating the staff's competency and qualifications. |
| Critical Incident        | An incident that results in substantial disruption of program operation involving or potentially affecting individuals enrolled in HCBS-AMH participation in the program.   |
| Crisis Plan              | A plan that is developed by the individual, RM and others involved in the PCRPs planning process that focuses on planning for, predicting, and preventing a crisis situation from occurring. A Crisis Plan establishes clear roles when an individual enrolled in HCBS-AMH is in a crisis situation. Crisis Plans must include steps to take for individuals to access crisis services, if needed.  |
| Direct Service Staff     | An employee or a subcontractor of an HCBS-AMH Provider Agency or HCBS-AMH Recovery Management Entity who provides an HCBS-AMH service(s) directly to an individual.   |
| Duplication of Services  | A situation in which an HCBS-AMH participant receives similar services from two different entitlements at the same time.  |
| Enrollment Dates         | Delineation of time in relation to the individual's enrollment into the program.  |
| Encounter Data           | Details related to the HCBS-AMH services rendered by provider to the individual enrolled in HCBS-AMH.   |
| Episode of Care          | The length of time from the date of enrollment of the individual in HCBS-AMH until the date of discharge from HCBS-AMH.   |
| Fair Hearing             | An informal proceeding requested by an individual held before an impartial Health and Human Services Commission hearings officer in which an individual appeals an agency action.   |
| Formal Supports          | Professional services provided by a formal structure, agency, network, etc. Examples of formal supports include counselors, RMs, medical care, etc.   |
| 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 individuals unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on the individuals who continue to use drugs.  |
| HCBS-AMH Provider Agency | An agency, organization, or individual 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 and /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   |

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|  | Manual, and Billing Guidelines regardless of service provision arrangement (directly or through subcontractors).   |
| HCBS-AMH Services                                | Services provided under the HCBS-AMH Program.  |
| Individual                                       | A person who is currently enrolled in the HCBS-AMH Program and receiving services or is involved in the enrollment process for HCBS-AMH.   |
| Individual Recovery Plan (IRP)                   | <p>A written, individualized plan developed in consultation with the individual and LAR, if applicable; the individual's treatment team and providers; and other persons according to the needs and desire of the individual, which identifies the necessary HCBS-AMH services to be provided to the individual. The IRP must be approved by HHSC before a provider may deliver HCBS-AMH services.</p> <p>The IRP also serves as the treatment plan or recovery plan and is developed in accordance with Texas Administrative Code Chapter 412, Subchapter D, Title 25 (relating to Mental Health Services--Admission, Continuity, and Discharge) and Chapter 412, Subchapter G, §412.322 of Title 25 (relating to Provider Responsibilities for Treatment Planning and Service Authorization). The IRP must be approved by HHSC before a provider may deliver HCBS-AMH.</p> |
| Invoice  | The file that an HCBS-AMH Provider submits to HHSC as evidence of HCBS-AMH services provided. This file is generated by encounter data.  |
| Legally Authorized Representative (LAR)          | An LAR is an individual or judicial or other body authorized by law to act on behalf of an individual with regard to a particular matter. The term may include a parent, guardian, or managing conservator of a minor.   |
| Licensed Practitioner of the Healing Arts (LPHA) | A person who is a physician, a licensed professional counselor, a licensed clinical social worker, a licensed psychologist, an advanced practice nurse, or a licensed marriage and family therapist.   |
| Local Mental Health Authority (LMHA)             | LMHAs are responsible to provide mental health services to a specific geographic area of Texas to plan, develop policy, coordinate, allocate, and develop resources for mental health and IDD services for that geographic area.   |
| Local Behavioral Health Authority (LBHA)         | LBHAs are responsible to provide behavioral health services to a specific geographic area of Texas to plan, develop policy, coordinate, allocate, and develop resources for behavioral health services for that geographic area.   |
| Medication Administration Record (MAR)           | A report that serves as a legal record of the drugs administered to a patient by a health care professional or authorized designee. The MAR is a part of a patient's permanent record on their medical chart. The health care professional or authorized designee signs off on the record at the time that the drug or device is administered. MARs are commonly referred to as drug charts.   |
| Motivational Interviewing                        | A counseling style that is goal-directed and seeks to gently help an individual discover why he is ambivalent to change. Motivational Interviewing assists in facilitating and engaging intrinsic motivation within the individual in order to change behavior.  |

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| Natural Supports  | Relationships and abilities that already exist or can be developed that enhance the quality and security of life for individuals. Natural supports can be people (family, neighbors, etc.); places (church, community center, school, etc.); or things (artistic ability, family pet, positive attitude, etc.)   |
| Non-HCBS-AMH Services   | Services provided by any funding source other than HCBS-AMH. Examples include but are not limited to other State Plan Services, Temporary Assistance for Needy Families (TANF), and Personal Care Services (PCS).  |
| Perpetual Medication Record   | A form completed by a healthcare professional or authorized designee that documents the individual's current medication, dosage, and quantity at the time of service initiation.   |
| Person-Centered Recovery Planning (PCRP)                            | The collaborative process used by the RM and directed by the individual to develop the IRP. The process occurs in partnership with the others involved in the PCRP planning process (providers and non-providers); supports preferences of the individual; and has a recovery orientation.   |
| Preauthorization  | The authorization an RM obtains for billing purposes prior to assisting an individual in disenrollment from another HCBS program and enroll in HCBS-AMH.   |
| Provider  | Any person or legal entity that has an agreement with HHSC to provide HCBS-AMH.  |
| Provider Agreement  | Executed contract between HHSC and the HCBS-AMH Provider Agency or HCBS-AMH Recovery Management Entity.  |
| Qualified Credentialed Counselors (QCCs)                            | 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:<br>(A) licensed professional counselor (LPC);<br>(B) licensed master social worker (LMSW);<br>(C) licensed marriage and family therapist (LMFT);<br>(D) licensed psychologist;<br>(E) licensed physician;<br>(F) licensed physician's assistant;<br>(G) certified addictions registered nurse (CARN); or<br>(H) 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) |
| Quality Management  | 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.   |
| Qualified Mental Health Professional – Community Services (QMHP-CS) | A staff member who is credentialed as a QMHP-CS who has demonstrated and documented competency in the work to be performed and:  |

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|   | <ul style="list-style-type: none"> <li>a. Has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major (as determined by the LMHA or Managed Care Organization (MCO) in accordance with §412.316(d) of this title (relating to Competency and Credentialing)) in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention;) – A person authorized by law to act on behalf of a child or adolescent with regard to a matter described in this subchapter, including, but not limited to, a parent, guardian, or managing conservator.</li> <li>b. Is a registered nurse; or</li> <li>c. Completes an alternative credentialing process identified by the HHSC.</li> </ul> |
| Recovery                                  | A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.   |
| Recovery Manager (RM)                     | Direct service staff of the Recovery Management Entity that provides recovery management services to the individual.  |
| Recovery Manager Conversion Services      | Preauthorized work, not billable to Medicaid, conducted by the RM when an individual is enrolled in another HCBS program and decides to discontinue services in that HCBS program when an individual is anticipating discharge from a nursing facility..  |
| Recovery Management Entity                | An agency, organization, or individual that meets credentialing standards defined by HHSC and enters into a Provider Agreement for HCBS-AMH. An entity that employs or contracts with individual recovery management providers.   |
| Recovery Management at an Intensive Level | Intensive services provided by the RM which includes a minimum of three visits per week to the individual, with one of these visits being in the individual's home. These services occur during the first three months of service provision in the community, crisis situations, discharge, and transfer planning.  |
| Recovery Management Transitional Services | Work conducted by the RM while a participant is still residing within a state hospital that helps the individual prepare for community living and develop community-based supports. Recovery management transitional services includes coordinating the provision of allowable HCBS-AMH services 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 individual to HCBS-AMH.   |
| Restrictive Interventions                 | The use of personal or mechanical restraint or seclusion.   |
| Safety Plan                               | A plan that focuses on the prevention of an individual's behaviors that put the individual at risk and the interventions needed if such behaviors occur. Safety plans are required for individuals with identified risks.   |
| Serious Mental Illness (SMI)              | An illness, disease, or condition (other than a sole diagnosis of epilepsy, dementia, substance use disorder, intellectual or developmental disability) that:   |

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|  | <ul style="list-style-type: none"> <li>a. substantially impairs thought, perception of reality, emotional process, development or judgment; or</li> <li>b. grossly impairs an individual's behavior as demonstrated by recent disturbed behavior.</li> </ul>  |
| Service Area   | A geographical area where the provider is contracted to provide HCBS-AMH services.  |
| State Plan Services                                  | Services that are offered under the Medicaid State Plan service array, which may be provided by any credentialed Medicaid State Plan service provider.  |
| Social Security Administration Pre-Release Agreement | A pre-release agreement between Social Security Administration and institutions which assists eligible individuals in expediting their reinstatement of benefits upon their discharge.  |
| Status Definitions                                   | The language that describes the status of the individual in relation to the enrollment process.   |
| Subcontractor  | A single person, organization, or agency that enters an agreement with an HCBS-AMH Provider Agency to provide one or more HCBS-AMH services. A subcontractor must meet minimum qualifications defined by HHSC.  |
| Supplemental Security Income Training                | A training that provides information on overview of SSI including the application process and maintaining benefits.   |
| Texas Resilience and Recovery (TRR)                  | Term used to describe the service delivery system in Texas for community mental health services   |
| Uniform Assessment                                   | <p>A standardized assessment identified by HHSC to determine HCBS-AMH program eligibility and clinical needs of the individual.</p> <p>To be determined eligible to participate in this program, each individual must receive a uniform assessment as defined by HHSC, based on the needs and strengths of the individual. The uniform assessment is the basis for the IRP. The assessor must consult with the individual; the individual's LAR, treatment team, providers; and other persons according to the needs and desire of the individual to conduct the uniform assessment. The uniform assessment must be conducted face-to-face; take into account the ability of the individual to perform two or more activities of daily living; and assess the individual's need for HCBS-AMH.</p> |
| Utilization Management                               | 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. Use of systematic data-driven processes to influence the individual's care and decision making to ensure an optimal level of service is provided consistent with the individual's diagnosis and level of functioning within the financial constraints of funding. Includes but is not limited to service authorization, prospective, concurrent and retrospective reviews, discharge planning, and Utilization Care Management.   |

## Acronyms:

Abuse, Neglect or Exploitation (ANE)  
Adult Needs and Strengths Assessment (ANSA)  
Behavioral Health Organization (BHO)  
Centers for Medicare and Medicaid Services (CMS)  
Code of Federal Regulations (CFR)  
Community Mental Health Center (CMHC)  
Clinical Management for Behavioral Health Services (CMBHS)  
Department of State Health Services (DSHS)  
Emergency Department (ED)  
HCBS-AMH Uniform Assessment (UA)  
Health and Human Services Commission (HHSC)  
Health Insurance Portability and Accountability Act (HIPAA)  
Home and Community Based Services (HCBS)  
Home and Community Based Services—Adult Mental Health Program (HCBS-AMH)  
Hospital Liaison (HL)  
Individual Recovery Plan (IRP)  
Initial Criteria Report (ICR)  
Interdisciplinary Team (IDT)  
Legally authorized representative (LAR)  
Licensed Practitioner of the Healing Arts (LPHA)  
Local Mental Health Authority (LMHA)  
Managed Care Organization (MCO)  
Medication Administration Record (MAR)  
Medicaid Management Information System (MMIS)  
Mental Retardation and Behavioral Health Outpatient Data Warehouse (MBOW)  
Outpatient Competency Restoration (OCR)  
Person-Centered Recovery Planning Process (PCRP)  
Protected Health Information (PHI)  
Qualified Credentialed Counselors (QCCs)  
Qualified Income Trust (QIT)  
Qualified Mental Health Professional (QMHP)  
Recovery Manager (RM)  
Serious Mental Illness (SMI)  
Specialty Provider Network (SPN)  
State Hospital (SH)  
State Hospital Social Worker (SHSW)  
Texas Administrative Code (TAC)  
Texas Medicaid and Health Partnership (TMHP)  
Texas Resiliency and Recovery (TRR)

The Health and Human Services Commission (HHSC) is pleased to release fifth addition of the Home and Community Based Services—Adult Mental Health (HCBS-AMH) Provider Manual. Texas received federal approval of the HCBS-AMH SPA from Centers for Medicaid and Medicare Services (CMS) on October 13, 2015. The approved HCBS-AMH program is designed for individuals with SMI and a history of extended

inpatient psychiatric stays. The 84th Legislature required HHSC to expand HCBS to divert populations with SMI from jails and emergency departments (EDs) into community treatment programs. HHSC plans to expand HCBS for the diversion populations by amending the current HCBS-AMH 1915(i) SPA to include the jail diversion and ED diversion populations. HCBS-AMH expansion populations are currently being negotiated with CMS. This manual is subject to change based upon the final terms and conditions approved by CMS for the expansion populations.

# **1000 Program Overview**

## **1100 Introduction**

Many individuals with a diagnosis of serious mental illness (SMI) have complex unmet needs, which have led to repeated psychiatric hospitalizations, arrests or emergency department (ED) visits. Some individuals have resided in mental health facilities for extended periods of time--in some cases, for years. Other individuals experience psychiatric crises and frequently cycle out of correctional facilities or emergency departments (ED).

Home and Community-Based Services--Adult Mental Health Program (HCBS-AMH) provides specialized supports through the provision home and community-based services (HCBS) to adults with a diagnosis of SMI and extended tenure in psychiatric hospitals, as well as those individuals with frequent arrests or ED visits.

The flexible array of services is designed to meet the person's individualized needs that are not currently addressed by other means and to assist in his/her recovery. The goal of HCBS-AMH is to enable individuals to live and experience successful tenure in his or her community and improve quality of life and functioning.

## **1200 Background**

As of September 2016, the Health and Human Services Commission has full authority over HCBS-AMH and no longer delegates any program authority to Department of State Health Services (DSHS).

Prior to creation of HCBS-AMH, DSHS formed the Continuity of Care Task Force, which included Local Mental Health Authority (LMHA) leadership, advocates, behavioral health service recipients, law enforcement, judges, inpatient providers and agency staff. The Task Force was charged 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 of the state, advised the state to consider implementing an HCBS-AMH program, and recommended a range of reforms.

Among the recommendations was the development of HCBS for adults with SMI. These recommendations led to legislative direction in the 83<sup>rd</sup> session of the Texas Legislature and appropriation of funds to establish an HCBS program for adults with SMI and a history of extended inpatient stays through a 1915(i) state plan amendment.

During the 84<sup>th</sup> Texas Legislature, HHSC received legislative directive to expand HCBS to divert populations with SMI from correctional facilities and emergency departments into community treatment programs.

Extensive external stakeholder input was sought from current community providers, the criminal justice system, advocacy agencies, potential beneficiaries, emergency department staff, and Managed Care Organizations (MCO) to inform the eligibility criteria and services needed for the jail and ED diversion populations.

## **1300 Administrative Structure**

HHSC, the single state Medicaid agency, administers the HCBS-AMH program.

HHSC is responsible for initial and on-going independent assessments and evaluation of program candidates, quality assurance, reporting, HCBS-AMH provider recruitment and enrollment, claims payment, and program oversight. HHSC is not and will not become a provider of HCBS-AMH services. HHSC approved contractors perform the independent assessments and HHSC completes the evaluation process by authorizing all services. Development of Individual Recovery Plans (IRP) are completed with individuals enrolled in HCBS-AMH by contracted Recovery Management (RM) Entities who provide services restricted only to HCBS-AMH Recovery Management.

## **1400 Target Population**

Individuals enrolled in the HCBS-AMH program must be 18 years of age or older and require the intensity of services provided by HCBS-AMH in order to improve functioning and establish or maintain stability in their preferred community. This is evidenced by the following:

- Needs based criteria:
  1. Long Term Hospitalization: three or more cumulative or consecutive years in an inpatient psychiatric hospital during the five years prior to enrollment;  
or
  2. Jail Diversion: two or more psychiatric crises (i.e., inpatient psychiatric hospitalizations and/or outpatient psychiatric crisis that meets inpatient psychiatric criteria) and four or more discharges from correctional facilities during the three years prior to enrollment;  
or
  3. ED Diversion: two or more psychiatric crises (i.e., inpatient psychiatric hospitalizations and/or outpatient psychiatric crisis that meets inpatient psychiatric criteria) and fifteen or more total ED visits during the three years prior to enrollment;
- Diagnosis of serious mental illness (SMI);
- Clinical eligibility based on the HCBS-AMH Uniform Assessment (UA);
- Financial eligibility as indicated by the UA;
- Services provided in the program can reasonably be expected to improve the condition of the individual or prevent further regression; and
- The individual is not accessing these services by any other means, including enrollment in Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Home and Community-based Services Waiver (HCS), Texas Home Living Waiver (TxHmL), Youth Empowerment Services (YES), or STAR+PLUS HCBS Waiver.

## **1500 Community-Based Service Provision**

HCBS-AMH services are provided in “home and community-based settings,” including individual homes, apartments, host home/companion care residence, assisted living facilities, and small community-based residences. Home and community-based settings must meet certain qualifications (See 11000 Settings Requirements).

## **1600 HCBS-AMH Services**

The following services are available in HCBS-AMH. (See 9100 HCBS-AMH Service Definitions and 9300 HCBS-AMH Provider Qualifications).

- Host Home/Companion Care;
- Supervised Living Services;
- Assisted Living;
- Supported Home Living;
- HCBS-AMH Psychosocial Rehabilitation services;
- Employment Services
  - Supported employment;
  - Employment assistance;
- Minor home modifications;
- Home-delivered meals;
- Transition assistance services;
- Adaptive aids;
- Transportation services (non-duplicative of state plan medical transportation);
- Community Psychiatric Supports and Treatment
- Peer support;
- Respite care (short term);
- Substance use disorder services;
- Nursing;
- Recovery Management; and
- Flexible Funds

Other state plan services may 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 services (See 9421 Coordination with Managed Care Organizations and 20000 Non-Duplication of Services).

## **2000 Roles and Responsibilities of the Recovery Management Entity and Recovery Manager**

### **2100 Overview of Roles and Responsibilities of the of Recovery Manager and Recovery Management Entity**

A Recovery Management Entity administratively oversees and the Recovery Manager coordinates, monitors, links, and advocate to assist the individual in gaining access to needed Medicaid services; as well as medical, social, educational, and other resources—regardless of funding source.

#### **2110 The Recovery Manager is responsible to:**

1. **Meet the minimum training and credentialing requirements for the provision of recovery management;**

RMs have at least 2 years of experience working with people with serious mental illness (SMI); have a master's degree in human services or a related field; demonstrate knowledge of issues affecting people with SMI and community-based interventions/resources for this population; and complete HHSC-required trainings for the provision of HCBS-AMH recovery management. (See Appendix A: Training Requirements)

**2. Be available to the individual;**

Caseload sizes for the individual RM shall preferably be 10 individuals or less and shall be no more than 15 individuals. Should the assigned RM not be available, the HCBS-AMH Recovery Management Entity is responsible to assign an RM to cover for the assigned RM.

It is recommended that the RM provides recovery management at an intensive level, three contacts per week, for the first three months of the individual's participation in HCBS-AMH services while in the community. During the IRP review, clinical indications will warrant if intensive services should be continued for the next 90 days. (See 9440 Frequency of Recovery Management Service Provision).

The RM, the individual, and the Person-Centered Recovery Planning (PCRP) participants review the individual's IRP not to exceed 90 days from the date of the last IRP, or as clinically indicated, and updates the IRP to ensure IRP is reflective of the individual's current needs and desired goals. Documentation generated by the RM and service encounters shall provide evidence of compliance with the requirements.

The RM's availability shall be identified as part of the individual's crisis plan. If the RM is not available to the individual 24/7 than alternative contacts must be identified on the Crisis Plan. (See 7226 Crisis Plan).

**3. Meet with the individual within fourteen days of notification of Recovery Management Selection; Educate and inform the individual about HCBS-AMH services, the Person-Centered Recovery Planning Process (PCRP), recovery resources, client rights, and responsibilities;**

The RM shall do the following:

- Educate and inform the individual about the HCBS-AMH program utilizing the PCRP format (See 8000 Person-Centered Recovery Planning).
- Explain the individual's rights as an individual enrolled in HCBS-AMH;
- Explain the services available in HCBS-AMH as they relate to the individual's recovery goals;
- Assist the individual with fair hearing requests when needed and upon request;
- Assist the individual with completing necessary consent forms and other program documentation; and
- Assist the individual with retaining HCBS-AMH and Medicaid eligibility.

**4. Coordinate with the referring entity (i.e. State Hospital Staff, LMHA/LBHA) to complete the necessary functions to facilitate successful transition to and tenure in the community for individuals enrolled in HCBS-AMH;**

If the individual is in a state hospital at time of enrollment in HCBS-AMH, the RM is responsible for Recovery Management Transitional Services— coordinating the provision of allowable HCBS-

AMH services inside the state hospital for up to 180 days prior to discharge from the hospital. Planning for the recovery management Transitional Services is a collaborative effort between the RM and the interdisciplinary team (IDT) at the state hospital. (See 9440 Frequency of Recovery Management Service Provision).

The RM shall complete fingerprinting and credentialing needed prior to working in a state hospital (See 13620 Credentialing for Service Provision within the State Hospitals).

The RM shall assist the State Hospital Social Worker (SHSW) with the Social Security Administration Pre-Release Application Process, while the individual is still in the hospital as applicable (See 14110 Social Security Administration Prerelease Program).

If the individual is referred from the community by an LMHA or LBHA, the RM will make contact with the referral source to coordinate services.

**5. When applicable, coordinate with courts, probation or parole officers, hospital staff, and crisis service providers;**

The RM coordinates with applicable parties involved in the individual's care (e.g. criminal justice system, EDs or crisis service providers) to ensure the individual gains access to any needed services.

**6. Provide Recovery Management Conversion Services to Coordinate with other HCBS Programs in the disenrollment of the individual;**

If the individual is currently enrolled in another HCBS program that precludes the individual from participating in HCBS-AMH (Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Home and Community-based Services Waiver (HCS), Texas Home Living Waiver (TxHmL), Youth Empowerment Services (YES), or STAR+PLUS HCBS Waiver), but is interested in receiving services in the HCBS-AMH program. The RM coordinates with HCBS program for the disenrollment/enrollment process. This coordination includes the following:

- Obtaining preauthorization through HHSC for Recovery Management Conversion Services;
- Contacting individual's HCBS program and obtaining necessary documentation about the individual; and
- Identifying needs of the individual and new providers and resources

**7. Provide Recovery Management Conversion Service for Individuals that Reside in a Nursing Facility;**

Conversion services are offered to an individuals' disenrollment from another HCBS program, or those individuals residing in nursing facilities.

In order to provide recovery management conversion services, the RM must obtain preauthorization. (See 9420\_Service Coordination and Recovery Management Conversion Services).

**8. Coordinate the development of the IRP using Person-Centered Recovery Planning and submit the IRP to HHSC for approval;**

The RM identifies services that may help the individual achieve his/her recovery goals and meet the needs of the individual as identified on the UA. As the IRP serves as the Recovery Plan/Treatment Plan, the initial IRP must be completed with the individual within fourteen days of enrollment, in accordance with TAC Chapter 412G Rule §412.322 relating to Provider Responsibilities for Treatment Planning and Service Authorization. (See 7000 Individual Recovery Plan (IRP), 7300 Initial IRP, 7400 Update IRP, 7700 IRP Approval Process, and 8000 Person-Centered Recovery Planning).

**9. Facilitate the provision of services to support the individual's recovery goals;**

The RM ensures the provision of services occurs through the following methods:

- Facilitation of the person-centered recovery planning process to help the individual identify and obtain needed services (See 8000 Person-Centered Recovery Planning and 8100 Qualities of Person-Centered Recovery Planning Process);
- Monitoring the IRP and coordinate services with providers;
- Meet with the individual as indicated to monitor provision of services;
- Development and pursuit of resources including:
  - Non-HCBS-AMH Medicaid services;
  - Services provided under Medicare, and/or private insurance or other community resources; and
  - Identifying and developing natural supports (family, friends, and other community members) and resources to promote the individual's recovery;
- Integration and coordination with managed care organizations, private insurances, private providers, and Local Mental Health Authorities providing services essential to physical and/or behavioral services for the individual to ensure that other services are integrated and support the individual's recovery goals, health, and welfare; and
- Advocating on behalf of the individual to resolve issues that impede access to needed services.

**10. Monitor the health, welfare, and safety of the individual through regular contacts (visits with the individual, paid and unpaid supports, and natural supports);**

**11. Respond to and assesses emergency situations and incidents and ensures that appropriate actions are taken to protect the health, welfare, and safety of individuals;**  
(See 7320 Requirements Specific to the Initial IRP).

**12. Monitor and update the IRP as clinically indicated using PCRIP to meet the needs and recovery goals of the individual;**  
(See 9430 Monitoring the IRP).

**13. Aid in the accuracy of the HCBS-AMH Uniform Assessment;**

The RM is instrumental in the accuracy of the UA. After the initial UA is completed, the RM will assist with gathering of information for subsequent reassessments. If the individual is not enrolled in Texas Resiliency and Recovery (TRR) at the LMHA/LBHA an independent contractor, approved by HHSC may perform the UA reassessment with information gathering assistance from the RM. (See 4000 HCBS-AMH Uniform Assessment (UA)).

The RM shall:

- Provide supporting documentation to be considered by individuals completing the reassessment of the HCBS-AMH Uniform Assessment as requested;
- Verify that services on the IRP are identified on the UA (See 7000 Individual Recovery Plan (IRP) and 7200 IRP Requirements);
- Notify the LMHA if an Update UA is clinically indicated; and
- If necessary, complete additional assessment of the individual. These assessments may identify needs of the individual that may not be present on the UA but are essential to the individual's success in their preferred community. (See 7260 Secondary Assessments Co-Occurring Diagnoses Needs Assessment).

## **2120 The Recovery Management Entity is responsible to:**

### **1. Adhere to applicable laws and regulations;**

The Recovery Management Entity shall comply with all applicable MSHA rules found at Title 25, TAC, Part 1, Chapters 401-421 and Title 40, TAC, Part 1, Chapter 17 as they currently exist and as they may be amended during the Recovery Management Entities' contract with HHSC; the Code of Federal Regulations (C.F.R.) Title 42, Parts 440, 441, 455 and 456; and applicable subchapters of 1 Texas Administrative Code Chapter 355; 45 C.F.R. Parts 46, 80, 84, 90 and 91; and the laws, rules and regulations cited in the various sections of the Manual.

### **2. Meet all HHSC credentialing criteria;**

HCBS-AMH Recovery Management Entities are enrolled through an Open Enrollment (OE) and must maintain the requirements agreed to in the Provider Agreement. The HHSC Recovery Management Entity credentialing process may include a desk review, on-site review, quality management review and training components. The process for applying to be an HCBS-AMH Recovery Management Entity can be found at <http://www.dshs.state.tx.us/mhsa/hcbs-amh/>.

### **3. Operate under an HCBS-AMH Provider Agreement with HHSC;**

The Recovery Management Entity shall operate under a provider agreement with HHSC for the provision of HCBS-AMH services. This includes adherence to the HCBS-AMH Provider Manual, HCBS-AMH Billing Guidelines, and all other relevant HCBS-AMH Policies and Procedures.

### **4. Maintain privacy and 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 (<http://www.hhs.gov/ocr/privacy/>).

All transmission of sensitive information must be sent via a HIPAA compliant secure method.

Data collected and published for the stakeholders' meetings is available to others under the Freedom of Information Act. This information is presented in summary form only with no identification of individuals receiving services.

### **5. Maintain personnel records of direct service staff;**

(See 13600 Personnel Records).

**6. Implement a No Reject Policy**

(See 6400 Recovery Management Entity Enrollment Responsibilities)

**7. Provide Recovery Management services and support the role of the Recovery Manager;**

The HCBS-AMH Recovery Management Entity shall assure that recovery management services are accessible to all individuals enrolled in the service area. Coordination and provision of services includes routine and emergency appointment availability. Recovery Management must be provided directly by the HCBS-AMH Recovery Management Entity.

Recovery Management is provided at an intensive level. Therefore, caseload sizes for the individual RM shall preferably be 10 or less and shall be no more than 15 individuals. This caseload limit should account for individuals in other waiver or state plan programs and other funding sources, unless the requirement is waived by HHSC. This maximum caseload requirement remains in effect unless this requirement is waived by HHSC.

The HCBS-AMH Recovery Management Entity has the ultimate responsibility to comply with the Provider Agreement and HCBS-AMH Provider Manual regardless of service provision arrangement.

The HCBS-AMH Recovery Management Entity must ensure that an alternate RM acts as the individual's assigned RM if an individual's assigned RM is not available. The name and contact information for an alternate RM must be identified and recorded on the IRP.

Services must be delivered in a manner that supports the individual's communication needs, including age-appropriate communication and translation services for beneficiaries that are of limited-English proficiency or who have other communication needs requiring translation assistance.

**8. Ensure ongoing staff development;**

The HCBS-AMH Recovery Management Entity shall participate in required trainings and ensure that direct service staff meets minimum training standards for the provision of services (See Appendix A: Training Requirements);

**9. Retain and maintain progress notes and individual records regarding HCBS-AMH service provision;**

(See 13200 Recovery Management Entity Maintenance of Records).

**10. Execute a provider agreement with Texas Medicaid and Health Partnership (TMHP) in order to obtain reimbursement through the Medicaid Management Information System (MMIS) system;**

Once modifications are complete, the State will use an electronic data system to collect clinical information and authorize service requests. The HHSC Clinical Management for Behavioral Health Services (CMBHS) system provides a platform for providers to electronically submit these data to the state. The CMBHS system interfaces with the MMIS system to allow service authorizations and claims payment through MMIS. Until the MMIS system is modified, HHSC

authorizes IRPs and pays claims manually. All claims are subject to final review and approval by HHSC.

**11. Submit correct billing/invoices to HHSC;**

The HCBS-AMH Recovery Management Entity shall develop a process for the correct and accurate submission of invoices to HHSC. This process shall include adherence to the HCBS-AMH Billing Guidelines a process by which the provider verifies the individual's Medicaid for a billing period.

**12. Ensure the timely payment of employees and subcontractors;**

**13. Submit accurate and timely encounter data to HHSC;**

The HCBS-AMH Recovery Management Entity shall submit to HHSC, a cumulative monthly encounter data report that includes all RM HCBS-AMH encounters, using the Encounter and Invoicing Template in accordance with the HCBS-AMH Billing Guidelines.

**14. Coordinate with the HCBS-AMH Provider Agency;**

**15. Coordinate with Managed Care Organizations (MCO);**

The HCBS-AMH Recovery Management Entity is responsible for ensuring coordination with Managed Care Organization also serving the participant. This includes but is not limited to the following areas:

- Communications with assigned MCO service coordinator and point of contact;
- Teleconferences with MCO service coordinator, based on the individual's needs;
- Obtaining pertinent documents regarding the individual's services;
- Planning and delivery of care;
- Evaluation and adjustment of the IRP;
- Available benefits;
- Referrals to specialists;
- Referrals to state plan services;
- Arrangements for special and insured services with any available community services;
- Coordination during discharge from STAR + PLUS HCBS waiver;
- Discharge, suspension and transfer of services; and
- Non-duplication of Medicaid services (See 20000 Non-Duplication of Services and 20100 RM's Role in Non-Duplication of Medicaid Services).

**16. When applicable, coordinate with Housing Providers;**

The HCBS-AMH Recovery Management Entity coordinates with housing providers including but not limited to the following areas:

- Evaluation of CFR HCBS 441.710 Rule settings requirements;
- Planning and delivery of services;
- Arrangement of Services with other providers;
- Arrangement for transition assistance services, home modifications, and one of the following services: supported home living, assisted living, supervised living services, or host-home/companion care;
- Eviction proceedings; and
- Discharge and transfer from housing.

**17. When applicable, coordinate with the LMHA/LBHA;**

The HCBS-AMH Recovery Management Entity coordinates with LMHA including but not limited to the following areas:

- Discharge and Admissions to State Hospitals;
- Referrals;
- Crisis Services;
- Planning and delivery of services on the IRP;
- Monitoring of tenure of individuals in the community;
- Discharge, transfer, and suspension of HCBS-AMH services; and
- Assessments.

**18. Create and adhere to a Quality Management Plan;**

The HCBS-AMH Recovery Management Entity shall implement a Quality Management plan to include participation in quality management oversight activities as requested by HHSC. (See 15000 Quality Management (QM)).

**19. Create and adhere to a Utilization Management (UM) Plan;**

Recovery Management Entity shall create improvement measures regarding clinical practice improvement initiatives, service/billing integrity verification, and compliance risk monitoring. The UM Plan should identify roles and responsibilities for service and authorization functions and how those activities are implemented, monitored, and managed.

**20. Develop Housing and Placement policies and procedures;**

This includes but is not limited to the following housing and placement policies and procedures:

- Monitoring and tracking housing placement and evictions
- Knowledge of the CFR §441.710 Home and Community-Based Setting requirements for provider owned and operated and non-provider owned and operated settings;
- Expansion of Community Housing Relationship Plan, and other procedures; and
- Resources regarding housing rights and eviction proceedings.

**21. Develop and maintain policies and procedures that support the individual and his/her recovery;**

These policies and procedures shall include the following:

- Supervision and coaching on Person-Centered Recovery Planning
- Notification of participant's rights and Medicaid Fair Hearing Process
- Outreach and conflict resolution
- Discharge procedures that address choice of the individual, continuity of care, and adhere to HCBS-AMH (see 7500 Discharge IRP and 10000 Discharge, Suspension, and Transfer); and
- Transfer of individuals to another HCBS-AMH provider or RM that promote choice of the individual, continuity of care and adhere to HCBS-AMH (see 10000 Discharge, Suspension, and Transfer).

**22. Make every effort to protect the safety, dignity, and respect of the individuals enrolled in HCBS-AMH.**

The HCBS-AMH Recovery Management Entity shall include the following in these efforts:

- Maintain a recovery focus;
- Utilize Person-Centered Recovery Planning process (PCRP) (See 8000 Person-Centered Recovery Planning);
- Adhere to the requirements of federal standards, rules, and guidance for Medicaid services under 1915(i) (See [http://www.ecfr.gov/cgi-bin/text-idx?SID=f375991e7967285a4ecef8f9e5e97b86&node=pt42.4.441&rgn=div5%20-%20se42.4.441\\_1530#sp42.4.441.m](http://www.ecfr.gov/cgi-bin/text-idx?SID=f375991e7967285a4ecef8f9e5e97b86&node=pt42.4.441&rgn=div5%20-%20se42.4.441_1530#sp42.4.441.m));
- Obtain necessary completed consent forms;
- Notify individuals of his/her rights and the procedure by which the individual files grievances and those grievances are processed;
- Notify individuals of his/her right to a Medicaid Fair Hearing (See 17100 Medicaid Fair Hearing Process);
- Report all critical incidents to HHSC (See 13530 Critical Incidents Reporting);
- Notify individuals of how to report abuse, neglect, or exploitation;
- Report abuse, neglect, and exploitation in accordance applicable laws (See 13540 Abuse, Neglect, and Exploitation (ANE));
- Minimize the use of behavior management; restrictive interventions (See 16000 Health and Safety); and
- Implement crisis and safety planning (See 7220 Essential Components of the IRP and 7220 Essential Components of the IRP Safety Plan).

## **2200 Roles of the HCBS-AMH Provider Agency**

### **The HCBS-AMH Provider Agency is responsible to:**

#### **1. Adhere to applicable laws and regulations;**

The HCBS-AMH Provider Agency shall comply with all applicable MSHA rules found at Title 25, TAC, Part 1, Chapters 401-421 and Title 40, TAC, Part 1, Chapter 17 as they currently exist and as they may be amended during the Provider Agency's contract with HHSC; the Code of Federal Regulations (C.F.R.) Title 42, Parts 440, 441, 455 and 456; and applicable subchapters of 1 Texas Administrative Code Chapter 355; 45 C.F.R. Parts 46, 80, 84, 90 and 91; and the laws, rules and regulations cited in the various sections of the Manual.

#### **2. Meet all HHSC credentialing criteria;**

HCBS-AMH Provider Agency Agencies are enrolled through an Open Enrollment (OE) and must maintain the requirements agreed to in the Provider Agreement. The HHSC Provider Agency credentialing process may include a desk review, on-site review, quality management review and training components. The process for applying to be an HCBS-AMH Provider Agency can be found at <http://www.dshs.state.tx.us/mhsa/hcbs-amh/>.

#### **3. Operate under an HCBS-AMH Provider Agreement with HHSC;**

The HCBS-AMH Provider Agency shall operate under a provider agreement with HHSC for the provision of HCBS-AMH services. This includes adherence to the HCBS-AMH Provider Manual HCBS-AMH Billing Guidelines, and all other relevant HCBS-AMH Policies and Procedures.

**4. Maintain privacy and confidentiality**

All parties involved with the 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 (<http://www.hhs.gov/ocr/privacy/>).

All transmission of sensitive information must be sent via a HIPAA compliant secure method.

**5. Maintain personnel records of direct service staff;**

(See 13600 Personnel Records).

**6. Implement a No Reject Policy**

The HCBS-AMH Provider Agency shall comply with the HCBS-AMH No Reject Policy (See 6510 HCBS-AMH Provider Agency No Reject Policy).

**7. Provide or arrange for provision of all HCBS-AMH services;**

The HCBS-AMH Provider Agency shall assure that all HCBS-AMH services are accessible to all individuals enrolled in the HCBS-AMH Provider Agency's service area. Coordination and provision of services includes routine and emergency appointment availability. Services may be provided directly and /or indirectly by establishing and managing a network of subcontractors. The HCBS-AMH Provider Agency shall notify HHSC if an HCBS-AMH service is unavailable for any period of time and submit a plan to remedy the situation.

Services must be delivered in a manner that supports the HCBS-AMH participant's communication needs, including age-appropriate communication and translation services for beneficiaries that are of limited-English proficiency or who have other communication needs requiring translation assistance.

The HCBS-AMH Provider Agency has the ultimate responsibility to comply with the Provider Agreement and Manual regardless of service provision arrangement (directly or through subcontractors).

**8. Ensure ongoing staff development;**

HCBS-AMH Provider Agency shall participate in required trainings and ensure that direct service staff (employees and subcontractors) meets minimum training standards for the provision of services (See Appendix A: Training Requirements).

**9. Retain and maintain progress notes and clinical records of individuals participating in HCBS-AMH, regarding HCBS-AMH service provision;**

The progress notes and clinical records shall be used to provide supporting documentation to be considered by individuals completing the HCBS-AMH Uniform Assessment and RMs monitoring the IRP.

The individual shall have access to the clinical record in accordance with Texas Health and Safety Code, §611.0045.

**10. Execute a provider agreement with TMHP in order to obtain reimbursement through the Medicaid Management Information System (MMIS) system;**

Once modifications are complete, the State will use an electronic data system to collect clinical information and authorize service requests. The HHSC Clinical Management for Behavioral Health Services (CMBHS) system provides a platform for providers to electronically submit data to the state. The CMBHS system will interface with the MMIS system to allow service authorizations and claims payment through MMIS. Until the MMIS system is modified, HHSC authorizes IRPs and pays claims manually. All claims are subject to final review and approval by HHSC.

**11. Submit correct billing/invoices to HHSC;**

HCBS-AMH Provider Agency shall develop a process for the correct and accurate submission of invoices to HHSC. This process shall include adherence to the HCBS-AMH Billing Guidelines a process by which the provider verifies the individual's Medicaid for a billing period. Refer to the HCBS-AMH Billing Guidelines for policy details.

**12. Ensure the timely payment of employees and subcontractors;**

The HCBS-AMH Provider Agency shall ensure that all employees and subcontractors of HCBS-AMH services receive payment for services in a timely manner.

**13. Submit accurate and timely encounter data to HHSC;**

HCBS-AMH Provider Agency shall submit to HHSC, a cumulative monthly encounter data report that includes all HCBS-AMH service encounters, using the Encounter and Invoicing Template in accordance with the HCBS-AMH Billing Guidelines.

**14. Coordinate with the Recovery Management Entity;**

HCBS-AMH Provider Agency shall ensure that all employees and subcontractors of HCBS-AMH services:

- Participate in recovery plan meetings;
- Participate in teleconferences with the RM and MCO service coordinator;
- Participate in the IRP planning process;
- Utilize the RM as the first point of contact regarding questions and concerns about services;
- Provide documentation about the individual requested by the RM; and
- Collaborate with the RM in the discharge, transfer, or suspension of the individual from services.

**15. Coordinate with The Managed Care Organization providing services to the individual;**

The HCBS-AMH Provider Agency is responsible for coordination with the Managed Care Organization also serving the participant. This includes but not limited to the following areas:

- Planning and delivery of care;
- Evaluation and adjustment of the IRP;
- Available benefits;
- Discharge, suspension, and transfer of services; and
- Non-duplication of Medicaid services (See 20000 Non-Duplication of Services).

**16. When applicable, coordinate with other entities involved in the individual's care (i.e. Local Mental Health Authority (LMHA), criminal justice system, ED, etc);**

**17. Create and adhere to a Quality Management Plan;**

HCBS-AMH Providers shall implement a Quality Management plan to include participation in quality management oversight activities as requested by HHSC;

**18. Create and adhere to a Utilization Management Plan;**

The primary Utilization Management (UM) activities are related to monitoring of service utilization for each individual. The HCBS-AMH Provider implements a Utilization Management (UM) plan to complement quality improvement activities of HCBS-AMH provider to include clinical practice improvement initiatives, service/billing integrity verification, and compliance risk monitoring.

**19. Develop Housing and Placement policies and procedures;**

This includes the monitoring and tracking 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.

**20. Develop and maintain policies and procedures that support the individual and his/her recovery;**

These policies and procedures shall include the following:

- Discharge procedures that address choice of the individual, continuity of care, and adhere to HCBS-AMH (See 10120 Discharge Procedure); and
- Transfer of individuals to another HCBS-AMH provider that promote choice of the individual, continuity of care, and adhere to HCBS-AMH (See 10320 Transfer Procedure).

**21. Make every effort to protect the safety, dignity and respect of the individuals enrolled in HCBS-AMH.**

The HCBS-AMH Provider shall include the following in these efforts:

- Maintain a recovery focus;
- Adhere to the requirements of federal standards, rules, and guidance for Medicaid services under 1915(i) (See [http://www.ecfr.gov/cgi-bin/text-idx?SID=f375991e7967285a4ecef8f9e5e97b86&node=pt42.4.441&rgn=div5%20-%20se42.4.441\\_1530#sp42.4.441.m](http://www.ecfr.gov/cgi-bin/text-idx?SID=f375991e7967285a4ecef8f9e5e97b86&node=pt42.4.441&rgn=div5%20-%20se42.4.441_1530#sp42.4.441.m));
- Obtain necessary completed consent forms;
- Notify individuals of his/her rights and the procedure by which the individual files grievances and those grievances are processed;
- Notify individuals or his/he right to a Medicaid Fair Hearing (See 17100 Medicaid Fair Hearing);
- Maintain policies and procedures for medication safety (See 16300 Medication Safety and Management);
- Report all critical incidents to HHSC (See 13530 Critical Incidents Reporting);
- Report abuse, neglect and exploitation in accordance applicable laws (See 13540 Abuse, Neglect, and Exploitation (ANE)); and
- Minimize the use of behavior management; restrictive interventions (See 16000 Health and Safety).

## **2300 Roles of State Hospital**

- 1. Adhere to applicable state and Federal laws, policies and procedures;**
- 2. Refer individuals to HCBS-AMH:** (See 5000 Referral and Pre-Enrollment Process).
- 3. Provide supporting documentation to be considered by individuals completing the HCBS-AMH Uniform Assessment;**
- 4. Perform the HCBS-AMH Uniform Assessment (UA) for individuals in the State Hospital, as indicated by HHSC;**

**5. Maintain privacy and confidentiality**

All parties involved with the 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 (<http://www.hhs.gov/ocr/privacy/>).

All transmission of sensitive information must be sent via a HIPAA compliant secure method.

- 6. Social Security Pre-Release Application;**  
(See 14110 Social Security Administration Prerelease Program)
- 7. Discharge Planning;**  
State Hospital IDT members work with the individual and RM to assist in discharge planning.
- 8. Participation in PCRPs;**
- 9. Coordination with direct service staff of Recovery Management Entity and HCBS-AMH Provider Agency;**
- 10. Adhere to policy and procedure regarding privileges of HCBS-AMH Provider Agency and Recovery Management Entity direct service staff to provide certain services to individuals in the state hospital.**  
(See 13620 Credentialing for Service Provision within the State Hospitals);

## **2400 Roles of Local Mental Health Authority (LMHA) or Local Behavioral Health Authority (LBHA)**

- 1. Adhere to applicable laws and HHSC policies and procedures;**
- 2. Operate a phone line to receive and respond to inquiries about HCBS-AMH;**

**3. Designate a Point of Contact (POC) to coordinate HCBS-AMH referral process for individuals residing in the community.**

POC is responsible to:

- Ensure appropriate information is being disseminated to inquiries and routed to the appropriate personnel;
- Attend monthly HCBS-AMH Eligibility Verification conference calls; and
- Act as the main contact with HHSC HCBS-AMH staff;

**4. Review the Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW) 1915i reports located in the CA Continuity of Care folder for evidence or supporting documentation of meeting initial eligibility criteria;**

**5. Coordinate with state hospital staff, as necessary, for individuals referred to the program who are currently in the state hospital;**

**6. Coordinate with criminal justice staff or emergency department staff, as necessary, for individuals referred to the program;**

**7. Complete the HCBS-AMH referral process for individuals residing in the community;**

(See 5000 Referral and Pre-Enrollment Process)

- Assist the individual and/or LAR in completing the HCBS-AMH Consent for Eligibility Determination Form;
- Complete the HCBS-AMH Uniform Assessment or assist in coordinating the date and location of the assessment;
- Attach supporting documentation, if applicable, for individuals on the MBOW 1915i reports or who otherwise meet referral criteria who are currently in the community;
- Verify CARE ID of the referred individual; and
- Submit the completed forms.

**8. If providing services to the HCBS-AMH participant, participate in the individual's HCBS-AMH recovery plan meetings, including coordination with the individual's HCBS-AMH recovery manager;**

**9. Maintain privacy and confidentiality**

All parties involved with the 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 (<http://www.hhs.gov/ocr/privacy/>).

All transmission of sensitive information must be sent via a HIPAA compliant secure method.

**10. Coordination service delivery with HCBS-AMH Recovery Management Entity and HCBS-AMH Provider Agency direct service staff;**

**11. Complete update HCBS-AMH Uniform Assessment for individuals enrolled in a Level of Care within the Texas Resiliency and Recovery (TRR) system at the LMHA/LBHA, as indicated by HHSC;**

**12. Coordinate state hospital discharge planning with HCBS-AMH Recovery Manager and state hospital staff;**

The LMHA/LBHA authority is not impacted by HCBS-AMH enrollment, including continuity of care responsibilities. The HCBS-AMH Recovery Manager (RM) may work with an individual residing in a state hospital for up to six months prior to his/her discharge. In this instance, the HCBS-AMH RM shall be included in discharge planning with the enrolled individual, LMHA/LBHA staff and state hospital staff.

Specific HCBS-AMH RM roles in discharge coordination include identifying needed HCBS-AMH services, community supports, and if applicable the LMHA/LBHA case manager contact.

## **2500 Roles of HHSC**

**1. Promulgate rules, policies, procedures, and information development governing HCBS-AMH;**

**2. Implement a referral process for HCBS-AMH;**

HHSC shall develop process by which individuals are referred. This information shall be disseminated by HHSC and made available online at <http://www.dshs.state.tx.us/mhsa/hcbs-amh/>.

**3. Determine eligibility for HCBS-AMH;**

HHSC shall use the Mental Retardation and Behavioral Health Outpatient Data Warehouse (MBOW) reports, Initial Criteria Report (ICR), and Uniform Assessment (UA), including financial criteria, and all other available evidence of eligibility to determine eligibility for the HCBS-AMH program.

**4. Implement HCBS-AMH enrollment process for individuals;**

Eligibility determinations are made by HHSC. Once an individual is referred, an independent evaluation is conducted that verifies the individual meets initial criteria, and meets clinical, functional, and financial eligibility. Enrollment is tracked by HHSC.

**5. Recruit and enroll HCBS-AMH Provider Agencies and Recovery Management Entities;**

HHSC participates in marketing and outreach for potential HCBS-AMH participants by disseminating HCBS-AMH programmatic information through regular interaction with the community and stakeholders; having an online presence; responding to inquiries or requests for information, or other outreach efforts identified by the state to reach the appropriate target population.

HCBS-AMH Provider Agencies and Recovery Management Entities shall be enrolled through an Open Enrollment process.

**6. Perform and maintain records of assessments and evaluations of individuals;**

HHSC designates state hospital staff or HHSC contractors to perform initial HCBS-AMH UA.

HHSC also designates independent assessors for on-going reassessments of the HCBS-AMH UA

. (See 4000 HCBS-AMH Uniform Assessment (UA).

Records of assessments and evaluations are maintained by HHSC (See 4300 Maintenance of UA Records).

Note: There must be a clear separation between provider functions and any person or entity providing the UA. Contractors delegated the responsibility to perform assessments who are an HCBS-AMH provider of last resort have a higher level of scrutiny. If HHSC delegates an entity other than state hospital staff to perform the UA, the distinct person conducting the UA must be independent of providers of HCBS-AMH services and any utilization review units and functions.

**7. Develop billing guidelines;**

The HCBS-AMH Billing Guidelines are available at <http://dshs.texas.gov/mhsa/hcbs-amh/billing/>

**8. Review and approve Individual Recovery Plans;**

**9. Develop and implement policy and procedure regarding privileges of HCBS-AMH direct service staff to provide certain services to individuals in the state hospital;**

(See 13620 Credentialing for Service Provision within the State Hospitals).

**10. Conduct Utilization Management;**

**11. Conduct quality assurance and quality improvement activities that are pursuant to, HHSC and the State's Quality Improvement Strategy policies and procedures.**

HHSC performs QM oversight of the HCBS-AMH Recovery Management Entities through encounter data reporting and regular desk and on-site reviews.

## **2600 Roles of the Individual**

**1. Choose to participate in the HCBS-AMH;**

**2. Choose HCBS-AMH Provider Agency and Recovery Management Entity in the service area of his/her choice;**

**3. Participate in the development of the Individual Recovery Plan;**

**4. Participate in HCBS-AMH services as identified in the IRP;**

5. **Notify the HCBS-AMH Recovery Management Entity and HCBS-AMH Provider Agency upon notice from CMS, HHSC, or SSI that their Medicaid coverage will be, or is denied or expired;**
6. **Notify the HCBS-AMH Recovery Management Entity if their place of residence changes. This includes a residence change outside of the HCBS-AMH Service area or a change in living arrangement (community setting to institutional setting); and**
7. **Notify HCBS-AMH Provider upon enrollment into another HCBS program that precludes the individual from participating in HCBS-AMH(Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Home and Community-based Services Waiver (HCS), Texas Home Living Waiver (TxHmL), Youth Empowerment Services (YES), or STAR+PLUS HCBS Waiver).**

Additional information regarding the individual and LAR's agreements and responsibilities are identified in the HCBS-AMH Enrollment Consent Form.

## **3000 HCBS-AMH Program Eligibility**

HCBS-AMH eligibility is determined using demographic, clinical, and financial criteria. Additionally, individuals cannot be dually enrolled or receive HCBS services by any other means; including enrollment in Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Home and Community-based Services Waiver (HCS), Texas Home Living Waiver (TxHmL), Youth Empowerment Services (YES) or STAR+PLUS HCBS Waiver.

### **3100 Initial Criteria**

Individuals must meet the following initial criteria in order to be eligible for HCBS-AMH:

- Diagnosis of serious mental illness (SMI);
- One of the following needs based criteria:
  1. Long Term Hospitalization (three or more cumulative years) in an inpatient psychiatric hospital during the five years prior to enrollment;  
or
  2. Jail Diversion: have an active Medicaid benefit and have two or more psychiatric crises (i.e., inpatient psychiatric hospitalizations and/or outpatient psychiatric crisis that meets inpatient psychiatric criteria) and four or more discharges from correctional facilities during the three years prior to enrollment;  
or
  3. ED Diversion: have an active Medicaid benefit and have two or more psychiatric crises (i.e., inpatient psychiatric hospitalizations and/or outpatient psychiatric crisis that meets inpatient psychiatric criteria) and fifteen or more total ED visits.
- The individual is not accessing these services by any other means, including enrollment in Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Home and Community-based Services Waiver (HCS), or Texas Home Living Waiver (TxHmL), Youth Empowerment Services (YES), or STAR+PLUS HCBS Waiver.

### **3200 Clinical Necessity**

Clinical necessity shall be determined as part of an independent evaluation of the individual. HHSC has identified the Adult Needs and Strengths Assessment (ANSA) as the standardized assessment tool to determine clinical eligibility as part of the HCBS-AMH UA.

### **3300 Financial Eligibility**

Individuals enrolled in HCBS-AMH meet Medicaid eligibility requirements in accordance with an income level less than or equal to 150% of the Federal Poverty Level (FPL).

Individuals that do not meet financial eligibility requirements may be placed on a waitlist under the following circumstances.

- Long Term Hospitalization needs based criteria is met but the individual does not meet an income level less than or equal to 150%; or
- Long Term Hospitalization needs based criteria and below 150% FPL is met but the individual has not been able to attain SSI eligibility. (See 14000 Benefits, Entitlements and Financial Resources and 5400 Waitlist and Pending Enrollment).

### **3400 Evaluation and Eligibility Determination**

HHSC determines eligibility through completion of the evaluation of all factors affecting the eligibility of an individual. (6000 Enrollment into HCBS-AMH).

## **4000 HCBS-AMH Uniform Assessment (UA)**

### **4100 HCBS-AMH Uniform Assessment Definitions**

| <b>Uniform Assessment Types</b> |   |
|---------------------------------|---|
| <b>Initial:</b>                 | The first UA that is saved in closed complete status in an individual's episode of care.  |
| <b>Update:</b>                  | UA saved in closed complete status following an Initial UA that does not meet definition of a Discharge UA.   |
| <b>Discharge:</b>               | UA completed with an individual who is anticipated to be discharged from the HCBS-AMH program. This includes voluntary and administrative discharges. |

| <b>Uniform Assessment Status</b> |   |
|----------------------------------|---|
| <b>Draft:</b>                    | UA that has been saved, is open for edits, and are not saved in Closed Complete status.<br>UAs saved in draft status are open for edits for 10 days.<br><b><i>This does not create an Active UA</i></b> |

|                         |  |
|-------------------------|--|
| <b>Closed Complete:</b> | UA that is completed and signed by the assessor to attest to the accuracy of the assessment on the date it was performed and saved in Closed Complete status.<br><b><i>UAs saved in Closed Complete status cannot be edited on or after the Enrollment Date.</i></b> |
| <b>Active:</b>          | The most recent UA that has been saved in Closed Complete status.  |
| <b>Expired:</b>         | A UA that is no longer active due to exceeding the Expiration Date   |
| <b>Pending:</b>         | A UA that has been evaluated by HHSC but has not been saved in closed complete status.   |

| <b>Uniform Assessment Dates</b> |  |
|---------------------------------|--|
| <b>Performed On:</b>            | Date the UA is administered with the individual.   |
| <b>Active Date:</b>             | Date the UA is approved by HHSC and saved in Closed Complete Status.   |
| <b>Expiration Date:</b>         | The following circumstances would be the Expiration Date of an Active UA: <ul style="list-style-type: none"> <li>• One year from the Active Date of the Active UA;</li> <li>• The date an individual is discharged from HCBS-AMH; or</li> <li>• 60 days from the Performed On date of a UA in Pending Status if the individual is not enrolled in HCBS-AMH.</li> </ul> |

## **4200 General HCBS-AMH Uniform Assessment Information**

The referring entity assists individuals who have met initial criteria to complete the Consent for Eligibility Determination and Enrollment. Once the Consent for Eligibility Determination and Enrollment form is signed, the HCBS-AMH Uniform Assessment (UA) is completed with the individual in accordance with TAC Chapter 416, Subchapter B (relating to Home and Community-Based Services—Adult Mental Health Program). The assessment is a person-centered process and guided by best practice and research on effective strategies that result in improved health and quality of life outcomes.

The initial HCBS-AMH Uniform Assessment (UA) is performed face-to-face by the referring entity approved by HHSC and by individuals who are not direct service providers of HCBS-AMH services to the individual. Information from an ANSA completed within 6 months of the initial UA can be used to complete the UA if there are no changes in the individual’s clinical information. Individuals performing the UA may not be under the purview of an HCBS-AMH Provider Agency or Recovery Management Entity unless they are the only willing and qualified entity in a geographic area as part of the evaluation process.

Upon completion of the UA the referring entity assists the individual with the following documents in the HCBS-AMH Enrollment Packet:

- HCBS-AMH Provider Selection Form- Individual selects an HCBS-AMH Provider Agency (PA) and Recovery Manager (RM) using the HCBS-AMH Provider Selection Form.;
- HCBS-AMH Participation of Rights Form;
- Provide the individual the HCBS-AMH Participant Brochure;
- Provide the individual the DSHS/HHSC Consumer Rights Handbook.

The referring entity sends the completed Consent for Eligibility Determination and Enrollment form, UA, and Enrollment Packet via email to HHSC at [HCBS-AMH@dshs.state.tx.us](mailto:HCBS-AMH@dshs.state.tx.us) with the subject line titled "Referral."

An evaluation using the HCBS-AMH UA is conducted at least every 12 months and/or when the individual's circumstances or needs change significantly. HHSC evaluates the UA and determines ongoing eligibility. Circumstances that indicate a re-evaluation include:

- Change in housing status
- Change in financial status
- Change in medical status
- Change in employment status
- Change in functioning status
- Change in clinical needs

The HCBS-AMH UA is based on the following:

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

HHSC may contact the referring entity with requests for additional information when necessary at any time during the Eligibility and Enrollment process. HCBS-AMH Provider Agencies and Recovery Management Entities are not directly involved in determining HCBS-AMH eligibility. The HCBS-AMH Provider Agency and Recovery Management entity may be consulted to provide information to aid in the completion of annual re-evaluation.

A re-evaluation using the UA occurs, no more than one year from the most recent UA. UAs expire 365 days from the date the assessment was performed. Authorization for services cannot occur without an Active UA.

#### **4210 HCBS-AMH UA Reassessment**

The reassessment is performed by an independent contractor or the LMHA/LBHA if the individual is receiving TRR services from the LMHA/LBHA. The annual reassessment is to be sent to HHSC at [HCBS-AMH@dshs.state.tx.us](mailto:HCBS-AMH@dshs.state.tx.us) within 3 business days with the subject line titled "UA Reassessment." HHSC evaluates the UA and determines ongoing eligibility.

Once the HCBS-AMH UA is completed, the reassessment of the HCBS-AMH UA is to be sent to HHSC at [HCBS-AMH@dshs.state.tx.us](mailto:HCBS-AMH@dshs.state.tx.us) within 3 business days with the subject line titled "UA Reassessment".

Authorization for HCBS-AMH services cannot occur without an active HCBS-AMH UA.

### **4300 Maintenance of UA Records**

HHSC shall maintain records of assessments and reassessments. The assessments shall be made available to the RM for creation of the IRP and the HCBS-AMH Provider Agencies and Recovery Management Entities shall maintain records of the assessment in the individual's clinical record.

### **4400 Adult Needs and Strengths Assessment (ANSA)**

The Adult Needs and Strengths Assessment (ANSA) is designed to support recovery planning, facilitate quality improvement, and to allow for monitoring clinical outcomes.

The ANSA was developed from a communication perspective and can facilitate a relationship between the assessment process and the development of individualized recovery plans—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 the individual. The ANSA Manual developed for HCBS-AMH Purposes is located at the following: <http://www.dshs.state.tx.us/mhsa/hcbs-amh/>.

Broadly speaking, each item on the ANSA can communicate a focus for recovery planning for the individual. There are four levels of each item on the ANSA with anchored definitions. The assessor uses these definitions to determine a score which can then be translated into the following action levels (separate for needs and strengths):

**For needs:**

- 0= No evidence
- 1= Watchful waiting/prevention
- 2= Action
- 3= Immediate/Intensive Action

**For strengths:**

- 0= Centerpiece strength
- 1= Strength that you can use in planning
- 2= Strength has been identified-must be built
- 3= No strength identified

If there is a clinical disagreement between the independent assessor and the Recovery Manager and/or the Provider Agency concerning the scores generated by the ANSA during the performance of the HCBS-AMH UA, all parties will submit the clinical justification for the disagreement to HHSC within 3 business days. HHSC will render an administrative decision based upon all submitted documentation within 3 business days of receiving the information.

### **4500 Financial Screening**

A financial screening is completed as part of the UA to determine financial eligibility for HCBS-AMH. The individual's income must be 150% of the Federal Poverty Level or below to be enrolled in HCBS-AMH.

Individuals that meet Jail Diversion or Emergency Department Diversion criteria must have an active Medicaid benefit to be enrolled in HCBS-AMH.

The following factors shall be taken into consideration during the enrollment process for individuals that meet the Long Term Hospitalization needs based criteria only:

| Factors Affecting Financial Eligibility   | Effect on Enrollment Process   |
|---|--|
| An individual who otherwise meets financial eligibility and is currently eligible or has been eligible for Medicaid in the past as an adult   | Assumed to currently be Medicaid eligible and not indigent. This factor does not prevent enrollment into the program.  |
| An individual who otherwise meets financial eligibility and has not previously applied for SSI and/or Medicaid. The individual or LAR agrees to apply for Medicaid, and eligibility is anticipated (awaiting official determination). | Assumed to be Medicaid eligible and not indigent. The individual may be enrolled in the program regardless of Medicaid eligibility determination.                              |
| An individual who otherwise meets financial eligibility and has been determined ineligible for SSI and/or Medicaid in the past.   | Assumed to be currently ineligible for Medicaid and indigent. The individual may be placed on a waitlist for enrollment until HCBS-AMH program capacity allows for enrollment. |
| Individual who otherwise meets financial eligibility has not applied for SSI and/or Medicaid in the past because they cannot prove his/her identity or do not meet SSI or Medicaid eligibility criteria.                              | Assumed to be currently ineligible for Medicaid and indigent. The individual may be placed on a waitlist for enrollment until HCBS-AMH program capacity allows for enrollment. |
| An individual who otherwise meets financial eligibility refuses to apply for SSI or Medicaid benefits.  | Assumed to be currently ineligible for Medicaid and indigent. The individual may be placed on a waitlist for enrollment until HCBS-AMH program capacity allows for enrollment. |

Individuals in a state hospital may qualify for the Social Security Administration Pre-Release Application Process. (See 14110 Social Security Administration Prerelease Program).

## **5000 Referral and Pre-Enrollment Process**

An individual can be referred to HCBS-AMH from the state hospital or the community LMHA/LBHA. This section describes the referral and enrollment process for each referring entity.

Eligibility determinations are made by HHSC. Once an individual is referred, an independent evaluation is conducted that verifies the individual meets initial criteria, and meets clinical, functional, and financial eligibility. Individuals with an active Medicaid who are determined eligible shall be enrolled in the program. Individuals who do not currently meet all eligibility requirements may be placed on a waitlist or pending status for enrollment.

## 5100 Enrollment Process Definitions

| Enrollment Status Definitions |   |
|-------------------------------|---|
| <b>Interested:</b>            | An individual is designated as “Interested” until they are determined fully eligible for HCBS-AMH, including Clinical and Financial eligibility.  |
| <b>Eligible:</b>              | An individual is designated as “Eligible” once approved for clinical and financial eligibility.   |
| <b>Waitlisted:</b>            | An individual who meets Long Term Hospitalization needs-based criteria and does not have an active Medicaid benefit or does not meet financial eligibility, but is otherwise eligible and is designated as “Waitlisted.”  |
| <b>Enrolled:</b>              | An individual is designated as “Enrolled” once an eligible individual has completed an Enrollment Packet.   |
| <b>Receiving Services:</b>    | An individual is designated as “Receiving Services” upon receipt of an HCBS-AMH service. This does not include the development of the Individual Recovery Plan (IRP).   |
| <b>Pending:</b>               | <p>An individual is designated “Pending” who otherwise meets eligibility criteria but is not yet enrolled in HCBS-AMH because the individual:</p> <ul style="list-style-type: none"> <li>• is on a forensic commitment and not presently in a community-based setting; or</li> <li>• is in the custody of the criminal justice system; or</li> <li>• has not completed an enrollment packet.</li> </ul> <p><b><i>An individual may have a pending status for no more than 60 days. After 60 days a new UA and eligibility determination is required to determine eligibility.</i></b></p> |
| <b>Suspended:</b>             | An individual who is not discharged from the program whose services are suspended. (See 10210 Reasons for Suspension and 10220 Suspension Procedure).   |
| <b>Discharged:</b>            | An individual is designated “Discharged” when they are no longer enrolled in the HCBS-AMH program and receiving HCBS-AMH services. (See 10110 Reasons for Discharge)  |

| Enrollment Date Definitions   |   |
|-------------------------------|---|
| <b>Enrollment Date:</b>       | The individual has been determined eligible for the program by HHSC and completes the enrollment packet for program.  |
| <b>Enrollment Expiration:</b> | <p>365 days after the Enrollment Date.</p> <p><b><i>Although the individual may continue to be enrolled in the program with an Expired UA for up to ten days, the individual must have an Active UA and Active IRP to receive HCBS-AMH services. (See 4100 HCBS-AMH Uniform Assessment Definitions)</i></b></p> |
| <b>Episode of Care:</b>       | The time between the active enrollment date of the individual to the current date in an active authorization without any discharges from HCBS-AMH.  |

## **5200 Referral Process from State Hospital**

### **5210 Initial Criteria Report (ICR)**

HHSC creates an Initial Criteria Report(ICR) of individuals who have been admitted to a psychiatric hospital for three of the past five years (cumulatively or consecutively). State Hospitals (SH) have access to the ICR.

### **5220 State Hospital IDT**

State Hospital Social Worker (SHSW) convenes the hospital Interdisciplinary Team (IDT) and reviews the ICR to identify eligible individuals currently residing in the SH.

The SHSW along with the SH IDT shall complete and electronically submit the following by secure email to [HCBS-AMH@dshs.state.tx.us](mailto:HCBS-AMH@dshs.state.tx.us), with the subject line titled "Referral":

- Consent for Eligibility Determination and Enrollment Form
- HCBS-AMH UA
- HCBS-AMH Provider Selection Form
- Notification of Participation Rights Form

SHSW assists the individual and LAR in the selection of an HCBS-AMH Recovery Management Entity and HCBS-AMH Provider Agency. The individual's choice is documented by completing the HCBS-AMH Provider Selection Form. The referring entity shall:

- Provide a list of all approved HCBS-AMH Recovery Management Entities and HCBS-AMH Provider Agencies serving the individual's county of residence to the individual and the LAR;
- Provide the individual and LAR with HCBS-AMH Recovery Management Entity and HCBS-AMH Provider Agency's location, contact information, and phone number.

(See <https://www.dshs.texas.gov/mhsa/hcbs-amh/State-Hospital-Referral-Enrollment-Process.aspx> to access this process)

The date the referral and enrollment forms are received electronically at [HCBS-AMH@dshs.state.tx.us](mailto:HCBS-AMH@dshs.state.tx.us) is the date HHSC shall use to verify that an individual meets initial eligibility criteria once reviewed and approved.

SHSW provides general information about HCBS-AMH to the individual and/or LAR. The information that may be provided at any time during the Eligibility and Enrollment Process includes, but is not limited to:

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

## **5300 Referral Process from Community**

### **5310 Initial Criteria Report (ICR)**

HHSC creates a report of individuals who meet the needs based criteria for Long Term Hospitalization, Jail Diversion, and Emergency Department Diversion based on available data sources. The Local Mental

Health Authority (LMHA) and Local Behavioral Health Authority (LBHA) have access to the reports in MBOW: 1915i reports in the CA Continuity of Care folder.

### **5320 LMHA/LBHA**

LMHA/LBHA completes the HCBS-AMH Community referral process (See <https://www.dshs.state.tx.us/mhsa/hcbs-amh/Community-Referral-and-Enrollment-Process.aspx> to access this process).

The LMHA/LBHA or SPN shall complete and electronically submit the following by secure email to [HCBS-AMH@dshs.state.tx.us](mailto:HCBS-AMH@dshs.state.tx.us), with the subject line titled "Referral":

- Consent for Eligibility Determination and Enrollment Form
- HCBS-AMH UA, including the ANSA
- Notification of Participation Rights Form-
- HCBS-AMH Provider Selection Form

LMHA/LBHA or SPN assists the individual and LAR in the selection of an HCBS-AMH Recovery Management Entity and HCBS-AMH Provider Agency. The individual's choice is documented by completing the HCBS-AMH Provider Selection Form. The referring entity shall:

- Provide a list of all approved HCBS-AMH Recovery Management Entities and HCBS-AMH Provider Agencies serving the individual's county of residence to the individual and the LAR;
- Provide the individual and LAR with HCBS-AMH Recovery Management Entity and HCBS-AMH Provider Agency's location, contact information, and phone number.

The date the referral and enrollment forms are received electronically at [HCBS-AMH@dshs.state.tx.us](mailto:HCBS-AMH@dshs.state.tx.us) is the date HHSC shall use to verify that an individual meets initial eligibility criteria once reviewed and approved.

LMHA/LBHA or SPN provides general information about HCBS-AMH to the individual and/or LAR. The information that may be provided at any time during the Eligibility and Enrollment Process includes, but is not limited to:

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

Once the LMHA/LBHA completes the HCBS-AMH Community Referral process and receives notification from HHSC that the individual is enrolled, they are to assign a contact person for the RM and Provider Agency to maintain a clinical dialogue.

### **5400 Waitlist and Pending Enrollment**

#### **5410 Waitlist for Individuals Meeting Long Term Hospitalization Needs Based Criteria**

If HCBS-AMH does not have capacity to serve an individual who meets the Long Term Hospitalization needs based criteria and has been determined eligible based on the UA apart from financial eligibility, the individual is placed on the Waitlist until capacity for enrollment exists. If the Active UA expires, the

individual needs a new Initial UA prior to enrollment into HCBS-AMH. (See 4100 HCBS-AMH Uniform Assessment Definitions).

### **5420 Pending Enrollment**

Individuals that meet HCBS-AMH clinical eligibility, but currently reside in a SH with a forensic commitment, in an Outpatient Competency Restoration (OCR) program, or are deemed an inmate of the criminal justice system are determined eligible but are pending enrollment until judge or district attorney allows the individuals to reside in the community in a setting that meets CFR 441.710 standards. The individual's enrollment may remain pending for up to 60 days at which time the Active UA expires. If the individual is not allowed to reside in the community within 60 days, the individual requires a new Initial UA prior to enrollment.

## **6000 Enrollment into HCBS-AMH**

### **6100 Notification and Consent of Individual**

#### **6110 Notification of Eligibility**

Once an individual is determined eligible for the HCBS-AMH program and they are not waitlisted, HHSC notifies the individual and/or their LAR.

HHSC completes the following:

- Notify the referring entity via e-mail of the individual's eligibility;
- Provide the individual and LAR with notification of eligibility and enrollment determination in writing;
- Notify the Provider Agency and Recovery Management Entity selected by the individual and identified on the HCBS-AMH Provider Selection Form of the enrollment.

The referring entity completes the following:

- Provide the individual and/or LAR with a Participant Handbook, which contains a written explanation of the HCBS-AMH program and services supports;
- Provide a copy of DSHS/HHSC Handbook of Consumer Rights, Mental Health Services in either English or Spanish as appropriate to the individual and LAR, if applicable; and
- Inform the individual and the LAR of the process for reporting allegations of abuse, neglect or exploitation (ANE) and given the toll free number for the Texas Department of Family and Protective Services (DFPS). Oral and written communication of this information is documented on the Notification of Participant Rights Form bearing the date and signatures of the individual and/or LAR and the staff person who provided this information.

#### **6120 Notification of Ineligibility**

If an individual is determined to be ineligible for HCBS-AMH, HHSC:

- Notifies the individual and/or LAR through a Determination Letter;

- the individual is denied enrollment in HCBS-AMH;
- the individual is denied continued enrollment in HCBS-AMH; or
- HCBS-AMH program services for the Medicaid eligible individual are reduced, suspended, transferred, or terminated.
- If the individual has Medicaid, this notification includes notification of the right to a fair hearing;
- Notifies the referring entity; and
- Refers the individual to other services available or other known community resources.

## **6200 Selection and Notification of HCBS-AMH Recovery Management Entity and HCBS-AMH Provider Agency**

### **6210 Selection of Recovery Management Entity and HCBS-AMH Provider Agency**

Once the referring entity receives email notification from HCBS-AMH staff that an individual is eligible for enrollment the referring entity assists the individual and LAR (if applicable) in the initial selection of an HCBS-AMH Recovery Management Entity and the HCBS-AMH Provider Agency. The referring entity documents the individual's choice of Recovery Management Entity and HCBS-AMH Provider Agency by completing the HCBS-AMH Provider Selection Form and submits the form to HHSC with the referral and enrollment forms (See 5300 Referral Process from Community).

Individuals may choose among available HCBS-AMH Recovery Management Entities and the HCBS-AMH Provider Agencies at any time (See 10300 Transfer).

### **6220 Notification of Recovery Management Entity and HCBS-AMH Provider Agency**

Upon selection by the individual, the HCBS-AMH Recovery Management Entity and HCBS-AMH Provider Agency shall be notified by HHSC. HHSC coordinates the referral to the HCBS-AMH Recovery Management Entity and HCBS-AMH Provider Agency by submitting the HCBS-AMH Provider Selection Form to the selected HCBS-AMH Recovery Management Entity and HCBS-AMH Provider Agency.

The selected Recovery Management Entity and HCBS-AMH Provider Agency shall both maintain a copy of the HCBS-AMH Provider Selection Form in the individual's clinical record.

HHSC shall provide selected service providers with instructions to complete fingerprinting and credentialing needed prior to working in a state hospital, if applicable (See 13620 Credentialing for Service Provision within the State Hospitals).

### **6230 Transfer of Records**

HHSC transfers copies of the following documents to HCBS-AMH Providers: Consent for Eligibility Determination and Enrollment Form, UA, Determination Letter, Notification of Participant's Rights Form, and HCBS-AMH Provider Selection Form. HCBS-AMH providers shall maintain transferred records in the HCBS-AMH participant's clinical record.

## **6400 Recovery Management Entity Enrollment Responsibilities**

### **6410 Recovery Management Entity Capacity**

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

Although HCBS-AMH staff may enroll individuals at any time, verification of the selection of the Recovery Management Entity by the individual is dependent upon the capacity of Recovery Management Entity.

### **6415 Good Faith Effort Exception**

An HCBS-AMH Recovery Management Entity may identify they are unable to serve an individual because of their inability to locate housing for the individual which meets their needs identified on the Uniform Assessment and ensures their safety in the community. In this instance, the provider must conduct the following:

- Complete Good Faith Effort Exception form located at <http://www.dshs.state.tx.us/mhsa/hcbs-amh/Forms.aspx>
- Submit Good Faith Effort Exception form to [HCBS-AMH@dshs.state.tx.us](mailto:HCBS-AMH@dshs.state.tx.us) with the subject line "Good Faith Effort Exception"

Through completion of this form, the HCBS-AMH Recovery Management entity must articulate that reasonable efforts taken to identify housing for the individual. The Recovery Management Entity must document that this housing the RM is unable to secure is critical to maintaining the success of the individual in the community.

HHSC responds 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 Recovery Management contractual requirement.

### **6420 No Reject Policy Special Considerations, Exceptions, and Appeals**

HCBS-AMH Program operates with a No Reject Policy. If an HCBS-AMH Recovery Management Entity is selected by an individual, an RM from the Recovery Management Entity shall fulfill the role of RM as outlined in the Recovery Management Entity Provider Agreement and HCBS-AMH Provider Manual.

### **6421 Discharge from State Hospital Appeal**

When an individual is in a State Hospital (SH), the RM shall work with the SH and the individual's identified HCBS-AMH Providers to determine an individual's readiness for participation in the HCBS-AMH program in the community. If an HCBS-AMH Recovery Management Entity determines they cannot support an individual in the community, the HCBS-AMH Recovery Management Entity follows the appeals process of the No Reject Policy (See 6400 Recovery Management Entity Enrollment Responsibilities

An appeal must be submitted to HCBS-AMH staff 30 days prior to the anticipated discharge of the individual and in accordance with 6422.1 No Reject Appeals Process.

### **6422.1 No Reject Appeals Process**

If the HCBS-AMH Recovery Management Entity determines they are unable to support an individual transitioning from the SH into the community, they must follow the HCBS-AMH appeals process as follows:

- Complete No Reject Appeal form located [at http://www.dshs.state.tx.us/mhsa/hcbs-amh/Forms.aspx](http://www.dshs.state.tx.us/mhsa/hcbs-amh/Forms.aspx).
- Submit the No Reject Appeal form to [HCBS-AMH@dshs.state.tx.us](mailto:HCBS-AMH@dshs.state.tx.us) with the subject line “No Reject Appeal”; and
- Participates in a conference call with the SH and HCBS-AMH

HCBS-AMH assessment for No Reject Appeals includes:

- No Reject Appeal form;
- Medical Necessity for in-patient level of care;
- Initial Criteria Report (ICR);
- HCBS-AMH Uniform Assessment;
- Completion of updated Uniform Assessment, if necessary;
- Availability of HCBS-AMH services in the service area that meet the individual’s needs identified on their Uniform Assessment; and
- Review of final determination from LMHA/LBHA Medical Director and SH Clinical Director

Upon completion of the Appeals review process, HHSC notifies the HCBS-AMH Provider of the determination of the No Reject Appeal.

- If an appeal is denied, HHSC notifies the HCBS-AMH Provider of the reason for the denial and the HCBS-AMH Provider is responsible for providing HCBS-AMH services to the individual.

If an appeal is granted, HHSC notifies the individual, the individual’s Recovery Manager, SH, and the individual’s HCBS-AMH providers.

### **6430 Recovery Manager Meets with Individual**

Upon receipt of the HCBS-AMH Provider Selection Form, the HCBS-AMH Recovery Management Entity shall assign an RM to the individual, giving choice of the direct staff assigned to the individual whenever possible. The assigned RM is not to share a caseload with another RM at the HCBS-AMH Recovery Management Entity. The assigned RM is responsible to meet with the individual within fourteen days of notification of selection by HHSC via HCBS-AMH Provider Selection Form.

The RM shall contact the referring entity (state hospital or LMHA/LBHA) to coordinate/facilitate a meeting with the enrolled individual for the development of the Initial IRP. In some cases the RM may

need more than one meeting with the individual and others involved in the PCRP planning process to complete the initial IRP.

The Initial IRP must be completed and submitted to HHSC for approval within fourteen days of individual's enrollment in HCBS-AMH services. A maximum of 8 billing units may be billed for the development of the initial IRP (See 7300 Initial IRP).

### **6431 Initial Contact in the State Hospital**

When the Recovery Management Entity is selected by an individual currently resides in the State Hospital, the Recovery Management Entity:

- Receives email from HHSC with the following documents:
  - Notification of selection as Recovery Management Entity;
  - The individuals and referral entity's contact information;
- Completes credentialing process (See RM Handbook located at <http://www.dshs.state.tx.us/mhsa/hcbs-amh/recoverymanager/>);
- Receives approval date from HHSC for Recovery Management Transitional Services to begin;
- Coordinates with state hospital point of contact;
- Obtain the HCBS-AMH Provider Agency's contact information from the HCBS-AMH Provider Selection Form;
- Notifies the selected HCBS-AMH Provider, and assists providers in completing the credentialing process (See RM Handbook located at <https://www.dshs.state.tx.us/mhsa/hcbs-amh/recoverymanager/>);
- Meets with the individual, completes, and submits the Initial IRP (See 7300 Initial IRP) within fourteen days of notification of Recovery Management Entity selection;
- Obtains approval of Initial IRP from HHSC; and
- After completion of the Initial IRP (See 7300 Initial IRP), contact selected HCBS-AMH provider and coordinate services to ensure services begin within seven business days of approval of initial IRP.

### **6432 Initial Contact in the Community**

When Recovery Management Entity is selected as a provider and the individual currently resides in the community, Recovery Management Entity:

- Receives email from HCBS-AMH staff with the following documents:
  - Notification of selection as Recovery Management Entity;
  - The individual and referral entity's contact information;
- RM meets with the individual within fourteen days of notification;
- Obtain the HCBS-AMH Provider Agency's contact information from the HBCS-AMH Provider Selection Form;
- Convenes a IRP meeting with HCBS-AMH Provider Agency, completes Initial IRP within 14 days of notification, and submits it to HHSC; and
- After completion of the Initial IRP (See 7300 Initial IRP), coordinates with selected HCBS-AMH Provider Agency to ensure services begin within seven business days of approval of initial IRP.

## **6500 HCBS-AMH Provider Agency Enrollment Responsibilities**

### **6510 HCBS-AMH Provider Agency No Reject Policy**

HCBS-AMH program operates with a No Reject Policy. If an HCBS-AMH Provider Agency is selected by an individual, the Provider Agency shall fulfill the role as outlined in the Provider Agreement and HCBS-AMH Provider Manual.

HCBS-AMH Providers Agencies do not have the ability to deny provision of service to any individual, unless the HCBS-AMH Provider does not have the capacity, as agreed to in the Provider Agreement, or as otherwise indicated by policy.

### **6511 HCBS-AMH Provider Agency Capacity**

HCBS-AMH Providers may determine their capacity to serve individuals enrolled in HCBS-AMH by evaluating direct service staff resources, subcontractor staff resources, administrative staff resources and other characteristics. Providers set the limit of their capacity to serve individuals enrolled in the HCBS-AMH program after entering into to a Provider Agreement with HHSC.

## **6520 No Reject Policy Special Considerations, Exceptions, and Appeals**

### **6521 Good Faith Effort Exception**

HCBS-AMH Provider may identify they are unable to serve an individual either directly or through subcontract due to the inability to provide a critical HCBS-AMH service for that individual. In this instance, the provider must conduct the following:

- Complete Good Faith Effort Exception form located at <http://www.dshs.state.tx.us/mhsa/hcbs-amh/>; and
- Submit Good Faith Effort Exception form to [HCBS-AMH@dshs.state.tx.us](mailto:HCBS-AMH@dshs.state.tx.us) with the subject line "Good Faith Effort Exception"

Through completion of this form, HCBS-AMH Providers must articulate that they have taken reasonable efforts to provide the critical service(s) directly or through subcontract. HCBS-AMH Providers must document that the service(s) they are unable to provide are critical to maintaining the success of the individual in the community.

HHSC responds 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 Provider contractual requirement.

### **6522 Discharge from State Hospital Appeal**

When an individual is in State Hospital (SH), providers shall work with the SH and the individual's RM to determine an individual's readiness for participation in the HCBS-AMH program in the community. If an HCBS-AMH Provider determines they cannot support an individual in the community, the HCBS-AMH Provider follows the appeals process of the no reject policy. An appeal must be submitted to HCBS-AMH staff 30 days prior to the anticipated discharge of the individual and in accordance with 6522.1 No Reject Appeals Process.

#### **6522.1 No Reject Appeals Process**

If an HCBS-AMH Provider determines they are unable to support an individual transitioning from the SH into the community, they must follow the HCBS-AMH appeals process as follows:

- Complete No Reject Appeal form located at <http://www.dshs.state.tx.us/mhsa/hcbs-amh/>.
- Submit the No Reject Appeal form to [HCBS-AMH@dshs.state.tx.us](mailto:HCBS-AMH@dshs.state.tx.us) with the subject line “No Reject Appeal”; and
- Participates in a conference call with the SH and HCBS-AMH staff.

HCBS-AMH assessment for No Reject Appeals includes:

- No Reject Appeal form;
- Medical Necessity for in-patient level of care;
- Initial Criteria Report (ICR);
- HCBS-AMH Uniform Assessment (UA);
- Completion of Update UA, if necessary;
- Availability of other HCBS-AMH service providers in that service area; and
- Review of final determination from LMHA/LBHA Medical Director and SH Clinical Director

Upon completion of the Appeals review process, HHSC notifies HCBS-AMH Provider of the determination of the No Reject Appeal.

- If an appeal is denied, HHSC notifies the provider of the reason for the denial and the HCBS-AMH Provider is responsible for providing HCBS-AMH services to the individual.
- If an appeal is granted, HHSC notifies the individual, the individual’s RM and SH.

### **6530 Change of Selected HCBS-AMH Provider Agency**

At any time, an individual may select a new HCBS-AMH Provider Agency, if an alternative is available within their county of residence. (See 10300 Transfer and 10320 Transfer Procedure).

## **6600 HCBS-AMH Provider Agency and Recovery Manager Coordination and Provision of Services**

### **6610 Consents**

The RM maintains open communication and coordination with each HCBS-AMH Provider Agency by obtaining appropriate written consent from each individual for the disclosure of protected health information or other sensitive personal information. Likewise, the HCBS-AMH Provider Agency shall also obtain appropriate written consent from each individual for the disclosure of protected health information or other sensitive personal information.

### **6620 Role of HCBS-AMH Provider Agency**

When an HCBS-AMH Provider Agency is selected by an individual, the Provider shall coordinate with the RM and fulfill the role of Provider Agency as outlined in the Provider Agreement.

The selected HCBS-AMH Provider Agency provides all services in the HCBS-AMH service array other than Recovery Management. The HCBS-AMH Provider Agency shall agree to be active participants in the process led by the RM to develop the IRP.

### **6630 Role of HCBS-AMH Recovery Management Entity**

The selected HCBS-AMH Recovery Management Entity provides Recovery Management and coordinate all services in HCBS-AMH with the selected HCBS-AMH Provider Agency.

### **6640 Development of IRP**

The RM shall include the HCBS-AMH Provider Agency, if the individual receiving services agree, in the individual's PCRCP participants and coordinate the continued development of the individual's IRP. The HCBS-AMH Provider Agency shall agree to be active participants in the process led by the RM to develop the IRP. A representative from the service provider must sign the IRP for services on the IRP to be approved by HHSC.

For more information on the development of the IRP (See 7000 Individual Recovery Plan (IRP), 7200 IRP Requirements, and 7300 Initial IRP).

### **6650 Ensuring HCBS-AMH Provider Agency Provision of Services**

The Provider Agency shall ensure provision of services as identified on the IRP as approved by HHSC without delay. Additionally the HCBS-AMH Provider Agency is responsible to assure that HCBS-AMH services are not provided without an approved and active IRP, which means the IRP cannot have an Authorization Date greater than 90 days.

Provider Agencies may not place individuals who are Medicaid eligible on a waitlist for services.

## **7000 Individual Recovery Plan (IRP)**

The Individual Recovery Plan (IRP) is developed for each person receiving HCBS-AMH services. IRPs are developed in a person-centered planning process (See 8000 Person-Centered Recovery Planning) in accordance with CFR §441.725 Person-centered Service Plan; based on information from the HCBS-AMH UA; take into account the individual's social, treatment and service history; and centers on the short and long term goals and preferences as defined by the individual.

The Person-Centered Recovery Planning (PCRCP) approach to development of requires the IRP be developed with the full participation of the individual; LAR; individual's Interdisciplinary Team (IDT) (as applicable); and other people, including service providers, according to the needs and desire of the individual (PCRCP participants). The Recovery Manager is responsible for contacting the selected HCBS-AMH Provider Agency and involving HCBS-AMH Provider Agency direct service staff in the development of the IRP.

The HCBS-AMH Provider Agency shall agree to be active participants in development of the IRP. The HCBS-AMH Service Providers do the following:

- Participate in recovery plan meetings in person or via teleconference;
- Notify the RM if unable to attend meetings;
- Submit an update on the individual prior to the recovery plan meeting;
- Assist in the development of the IRP;
- Sign all necessary documents related to the IRP;
- Abide by conflict of interest standards, when applicable; and
- Abide by UM guidelines (See 12200 Utilization Management Guidelines).

Using PCRP the individual and other participants in the IRP development identify the individual's strengths, needs preferences and desired outcomes to determine the nature, amount and scope of Medicaid and non-Medicaid services required.

The RM signs the IRP attesting that the individual meets needs-based criteria for services reflected on the IRP.

IRPs are submitted to HHSC who ensures that conflict of interest does not occur (See 19000 Managing Conflicts of Interest). Review and authorization of IRPs are conducted by HHSC. (See 7700 IRP Approval Process).

### **7100 IRP Definitions**

| <b>IRP Types</b>    |   |
|---------------------|---|
| <b>Initial:</b>     | The first IRP authorized by HHSC in an individual's Episode of Care.  |
| <b>Update:</b>      | IRPs authorized by HHSC subsequent to an Initial IRP that do not meet criteria of a Discharge IRP or Transfer IRP.  |
| <b>Transfer:</b>    | IRPs authorized by HHSC subsequent to a transfer of an individual to another Recovery Management Entity and/or HCBS-AMH Provider Agency that do not meet criteria of a Discharge IRP. |
| <b>Discharge:</b>   | The last IRP authorized by HHSC in an individual's Episode of Care where there is a planned discharge from HCBS-AMH. Discharge IRPs require a discharge UA.                           |
| <b>Expired IRP:</b> | An IRP that has exceeded the Expiration Date of the IRP. An IRP cannot be active without at active UA.  |

| <b>IRP Status Definitions</b> |  |
|-------------------------------|--|
| <b>Draft:</b>                 | An IRP that has been initiated by the RM. A Draft IRP cannot be initiated without an Active UA as IRPs must be developed to reflect the individual's current assessed needs. Once an IRP is saved in Draft Status no edits can be made to the Active UA. |
| <b>Ready for Review:</b>      | An IRP that has been submitted to HHSC for review and approval by an RM attesting that the individual meets needs-based criteria for services reflected on the IRP.  |
| <b>Closed Complete:</b>       | An IRP that has been approved by HHSC.   |
| <b>Active:</b>                | An active IRP is an initial or update IRP that has been approved by HHSC and given an Authorization Date. An IRP cannot be active without at Active UA. HCBS-AMH Services cannot be provided without an Active IRP.                                      |

| <b>IRP Dates</b> |
|------------------|
|------------------|

|                            |  |
|----------------------------|--|
| <b>Completion Date:</b>    | The date the IRP is signed by the RM attesting that the individual meets needs-based criteria for services reflected on IRP, saved in Closed Complete status, and submitted to HHSC.   |
| <b>Authorization Date:</b> | The authorization date shall be the date the IRP is authorized. HCBS-AMH Services cannot be provided without an authorized IRP. An IRP cannot be authorized without at active UA.  |
| <b>Expiration Date:</b>    | The expiration date of the IRP includes: <ul style="list-style-type: none"> <li>the expiration date of the Active UA,</li> </ul> <p><b><i>Although the individual may be enrolled without an Active IRP, HCBS-AMH services cannot be provided.</i></b></p> |

## **7200 IRP Requirements**

The IRP shall reflect the most appropriate type and amount of HCBS-AMH program services to meet the individual's needs identified through the HCBS-AMH UA (See 12200 Utilization Management Guidelines). When applicable, the Recovery Management Entity may utilize additional functional needs assessments to ascertain additional needs of the individual (See 7260 Secondary Assessments Co-Occurring Diagnoses Needs Assessment). The IRP should also include what is important to the individual with regard to preferences for the delivery of such services and supports and to ensure his/her health and welfare in the community

The IRP includes all HCBS-AMH services to be provided and additionally reflects coordination with managed care by the inclusion of Non-HCBS-AMH Services (i.e. other Non-HCBS-AMH Medicaid State Plan Services or Non-HCBS-AMH Services – Services provided by other Funding Sources). In order for an individual to have continued enrollment in HCBS-AMH, an individual must require the provision of at least one HCBS-AMH service, as documented in the IRP.

If one or more of the HCBS-AMH services specified in the IRP does not meet standard UM guidelines (See 12200 Utilization Management Guidelines), HCBS-AMH:

- Notifies the individual's RM of services that require additional information; and
- Sends written notice to the individual and/or LAR that the individual's HCBS-AMH services require additional information for approval

The RM shall coordinate with HCBS-AMH provider to obtain justification for a service and report back to HCBS-AMH within five business days.

If an individual requires assistance which may alter person-centered requirements, this modification must be listed on the individual's IRP. These modifications must include the specific modification directly proportionate to the individual's condition, the individual's assessed need, positive interventions and supports used prior to interventions, previous interventions that did not work, established time limit for intervention, informed consent from the individual, and assurance that the modification does not cause harm to the individual.

HHSC may request to review goals, objectives, strategies, and modifications (if applicable), to assist in the IRP approval process. The Recovery Management Entity obtains IRP approval by HCBS-AMH for each individual's IRP.

### **7210 Requirements for Approval by HHSC**

The IRP must be developed by the RM using PCR, approved by HHSC and authorized prior to the provision of HCBS-AMH services. To be approved by HHSC, the IRP must:

- Be developed in accordance with TAC Chapter 416, Subchapter B (relating to Home and Community-Based Services—Adult Mental Health Program);
- Provide attestation to needs-based criteria, signed for by the RM;
- Include the type, amount and duration of services to be provided, effective dates of service and the individual's goals and objectives (this includes services to be coordinated through managed care organization (non-HCBS Medicaid services) and non-Medicaid HCBS-AMH services (i.e. Flexible Funds);
- Include a crisis plan;
- Include a safety plan (if applicable);
- Identify service providers and credentials of the service provider (when applicable);
- Include a narrative summary that interprets the data gathered in the UA and provides an understanding of underlying needs. This summary describes the clinical needs as well as the individual's experiences and activities which may attempt to explain the underlying cause of those needs. Barriers to achieving goals are included in the narrative summary;
- Be the most appropriate type and amount of services to meet the individual's needs and identify which identified need each service is intended to address;
- Be based on the individual's preferences, needs, strengths, goals and desired outcomes;
- Be finalized and agreed to, with the informed consent of the individual, in writing by the individual and signed by all individuals and providers responsible for its implementation; and
- Include the essential components of the IRP. (See 7220 Essential Components of the IRP).

### **7220 Essential Components of the IRP**

#### **7221 Goal Statements**

The foundation of IRP goals are the individual's strengths, needs, abilities, and preferences. Discussion of goals should occur throughout the assessment process and result in the selection of one (or more) goals that guide the planning process. The goal selected by the person to guide services shall be captured in a goal statement on the IRP.

IRP goal statements should:

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

- If the individual is unable to communicate his/her own goals, then a family member, LAR, or the clinician that the individual has chosen to represent them may help clarify or provide initial treatment goals until the individual is able to actively participate in the development of his/her treatment plan.

## **7222 Strengths**

The individual's strengths and abilities refer to characteristics of the individual that are elements in the individual's life, used in the past or present, to help them cope with stressful situations. The individual's strengths are used to help promote an individual's success in reaching their goals.

An individual's strengths include anything that may aid them in the pursuit of their identified goal(s), including factors that are both internal and external to the person. These factors can include personal characteristics or attributes, access to concrete resources, abilities of the person or natural support system, personal interests, skills, past achievements, and cultural factors. Strengths should be identified and captured in a way that enables their use toward achieving goals and objectives. Providers should assist individuals (and natural supports/LARs) to identify a diverse range of strengths, which may be actively used in the plan for recovery. If the individual is unable to communicate his/her strengths, then a family member, LAR, or other representative may help clarify or identify the individual's strengths to help shape the recovery process.

Examples of strengths include the following:

- Principles;
- Religious beliefs;
- Supportive friends;
- Supportive family;
- Being able to work; and
- Hope.

Examples of abilities include the following:

- Attend to activities of daily living (ADLs);
- Skills in reading and writing;
- Saves money;
- Follows instructions;
- Recognizes side effects of medication; and
- Asks for help.

## **7223 Barriers/Needs**

The Barriers/Needs on an IRP identify what is keeping the individual from their goals. Barriers should communicate the true nature of the obstacle to be overcome. Barriers should be specific enough to suggest next steps for how a person's progress may be measured and what services may benefit them.

Barriers/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 activities of daily living; and
- Threats to basic health and safety.

## 7224 Objectives

Objectives on an IRP are the short-term changes needed for the individual to progress toward their goals. Objectives communicate what evidence show a barrier has been overcome. Objectives should:

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

## 7225 Interventions

Interventions on an IRP are actions taken by an individual's providers, peers, family, friends, natural supports and other PCRIP participants for the purpose of attaining desired changes. Interventions should:

- Be specific to an objective;
- Respect an individual's choice and preference;
- Be specific to the stage of change/recovery;
- Incorporate a person's identified strengths/abilities;
- Take into consideration cultural factors;
- Specify provider and professional discipline;
- Specify modality;
- Specify frequency, and duration; and
- Specify purpose, intent, and impact.

## 7226 Crisis Plan

Crisis plans focus on planning for, predicting, and preventing a crisis situation (as identified by the individual and/or others involved in the PCRIP planning process, as applicable) from occurring. Submitted with the IRP, individuals enrolled in HCBS-AMH shall have a crisis plan that addresses any identified risk that could place the individual or others in danger of deterioration of mental health, physical harm, or exploitation. Crisis plans shall be developed by the RM with the individual, LAR, and other PCRIP participants during the first meeting with the individual and are expanded as needed.

Identification of accessible crisis related services shall be included in the IRP in collaboration with the individual, the LMHA/LBHA in the individual's chosen county of residence, the HCBS-AMH Provider Agency, and other identified members of the individual's team. This could include stabilization through Medicaid funded crisis or emergency services (outside of the HCBS-AMH Program) such as mobile crisis outreach services, emergency departments, or psychiatric hospitals and services at the LMHA/LBHA Crisis Services Program.

The RM's availability shall be identified as part of the individual's crisis plan. If the RM is not available to the individual 24/7 then alternative RM contacts must be identified on the Crisis Plan.

If the RM is part of an LMHA/LBHA, the RM may also utilize the LMHA/LBHA Crisis Services Program as an alternate contact for the individual. The RM must coordinate with the LMHA/LBHA to ensure they are notified when an individual accesses the Crisis Services Program.

An individual's crisis plan shall include but is not limited to the following:

- Identifying information;
- Emergency Contact;
- Service Providers;
- Cultural/Spiritual beliefs;
- What supports are most helpful to the individual in crisis including cultural and spiritual beliefs;
- Who the individual wants contacted or consulted; and
- Alternate contact information of qualified individual if the RM is not available.

### **7227 Safety Plan**

Safety Plans focus on the prevention of risk behavior and interventions needed for such behaviors. When developing Safety Plans, RMs should ensure the plan meets the expectations of the individual and PCRP participants.

If it is identified that the individual needs a safety plan through review of UA and supporting documents, the individual should be assessed for susceptibility to abuse by others and the person's risk of abusing other vulnerable people in the following areas:

- Physical Abuse;
- Emotional Abuse;
- Sexual Abuse;
- Self-abuse; and
- Financial exploitation

If an individual is deemed susceptible to abuse or exploitation as identified above, the RM, individual and/or LAR and PCRP participants should do the following:

- Indicate reason the individual is susceptible;
- Identify specific measures to be taken to minimize the risk within the scope of licensed services;
- Identify referrals needed when the individual is susceptible outside the scope or control of the licensed services; and
- Identify entity and process where providers, RMs, friends, or family report threats or concerns.

### **7230 Administrative IRP Requirements**

In addition to requirements for approval by HHSC, administrative requirements dictate the IRP must:

- Be reviewed and updated with the individual at least every 90 days, when the individual's circumstances or needs change significantly, and at the request of the individual;
- Have a copy maintained in the individual's clinical record;
- Reflect that the setting in which the individual resides is chosen by the individual;
- Reflect the individual's strengths and preferences;
- Reflect clinical and support needs as identified through UA, supporting documents, and any additional functional assessment tools used to provide additional guidance on the individual's needs and strengths;

- Reflect the services and supports (paid and unpaid) that assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports;
- Reflect risk factors and measures in place to minimize them, including safety plans (if applicable) and crisis plans and strategies when needed;
- Identify the individual and/or entity responsible for monitoring the plan;
- Be signed by all individuals involved in the development of the IRP and a copy distributed to the individual and all other people involved in the plan; and
- Be signed by the RM attesting that the individual meets needs-based criteria for services reflected on the IRP.

### **7240 Quality Management IRP Requirements**

Additionally, the IRP must be developed using Person-Centered Recovery Planning Process. (See 15000 Quality Management (QM)). Elements of that process should be reflected by assuring the IRP:

- Prevents the provision of unnecessary or inappropriate care;
- Prepares for the individual's effective transition to the community;
- Promotes the individual's inclusion into the community;
- Protects the individual's health and welfare in the community;
- Supplements, rather than replaces, the individual's natural support systems and resources;
- Is designed to prevent or reduce the likelihood of the individual's admission into an inpatient psychiatric facility; and
- Is understandable to the individual receiving services and supports, and the individuals important in supporting him or her, using the individual's own words to the greatest extent possible (for Medicaid purposes, some adaptation may be required).

### **7250 Deviations from Service Standards**

The IRP documents any planned intervention which could potentially impinge on individual autonomy, especially for Community-based Residential Services and administration of medication (See 11000 Settings Requirements, 16200 Use of Restrictive Interventions, and 16300 Medication Safety and Management). These planned interventions are documented as modifications on the modification section of the IRP. The modification section of the IRP must include the following (See 7200 IRP Requirements):

- Informed consent of the individual to the intervention;
- Specific need for the intervention in supporting the individual to achieve his/her goals;
- Assurance that the intervention is the most inclusive and person-centered option;
- Time limits for the intervention;
- Periodic reviews of the intervention to determine if it is still needed;
- Assurance that the intervention will cause no harm to the individual; and
- Confirmation that the individual has received information on how to report incidences of abuse, neglect, or exploitation.

Individuals must provide informed consent regarding the potential use of restrictive intervention. This potential must be included on the individual's safety plan on the IRP, this includes understanding of their rights, how to report abuse, neglect, and exploitation.

### **7260 Secondary Assessments Co-Occurring Diagnoses Needs Assessment**

When applicable, the Recovery Management Entity may utilize additional functional needs assessments to ascertain additional needs of the individual. Additional assessment and planning may need to occur for individuals that have co-occurring diagnoses from the following neurodevelopmental and neurocognitive disorders:

- Intellectual and Developmental Disability (IDD) Diagnoses: Mild, Moderate, Severe, Profound, or Unspecified Severity;
- Autism Spectrum Disorder;
- Traumatic Brain Injury; or
- Dementia

### **7300 Initial IRP**

#### **7310 Timeframe of Initial IRP**

The RM is responsible to meet with the individual complete and submit the Initial IRP to HHSC within fourteen days of receipt of the HCBS-AMH Provider Selection Form, by HHSC. The RM shall contact the referring entity within the timeframe needed to coordinate/facilitate meeting with the enrolled individual. The RM is allowed to bill for 8 units of Recovery Management services in the initial IRP process (see HCBS-AMH Billing Guidelines Section 4112.1). If the IRP is unable to be completed within the 14 day timeframe, documentation in the clinical record is required.

#### **7320 Requirements Specific to the Initial IRP**

The Initial IRP shall meet requirements set forth in section 7200 IRP Requirements and specifically address the following:

- Narrative summary of the individual which includes the following:
  - Demographic information;
  - Housing history;
  - History of hospitalization;
  - Psychiatric and Medical Diagnoses; and
  - Current medications;
- Medication compliance;
- Current housing needs/barriers; and
- Assistance in accessing financial resources.

#### **7330 Needs-Based Criteria**

During the development of the Initial IRP, the RM is responsible to attest to the needs-based criteria of HCBS-AMH services. (See HCBS-AMH Billing Guidelines <http://www.dshs.state.tx.us/mhsa/hcbs-amh/billing/> for more information about needs-based criteria for individual HCBS-AMH services). This attestation must be signed by the RM.

#### **7400 Update IRP**

Throughout the individual's enrollment in HCBS-AMH updates to the IRP are required. IRPs are updated as follows:

- Not to exceed 90 days from the date of the last IRP or at the request of the individual;
- When the individual is ready to be discharged from the state hospital;
- When the individual is placed in or removed from Suspended status (See 10220 Suspension Procedure); and
- When clinically indicated because the individual's IRP no longer meets the recovery goals and/or clinical needs of the individual or a crisis event has occurred.

### **7410 Requirements Specific to the Update IRP**

The individual's Update IRP shall indicate one of the following reasons for the update:

- Review/Administrative;
- Transition to Community (completed prior to discharge from hospital);
- Suspension (See 10210 Reasons for Suspension);
- Clinically Indicated; or
- Reinstatement of Services.

### **7500 Discharge IRP**

An individual may be discharged from HCBS-AMH. (See 10110 Reasons for Discharge). If possible, the RM should create a Discharge IRP to reflect the transition of the individual from the HCBS-AMH Program to utilizing other resources in the community, a crisis plan, and both natural and formal supports available to the individual. Discharge IRPs are to be submitted to HHSC within three business days of final request to discharge.

### **7510 Requirements Specific to the Discharge IRP**

The individual's discharge IRP should include but is not limited to the following:

- Reason for discharge;
- The individuals' current status (e.g., diagnosis, medications, level of functioning) and unmet needs;
- A summary of the mental health community services and treatment the individual received as an HCBS-AMH participant;
- Current barriers and needs;
- Current strengths and resources;
- Current crisis plan and safety plan (if applicable)
- Current setting in which the individual resides;
- Information from the individual and the LAR regarding the individual's strengths, preferences for mental health community services, and responsiveness to past interventions; and
- The mental health and other community services the individual will receive for the continuity of services without disruption.
- The individual's preference for community services; and
- Referral to alternate community services (if applicable).

### **7600 Role of the Recovery Manager in Development of the IRP**

Development of the IRP is the responsibility of the individual's RM. Additionally, RMs:

- Ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;

- Are responsible for monitoring and coordinating the provision of services included in the IRP to ensure that the individual's needs, preferences, health and welfare are promoted;
- Inform the individual and/or LAR, and PCRCP participants of qualified provider options. Documentation regarding provider choice is included in the individual's record and updates to that record (See 13410 Documentation of Provider Choice).
- Ensure that the IRP is signed by the individual, all parties participating in the PCRCP, all providers on the IRP, and the RM verifying the individual meets needs-based criteria for services reflected on the IRP; and
- Ensure that all parties have a copy of the Active IRP; and
- Ensures the Active IRP is kept in the individual's clinical record.

## **7700 IRP Approval Process**

### **7710 Submission of the Initial IRP**

The Recovery Management Entity sends a secure electronic submission to [HCBS-AMH@dshs.state.tx.us](mailto:HCBS-AMH@dshs.state.tx.us)

- The subject line must read: "INITIAL: IRP Approval Request (insert the individual's initials and the last four digits of CARE ID number)"
- The completion of the IRP includes selection of "initial" on the IRP type.
- Submitted to HHSC within 14 days of enrollment
- The contents of the email must include:
  1. Individual Recovery Plan Form;
  2. Attestation of needs-based criteria for services reflected on IRP, signed by the RM. (Electronic signatures are accepted; however the Recovery Management Entity and HCBS-AMH Provider Agency must maintain hardcopy signatures in the individual's clinical record.)
  3. Clinical documentation that reflects justification for services requested.

### **7711 HHSC Review of the Initial IRP**

The IRP must reflect clinical needs identified on the Active UA. HHSC shall make this determination within five business days. This determination is made according to the following:

- Needs are identified on the active UA; or
- Additional information is required

HHSC shall communicate the determination by replying to the email request within five business days.

- The subject line should read: "RE: INITIAL: IRP Approval Request (insert the individual's initials, and the last four digits of CARE ID number)"
- The contents of the email should state the status of the IRP (approved, denied, or if more information requested) by HHSC.
- HHSC provides justification of any denial of IRPs which the RM shall address. If HHSC requests more information, the RM responds with necessary information within five business days.

### **7720 Submission of Update IRP**

The Recovery Management Entity is responsible to ensure that there is an Active IRP and the IRP is reviewed, updated, and approved by HHSC not to exceed 90 days from the date of the last IRP.

Additionally, the RM may determine the IRP approved by HHSC should be updated to meet the needs of

the individual. (See 7400 Update IRP). In both instances an Update IRP is required for the provision of HCBS-AMH Services. Completion of this update includes selecting “update” on the IRP type. The updated IRP must be submitted to HHSC within three business days of completion of the update.

The Recovery Management Entity submits the Update IRP through secure electronic submission to [HCBS-AMH@dshs.state.tx.us](mailto:HCBS-AMH@dshs.state.tx.us)

- The subject line must read: “UPDATE: IRP Revision Request (insert the individual’s initials and the last four digits of CARE ID number)”
- The contents of the email must include:
  1. Individual Recovery Plan Form;
  2. Attestation that the individual meets needs-based criteria for services reflected on IRP, signed by the RM. (Electronic signatures are accepted; however the Recovery Management Entity and HCBS-AMH Provider Agency must maintain hardcopy signatures in the individual’s clinical record.)
  3. Clinical documentation that reflects justification for services requested.

### **7721 HHSC Review of the Update IRP**

The Update IRPs should be used to demonstrate progress on current goals and objectives. If an individual’s needs, goals, or objectives change significantly, HHSC may request an Update UA as part of the additional information required to approve an Update IRP. The Update IRP must reflect clinical needs identified on the Active UA. HHSC shall make this determination within five business days. This determination is made according to the following:

- Needs are identified on the active UA; or
- Additional information is required.

HHSC shall communicate the determination by replying to the email request within five business days.

- The subject line should read: “RE: INITIAL: IRP Approval Request (insert the individual’s initials, and the last four digits of CARE ID number)”
- The contents of the email should state the status of the IRP (approved, denied, or if more information requested) by HHSC.

HHSC provides justification of any denial of IRPs which the RM shall address. If HHSC requests more information, the RM responds with necessary information within five business days.

### **7730 Submission of Transfer IRP**

In the event the individual is transferred to a new HCBS-AMH Provider Agency and/or Recovery Management Entity, the RM updates the IRP approved by HHSC to reflect the transfer of the IRP to the new HCBS-AMH provider. Completion of this update includes selecting “transfer” on the IRP type. (See 10300 Transfer).

The Recovery Management Entity submits the Transfer IRP through secure electronic submission to [HCBS-AMH@dshs.state.tx.us](mailto:HCBS-AMH@dshs.state.tx.us) within three business days of completion.

- The subject line must read: “TRANSFER: IRP Revision Request (insert the individual’s initials and the last four digits of CARE ID number)”
- The contents of the email must include:
  1. The Updated HCBS-AMH Provider Selection Form;

2. Individual Recovery Plan Form;
3. Attestation the individual meets needs-based criteria for services reflected on IRP, signed by the RM. (Electronic signatures are accepted; however the Recovery Management Entity and HCBS-AMH Provider Agency must maintain hardcopy signatures in the individual's clinical record.)
4. Clinical documentation that reflects justification for transfer

### **7731 HHSC Review of the Transfer IRP**

The Transfer IRP must reflect clinical needs identified on the active UA. HHSC shall make this determination within five business days. This determination is made according to the following:

- Needs are identified on the active UA; or
- Additional information is required.

HHSC shall communicate the determination by replying to the email request within five business days.

- The subject line should read: "RE: TRANSFER: IRP Approval Request (insert the individual's initials, and the last four digits of CARE ID number)"
- The contents of the email should state the status of the IRP (approved, denied, or if more information requested) by HHSC.
- HHSC provides justification of any denial of IRPs which the RM shall address. If HHSC requests more information, the RM responds with necessary information within 5 business days.

### **7740 Submission of Discharge IRP**

An individual may be discharged from HCBS-AMH (See 10110 Reasons for Discharge). If possible, the RM should create a Discharge IRP to reflect the transition of the individual from the HCBS-AMH Program to utilizing other resources in the community, a crisis plan, and both natural and formal supports available to the individual. Completion of this IRP includes selecting "discharge" on the IRP type. Discharge IRP's are to be submitted to HHSC within three business days of final request.

The Recovery Management Entity submits the Discharge IRP through secure electronic submission to [HCBS-AMH@dshs.state.tx.us](mailto:HCBS-AMH@dshs.state.tx.us)

- The subject line must read: "DISCHARGE: IRP Revision Request (insert Reason for Discharge from section 10110 Reasons for Discharge) and (insert the individual's initials and the last four digits of CARE ID number)"
- The contents of the email must include the Individual Recovery Plan Form
- Clinical Documentation that reflects justification for discharge request

### **7741 HHSC Review of the Discharge IRP**

It is preferable that a Discharge UA is completed prior to discharge of the individual. If it is a planned discharge, the RM should request an appointment for the Discharge UA to be completed with the individual.

HHSC shall review the IRP and make this determination within five business days. This determination is made according to the following:

- Reflect the transition of the individual from the HCBS-AMH Program to utilizing other resources in the community;

- Crisis plan; and both natural and formal supports are available to the individual; or
- Additional information is required.

HHSC shall communicate the determination by replying to the email request within five business days.

- The subject line should read: “RE: DISCHARGE: IRP Approval Request (insert the individual’s initials, and the last four digits of CARE ID number)”
- The contents of the email should state the status of the IRP (approved, denied, or if more information requested) by HHSC.
- DSH provides justification of any denial of IRPs which the RM shall address. If HHSC requests more information, the RM responds with necessary information within five business days.

### **7750 Authorization and expiration date for the IRP**

Services shall not be reimbursable prior to the IRP authorization date or after an expiration date. (See 7100 IRP Definitions for authorization and expiration dates of the IRP).

### **7800 Documentation Requirements of the IRP**

In addition to the requirements identified in this section, 7000 Individual Recovery Plan, there must be a documented link between the service, objectives, goals, and identified needs. (See 7220 Essential Components of the IRP and <http://www.dshs.state.tx.us/mhsa/hcbs-amh/Forms.aspx> for access to the Individual Recovery Plan Template).

## **8000 Person-Centered Recovery Planning**

PCRCP is the collaborative process, utilized by the RM and directed by the individual, to create the IRP. PCRCP uses a recovery orientation and team approach that includes the individual, formal supports, and natural supports to best support the individual’s recovery and goals. The process provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

The IRP is developed collaboratively with the individual; the individual’s LAR, if applicable; treatment providers (formal supports); and others chosen by the individual (informal supports). The goal of this collaboration is to develop an IRP and implement a plan of action that assists the individual in achieving their unique and individual goals along their journey to recovery.

The IRP shall be developed in accordance with CFR §441.725 Person-centered service plan:

[http://www.ecfr.gov/cgi-bin/text-idx?node=se42.4.441\\_1725&rgn=div8](http://www.ecfr.gov/cgi-bin/text-idx?node=se42.4.441_1725&rgn=div8)

### **8100 Qualities of Person-Centered Recovery Planning Process**

#### **8110 Identification of the Individual’s PCRCP Participants**

The Recovery Management Entity is responsible for working with the individual, LAR (if applicable), and referring entity in identifying, coordinating, and involving the individual’s identified participants in the PCRCP process.

The PCR process assesses the strengths and needs of the individual with input from the person requesting and/or receiving services and from those providing services. The PCR participants work to develop and implement the person's IRP. The PCR participants include the individual and may include the following based on the individual's needs and preferences:

- Psychologist/Psychiatrist;
- Social Worker;
- Doctor/Nurse;
- Nutritionist;
- OT/PT;
- Residential Representative;
- Day Program Representative C Vocational Rep/Job Coach ;
- Friends;
- Family;
- Guardians;
- Peer specialists; and
- Others as identified by the individual.

### **8120 Qualities of the Process**

To be considered PCR the process to develop the IRP should:

- Provide necessary information and support to ensure that the individual 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 individual;
- Reflect cultural considerations of the individual;
- Include strategies for solving conflict or disagreement with the process, including clear conflict of interest guidelines for all planning participants;
- Ensure the individual's choices and preferences shall always be honored and considered, if not always granted;
- Offer choices to the individual regarding the services and supports they receive and from whom;
- Include a method for the individual to request updates to the plan, as needed; and
- Record the alternative home and community-based settings that were considered by the individual.

### **8130 Qualities of Person-Centeredness**

For a plan 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 utilize professional jargon;
- Express the individual's goals and aspirations in their own words as much as possible;
- Articulate the individual's own role and the role of both paid (formal supports) and natural supports in assisting the individual achieve their goals;
- Focus and build on the individual's capacities, strengths, and interests;
- Emphasize the use of natural community settings rather than segregated program settings;
- Allow for uncertainty, setbacks, and disagreements as inevitable steps on the path to greater determination;
- Include individual-defined goals, realistic objectives that address relevant and immediate barriers and impediments, as well as effective services and interventions; and

- Be outcome-oriented.

### **8500 Peer Support in PCRCP**

It is encouraged that the direct service provider of HCBS-AMH Peer Support be involved in all PCRCP activities and the RM and other direct service providers work in collaboration with them. Certified Peer Support Specialists have the unique ability to foster healing relationships and create an environment conducive for recovery with the individual through the sharing of their lived experience with mental health and/or substance abuse. Peer Support Specialists bring an authenticity and connectedness to both recovery-oriented transformation work and work with the individuals that receive service in a way that traditional providers are not able, building trust and bringing credibility to this work to benefit everyone.

Certified Peer Support Specialists provide coaching in advance of, and/or during the PCRCP process. This coaching can:

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

Additionally, Certified Peer Support Specialists 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 their recovery.

### **9000 Provision of Services**

HCBS-AMH services shall be provided in accordance with the Active IRP (See 7000 Individual Recovery Plan (IRP)) and in home and community-based settings (See 11000 Settings Requirements). An IRP cannot be authorized without at active UA (See 7200 IRP Requirements). The HCBS-AMH Provider Agency is responsible for the provision of all HCBS-AMH services and service quantities detailed on the IRP, including those provided through subcontract arrangements.

All HCBS-AMH services, Non- HCBS-AMH services, and State Plan services shall be identified during the PCRCP process and on the IRP. State plan services other than HCBS-AMH services are provided as medically necessary and shall be coordinated with the HCBS-AMH services.

See HCBS-AMH Billing Guidelines for:

- Additional information regarding requirements and standards for HCBS-AMH services;
- Documentation requirements;
- Needs-based criteria;
- Rates; and
- Units

### **9100 HCBS-AMH Service Definitions**

| Service |  |
|---------|--|
|---------|--|

|                                   |   |
|-----------------------------------|---|
| <b>Adaptive Aids</b>              | <p>Specialized equipment and supplies including devices, controls, and appliances that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.</p> <p>This service also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not otherwise available under the Medicaid State Plan.</p>   |
| <b>Host-Home/Companion Care</b>   | <p>Fosters recovery and independence by providing personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of cognitive training or specialized mental health therapies/activities; assistance with medications based upon the results of an RN assessment and the performance of tasks delegated by a RN in accordance with the Texas Board of Nursing rules as defined by Title 22 of the Texas Administrative Code, Part 11, Chapter 225; and supervision of the individual's safety and security.</p>             |
| <b>Assisted Living</b>            | <p>Fosters 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.</p>  |
| <b>Supervised Living Services</b> | <p>Fosters recovery and independence by providing individuals with personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of specialized rehabilitative, habilitative or psychosocial therapies; assistance with medications based upon the results of an RN assessment; the performance of tasks delegated by a RN in accordance with the Texas Board of Nursing rules as defined by Title 22 of the Texas Administrative Code, Part 11, Chapter 225; and supervision of the individual's safety and security.</p> |
| <b>Supported Home Living</b>      | <p>Direct personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of behavioral support or specialized therapies activities; assistance with medications and the performance of tasks delegated by a registered nurse in accordance with the Texas Board of Nursing rules as defined by Title 22 of the Texas Administrative Code, Part 11, Chapter 225;</p>   |

|   |   |
|---|---|
|   | and supervision as needed to ensure the individual's health and safety; and supervision of the individual's safety and security.  |
| <b>Community Psychiatric Supports and Treatment</b> | Goal directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the individual's IRP.  |
| <b>Employment Services</b>                          | Employment services help people with SMI work at regular jobs of their choosing and to achieve goals meaningful to them, such as increasing their economic security.  |
| <b>Employment Assistance</b>                        | Helps the individual locate and maintain paid employment in the community and may include activities on behalf of the individual to assist in obtaining employment.   |
| <b>Supported Employment</b>                         | Provides individualized services to sustain individuals in paid jobs in regular work settings, who, because of disability, require support to be self-employed, work from home, or perform in a work setting at which individuals without disabilities are employed.  |
| <b>Flexible Funds</b>                               | <p>Monies utilized for non-clinical supports that augment the IRP to reduce symptomatology and maintain quality of life and community integration.</p> <p>Flexible Funds may be used in accordance with the following guidelines:</p> <ul style="list-style-type: none"> <li>• Flexible funds are reserved for indigent individuals.</li> <li>• All services provided with Flexible Funds must be identified on the IRP for review and prior-approval by HHSC.</li> <li>• HHSC reviews to ensure that the indicated service does not fall within the scope of the HCBS-AMH service array before approving.</li> </ul>   |
| <b>Peer Support</b>                                 | Services provided by people with lived experience who are in recovery from mental illness and/or substance use disorders to help individuals 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.   |
| <b>Home Delivered Meals</b>                         | Provides a nutritionally sound meal to individuals that are delivered to the individual's home.   |
| <b>Minor Home Modifications</b>                     | Physical adaptations to an individual's home that are necessary to ensure the individual's health, welfare, and safety, or that enable the individual to function with greater independence in the home.  |
| <b>Nursing</b>                                      | Services that are within the scope of the Texas Nurse Practice Act and are provided by a Registered Nurse (RN) (or licensed vocational nurse(LVN) under the supervision of an appropriate Clinical Supervisor RN), licensed to practice in the state. HCBS-AMH Nursing 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. |
| <b>Recovery Management</b>                          | Services assisting individuals 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.   |

|  |   |
|--|---|
| <b>HCBS-AMH Psychosocial Rehabilitation Services</b> | Evidence-based or evidence-informed interventions which support the individual's recovery by helping the individual develop, refine and/or maintain the skills needed to function successfully in the community.. |
| <b>Respite Care</b>                                  | Respite is a service that provides temporary relief from care giving to the primary caregiver of an individual during times when the individual's primary caregiver would normally provide care.                  |
| <b>Substance Use Disorder services (SUD)</b>         | Assessment and ambulatory group and individual counseling for substance use disorders. Services are specialized to meet the needs of individuals who have experienced extended institutional placement.           |
| <b>Transition Assistance Services (TAS)</b>          | Payment of set-up expenses for individuals transitioning from institutions into community settings necessary to enable individuals to establish basic households.   |
| <b>Transportation Services</b>                       | Non-medical transportation that enables individuals to gain access to services, activities, and resources, as specified in the IRP.   |

## **9200 Description of Service Provision**

### **9201 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 reachers, 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 prior approved by HHSC.

Items costing over \$500.00 must be recommended in writing by a service provider qualified to assess the individual's need for the specific adaptive aid and be approved by HHSC. (See HCBS-AMH Billing Guidelines <http://www.dshs.state.tx.us/mhsa/hcbs-amh/billing/> for requirements of the written recommendation).

### **9202 Supported Home Living**

Supported home living is provided to individuals residing in their own or family residence. This service includes activities that facilitate the individual's inclusion in community activities, use of natural supports and typical community services available to all people, social interaction and participation in leisure activities, and development of socially valued behaviors and daily living and functional living skills.

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

Supported Home Living is inclusive of assisting individuals 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 individuals 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 individual in shopping and other necessary activities of community and civic life, including self-advocacy. Assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) are included.

The following standards apply:

- An individual has a right to privacy;
- Sleeping and individual living units may be locked at the discretion of the individual, with keys available only to appropriate staff or landlords;
- Each living unit is separate and distinct from each other;
- The individual retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk;
- Service provision shall foster the independence of each individual;
- Routines of service delivery must be individual-driven;
- Any variations from the standards must be documented in the IRP (See 7250 Deviations from Service Standards).

Residential services are provided to individuals in settings licensed or certified by the State of Texas. Residential services are necessary, as specified in the individual's IRP, to enable the individual to remain integrated in the community and ensure the health, welfare, and safety of the individual in accordance with 42 CFR § 441.710.

### **9203 Assisted Living**

Assisted living services are personal care, homemaker, and chore services; medication oversight; and therapeutic, social, and recreational programming provided in a home-like environment in a licensed assisted living facility in conjunction with residing in the community based.

This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security. Other individuals or agencies may also furnish care directly or under arrangement with the community setting, but the services provided by these other entities supplement that provided by the community setting and do not supplant it.

Individuals have the freedom and support to control their own schedules and activities, have access to food and visitors of their choosing at any time, have access at any time to the common/shared areas (including kitchens, living rooms, activity centers), and have the freedom to furnish and decorate units. HCBS-AMH Assisted Living Services cannot be provided in a setting where the individual would not have a reasonable expectation of privacy, access to a kitchen/kitchenette and/or living room, and access to food and visitors at any time of the individual's choosing.

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

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

Assisted Living is inclusive of assisting individuals 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 individuals 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 individual in shopping and other necessary activities of community and civic life, including self-advocacy. Assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) are included.

The following standards apply:

- An individual has a right to privacy;
- Sleeping and individual living units may be locked at the discretion of the individual, with keys available only to appropriate staff or landlords;
- Each living unit is separate and distinct from each other;
- The individual retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk;
- Service provision shall foster the independence of each individual;
- Routines of service delivery must be individual-driven;
- Any variations from the standards must be documented in the IRP (See 7250 Deviations from Service Standards).

Residential services are provided to individuals in settings licensed or certified by the State of Texas. Residential services are necessary, as specified in the individual's IRP, to enable the individual to remain integrated in the community and ensure the health, welfare, and safety of the individual in accordance with 42 CFR § 441.710.

### **9204 Supervised Living**

Supervised living provides residential assistance as needed by individuals who live in residences in which the HCBS-AMH provider holds a property interest and that meet program certification standards. This service may be provided to individuals in one of two modalities:

1. By providers who are not awake during normal sleep hours but are present in the residence and able to respond to the needs of individuals during normal sleeping hours; or
2. By providers assigned on a shift schedule that includes at least one complete change of staff each day. Transportation costs are included in the rate. Type and frequency of supervision is determined on an individual basis based on the level of need for each individual.

Supervised Living is inclusive of assisting individuals 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 individuals 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 individual in shopping and other necessary activities of community and civic life, including self-advocacy. Assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) are included.

The following standards apply:

- An individual has a right to privacy;
- Sleeping and individual living units may be locked at the discretion of the individual, with keys available only to appropriate staff or landlords;
- Each living unit is separate and distinct from each other;
- The individual retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk;
- Service provision shall foster the independence of each individual;
- Routines of service delivery must be individual-driven;
- Any variations from the standards must be documented in the IRP (See 7250 Deviations from Service Standards).

### **9205 Host Home/Companion Care**

Host home/companion care is provided in a private residence meeting HCBS requirements by a host home or companion care provider who lives in the residence. Type and frequency of supervision is determined on an individual basis based on the level of need for each individual.

In a host home arrangement, the host home provider owns or leases the residence.

In a companion care arrangement, the residence may be owned or leased by the companion care provider or may be owned or leased by the individual. Host Home/Companion Care is inclusive of assisting individuals 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 individuals 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 individual in shopping and other necessary activities of community and civic life, including self-advocacy. Assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) are included.

No more than three HCBS-AMH individuals may live in the host home/companion care arrangement. A family member, court-appointed guardian, or LAR is eligible to provide Host Home/Companion Care if they meet the necessary provider requirements. For the purposes of the HCBS-AMH program, an individual's spouse is not eligible to provide host/home companion care services.

A family member, court appointed guardian, or LAR who provides Host/Home Companion Care, is not eligible to receive HCBS-AMH Respite Services (See 9214 Respite Care).

The following standards apply:

- An individual has a right to privacy;
- Sleeping and individual living units may be locked at the discretion of the individual, with keys available only to appropriate staff or landlords;
- Each living unit is separate and distinct from each other;

- The individual retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk;
- Service provision shall foster the independence of each individual;
- Routines of service delivery must be individual-driven;
- Any variations from the standards must be documented in the IRP (See 7250 Deviations from Service Standards).

Residential services are provided to individuals in settings licensed or certified by the State of Texas. Residential services are necessary, as specified in the individual's IRP, to enable the individual to remain integrated in the community and ensure the health, welfare, and safety of the individual in accordance with 42 CFR § 441.710.

### **9206 Community Psychiatric Supports and Treatment (CPST)**

CPST addresses specific individual needs with evidence-based and evidence-informed psychotherapeutic practices designed specifically to meet those needs. Examples include, but are not limited to:

- Cognitive Behavioral Therapy (CBT);
- Cognitive Processing Therapy (CPT); and
- Dialectical Behavior Therapy (DBT).

CPST is provided face-to-face with the individual present; however, family or other persons significant to the individual may also be involved. (See HCBS-AMH Billing Guidelines <http://www.dshs.state.tx.us/mhsa/hcbs-amh/billing/> for billable service components).

### **9207 Employment Services**

Employment services must follow evidence-based or evidence-informed practices approved by HHSC. (See Appendix A: Training Requirements for allowable protocols and required trainings). Providers must document that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973, relating to vocational rehabilitation services, or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), relating to special education.

Employment services:

- Focus on the individual's strengths and preferences;
- Promote recovery and wellness by enabling individuals to engage in work which is meaningful to them and compensated at a level equal to or greater than individuals without SMI or other disabilities (competitive employment);
- Include systematic job development based on individuals' interests, developing relationships with local employers by making systematic contacts;
- May not be for job placements paying below minimum wage;
- Must be delivered in a manner that supports and respects the individual's communication needs including translation services, assistance with, and use of communication devices and
- Do not supplant existing resources, such as state vocational rehabilitation programs available to the individual.

Employment Services may be used for an individual to gain work-related experience considered crucial for job placement (e.g., unpaid internship), only if such experience is vital to the person to achieve his or her vocational goal. Employment Services are individualized and extended as needed to assist the individual attain and maintain meaningful work. Services are provided based on individual preference

and choice without exclusions based on readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, level of disability, or legal system involvement.

Services must be provided in regular integrated settings and do not include sheltered work or other types of vocational services in specialized facilities, or incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Payments that are passed through to the individual;
- 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 individual; or
- Payments used to defray the expenses associated with starting up or operating a business.

The services are coordinated within the context of the IRP which delineates how Employment Services are intended to achieve the identified goals.

The documentation of employment services must be available to HHSC and to the RM for monitoring at all times on an ongoing basis. The RM monitors this services at least on a quarterly basis to see if the objectives and outcomes are being met.

#### **9207.1 Supported Employment**

Supported Employment includes adaptations, assistance, and training essential for individuals to sustain paid employment at or above the minimum wages and benefits provided to non-disabled workers performing similar jobs. (See HCBS-AMH Billing Guidelines <http://www.dshs.state.tx.us/mhsa/hcbs-amh/billing/> for billable components).

#### **9207.2 Employment Assistance**

Employment Assistance helps the individual locate and maintain paid employment in the community and may include activities on behalf of the individual to assist in maintaining employment. (See HCBS-AMH Billing Guidelines <http://www.dshs.state.tx.us/mhsa/hcbs-amh/billing/> for billable components).

#### **9208 Home Delivered Meals**

Home Delivered Meals services provide a nutritionally sound meal to individuals. Each meal shall provide a minimum of one-third of the current recommended dietary allowance (RDA) for the individual as adopted by the United States Department of Agriculture. The meal is delivered to the individual's home. Home delivered meals do not constitute a full nutritional regimen.

The services are coordinated within the context of the IRP. The individual has met needs-based criteria for Home Delivered Meals if the individual:

- Is unable to do meal preparation on a regular basis without assistance;
- Does not have access to alternate resources for the provision of the meal provided by this service; and
- Does not have natural supports available that are willing and able to provide meal preparation services.

The provider must be in compliance, during all stages of food service operation, with applicable federal, state and local regulations, codes, and licensor requirements relating to fire; health; sanitation; safety; building and other provisions relating to the public health, safety, and welfare of meal patrons.

Foods must be prepared, served, and transported:

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

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

Home Delivered Meals providers must be able to demonstrate that menu standards are developed to sustain and improve a participant's health through the provision of safe and nutritious meals that are approved by a dietician.

All providers must have a safety plan to ensure individuals receive meals during emergencies, weather-related conditions, and natural disasters. Plans could include, but are not limited to, 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 an individual 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 individual. An occurrence of a non-delivered meal shall be updated in progress notes.

Home delivered meals providers must be provided in-person delivery whereby a paid staff or volunteer delivers the meal to the individual's home. To the extent possible, the staff or volunteers must report any changes in the individual's condition or concerns to the individual's RM.

#### Nutrition Screening Survey

A nutrition screening survey must be designed to indicate signs of poor nutritional health. In situations in which the screening shows that the individual has poor nutritional health, the provider contacts the individual's RM. Nutrition screening surveys are completed by the HCBS-AMH Provider Agency at intake and annually after that.

#### **9209 Minor Home Modifications**

All minor home modifications are provided in accordance with applicable state or local building codes. The HCBS-AMH Provider Agency must comply with the requirements for delivery of minor home modifications, which include requirements as to type of allowed modifications, time frames for completion, specifications for the modification, inspections of modifications, and follow-up on the completion of the modification.

The minor home modifications must be necessary to address specific functional limitations documented in the IRP and must be approved by HHSC. Items costing over \$1000.00 must be recommended in writing by a services provider qualified to assess the individual's need for the specific adaptive aid and be approved by HHSC. (See HCBS-AMH Billing Guidelines <http://www.dshs.state.tx.us/mhsa/hcbs-amh/billing/> for requirements of the written recommendation).

## **9210 Nursing**

Nursing services are provided only after benefits available through Medicare, Medicaid, or other third party resources have been exhausted or are not applicable, including home health benefits. 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. This broadens the scope of these services beyond other state plan nursing services. (See HCBS-AMH Billing Guidelines <http://www.dshs.state.tx.us/mhsa/hcbs-amh/billing/> for billable components).

HCBS-AMH nursing providers shall comply with all nursing delegations in accordance to Texas Administrative Code, Title 22, Part 11, Chapter 224. This includes General Criteria for Delegation §224.6 and Delegation of Tasks §224.8. These must be met before the RN delegates nursing tasks to unlicensed persons. These criteria apply to all instances of RN delegation.

Nursing services are coordinated within the context of the IRP which delineates how Nursing Services are intended to achieve the identified goals.

## **9211 Peer Support**

Peer Support services are recovery-focused services provided by Certified Peer Specialists who are in recovery from mental illness and/or substance use disorders. Peer Support promotes development of skills for coping with symptoms of SMI and/or substance use disorders, which includes the identification and/or development of natural supports and strengths.

Peer support specialists use their own experiences with mental illness, substance use disorder (SUD), and/or another co-occurring disorders (such as a chronic health condition), to help the individual reach his/her recovery goals.

Peer Support Services Include (See HCBS-AMH Billing Guidelines <http://www.dshs.state.tx.us/mhsa/hcbs-amh/billing/> for billable components):

1. Helping individuals make new friends and begin to build alternative social networks;
2. Promoting coping skills;
3. Facilitating use of natural resources/supports;
4. Enhancing recovery-oriented attributes such as hope and self-efficacy;
5. Assisting the individual with tasks such as setting recovery goals, developing recovery action plans, and solving problems directly related to recovery, including finding sober housing; making new friends, finding new uses of spare time, and improving one's job skills;
6. Providing assistance with issues that arise in connection with collateral problems such as having a criminal justice record or coexisting physical or mental challenges;
7. Helping individuals navigate the formal treatment system, advocating for their access and gaining admittance, as well as facilitating discharge planning, typically in collaboration with treatment staff;
8. Encouraging participation in mutual aid groups in the community;
9. Facilitating participation in educational opportunities; and
10. Developing linkages 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 are coordinated within the context of the IRP which delineates how Peer Support services are intended to achieve the identified goals. Peer Support Services are intended to assist individuals in achieving and maintaining long-term recovery. Peer Support services are not intended to supplant or substitute for natural supports.

### **9212 Recovery Management**

Recovery Management includes services 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 <http://www.dshs.state.tx.us/mhsa/hcbs-amh/billing/> for billable components).

Caseload sizes for the individual RM shall preferably be 10 or less and shall be no more than 15 individuals. This caseload limit should account for individuals in other waiver or state plan programs and other funding sources, unless the requirement is waived by HHSC. This maximum caseload requirement remains in effect unless this requirement is waived by HHSC. (See 2100 Overview of Roles and Responsibilities of the of Recovery Manager and Recovery Management Entity).

#### **9212.1 Recovery Management Provider of Last Resort**

HCBS-AMH Provider Agencies and Recovery Management Entities are enrolled through separate Open Enrollments. HHSC anticipates that some service areas may not have separate Provider Agencies and Recovery Management Entities that meet requirements of the program and provider agreement. In lieu of denying an individual life in his/her community of choice due to lack of available HCBS-AMH Provider Agencies and Recovery Management Entities, an HCBS-AMH Provider Agency of last resort may also provide recovery management services with certain conflict of interest protections in place (See 19200 Administrative Firewall for Providers of Last Resort).

#### **9212.2 Recovery Management Conversion Services**

Conversion services are for an individual who is moving from one HCBS program to HCBS-AMH, or from a nursing facility to a community setting. Conversion Services are authorized for one month and begin on the first day of the month authorized and end on the last day of the authorized month.

##### Conversion Services from one HCBS program to HCBS-AMH:

Some individuals determined eligible for the HCBS-AMH program, maybe enrolled in another HCBS program and choose to disenroll from his/her current HCBS program into the HCBS-AMH program. The individual maybe enrolled in one of the following HCBS programs:

- Community Living Assistance and Support Services (CLASS);
- Deaf Blind with Multiple Disabilities (DBMD);
- Home and Community-based Services Waiver (HCS);
- Texas Home Living Waiver (TxHmL); or
- STAR+PLUS HCBS Waiver.

If an individual decides to disenroll from his/her current HCBS program and enroll into HCBS-AMH, the RM will provide RM conversion services (See HCBS-AMH Billing Guidelines <http://www.dshs.state.tx.us/mhsa/hcbs-amh/billing/> for billable components) to the individual during the individual's enrollment/disenrollment process. The Recovery Manager will complete an initial IRP for up to 8 units of Recovery Manager Services prior to the beginning of Conversion Services. This IRP development will document the process for Conversion Service implementation at the beginning of the service month.

#### Conversion Services from a Nursing Facility:

Eligible HCBS-AMH participants may be residing in a nursing facility at the time of their enrollment into the HCBS-AMH program. Once the enrolled individual selects their RM and HCBS-AMH Comprehensive Provider, it will be the RM's responsibilities to work with all appropriate staff and service providers to help the individual transition from the nursing facility and into the community.

#### Preauthorization for Conversion Services:

In order to provide RM conversion services, the RM must obtain preauthorization. Preauthorization is approved by HCBS-AMH staff for coverage of Recovery Management services prior to the individual's enrollment in HCBS-AMH. RM conversion services are the only services eligible for preauthorization. (See HCBS-AMH Recovery Management Handbook <http://dshs.texas.gov/mhsa/hcbs-amh/recoverymanager/> for additional guidance and HCBS-AMH Billing Guidelines <http://www.dshs.state.tx.us/mhsa/hcbs-amh/billing/> for billable components).

### **9213 HCBS-AMH Psychosocial Rehabilitation Services**

Provision of HCBS-AMH Psychosocial Rehabilitation Services must be intended to achieve the identified goals or objectives as set forth in the individual's IRP. (See HCBS-AMH Billing Guidelines <http://www.dshs.state.tx.us/mhsa/hcbs-amh/billing/> for billable components).

Skills include, but are not limited to:

- Illness/recovery management;
- Self-care;
- Activities of daily living (ADL); and
- Instrumental activities of daily living (IADLs).

The modality(ies) used for the provision of HCBS Psychosocial Rehabilitation Services must be approved by HHSC. A variety of evidence-based practices may be used as appropriate to individual needs, interests and goals. Approved protocols include:

- Cognitive Adaptive Training;
- Illness Management and Recovery; and
- Seeking Safety.

### **9214 Respite Care**

Respite is provided for the planned or emergency short-term relief for natural, unpaid caregivers. Respite is provided intermittently when the natural caregiver is temporarily unavailable to provide supports. (See HCBS-AMH Billing Guidelines <http://www.dshs.state.tx.us/mhsa/hcbs-amh/billing/> for service components).

Other services indicated on the IRP may be provided during the period of respite, if they are not duplicative of or integral to services which can be reimbursable as respite or otherwise excluded by the HCBS-AMH Billing Guidelines.

The HCBS-AMH provider must ensure that respite is provided in accordance with the IRP.

In-home respite is provided in the individual's home or place of residence, 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 individual needs of each individual.

### **9215 Substance Use Disorder Services**

HCBS-AMH Substance Use Disorder (SUD) services are specialized to meet the needs of individuals who have experienced extended institutional placement. They assist the individual in achieving specific recovery goals identified in the IRP and in preventing relapse; and are provided using a team approach with other HCBS-AMH services, such as peer support. Individuals must exhaust other state plan SUD benefits before choosing the HCBS-AMH SUD benefit unless other state plan benefits are not appropriate to meet the individual's needs, limitations, and recovery goals as determined by the independent evaluation (e.g. severe cognitive or social functioning limitations, or a mental disability).

HCBS-AMH SUD services may only be utilized when other state plan SUD services are exhausted or not appropriate. SUD services include:

- Assessment;
- Ambulatory 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;
- Psycho-education;
- Medication management;
- Harm reduction; and
- Relapse prevention.

Substance Use Disorder Services may be provided in a group setting if identified as clinically appropriate by the PCRPs participants and in accordance with the approved IRP.

#### **9215.1 Substance Use Disorder Assessment**

An integrated assessment must be conducted to consider relevant past and current medical, psychiatric, and substance use information, including:

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

### **9216 Transition Assistance Services**

Transition Assistance Services (TAS) 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 an individual's health and welfare, such as pest eradication and one-time cleaning prior to occupancy; and
- Activities to assess need, arrange for, and procure needed resources (limited to up to 180 consecutive days prior to discharge).

### **9217 Transportation**

This service does not duplicate transportation provided as part of other services or under the State Plan medical transportation benefit. This service must be provided in support of the individual's recovery goals as identified on the IRP.

Transportation is provided to the individual. HCBS-AMH Providers and direct service staff may not bill for service time spent transporting an HCBS-AMH participant when the transportation is related to or a part of another HCBS-AMH service such as Supported Home Living or Employment Services. HCBS-AMH transportation is provided in accordance with program policies and procedures and billing guidelines. (See HCBS-AMH Billing Guidelines <http://www.dshs.state.tx.us/mhsa/hcbs-amh/billing/> for billable service components).

### **9300 HCBS-AMH Provider Qualifications**

The HCBS-AMH Provider Agency shall ensure all direct service staff, including employees and Subcontractors, meet the necessary credentialing and licensure requirements, as listed in the following table.

(Appendix A: Training Requirements for additional requirements of direct service providers).

| <b>Service</b>               | <b>Provider Qualifications</b>  |
|------------------------------|---|
| <b>Adaptive Aids</b>         | HCBS-AMH Provider Agency employs or contracts with adaptive aid providers. Adaptive aid providers and their employees must comply with all applicable laws and regulations for the provision of adaptive aids.  |
| <b>Supported Home Living</b> | Must comply with the following requirements: <ul style="list-style-type: none"><li>• Residential settings must meet relevant state and local requirements;</li><li>• Direct service providers must:<ul style="list-style-type: none"><li>○ Be at least 18 years of age;</li><li>○ Have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including the ability to provide the required services as needed by</li></ul></li></ul> |

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|                          | <p>the individual to be served as demonstrated through a written competency-based assessment;</p> <ul style="list-style-type: none"> <li>○ Have at least three personal references from persons not related within three degrees of consanguinity that evidence the ability to provide a safe and healthy environment for the individual(s) to be served;</li> <li>○ Complete initial and periodic training provided by HCBS-AMH Provider Agency; and</li> <li>○ Pass a criminal background check</li> </ul> <ul style="list-style-type: none"> <li>● Transportation of individuals must be provided in accordance with applicable state laws;</li> <li>● Direct service providers transporting individuals must have a valid driver’s license and proof of insurance; and</li> <li>● Assisting with tasks delegated by an RN must be in accordance with state law.</li> </ul>   |
| <b>Assisted Living</b>   | <p>Must comply with the following requirements:</p> <ul style="list-style-type: none"> <li>● Residential settings must meet relevant state and local requirements;</li> <li>● Direct service providers must: <ul style="list-style-type: none"> <li>○ Be at least 18 years of age;</li> <li>○ Have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including the ability to provide the required services as needed by the individual to be served as demonstrated through a written competency-based assessment;</li> <li>○ Have at least three personal references from persons not related within three degrees of consanguinity that evidence the ability to provide a safe and healthy environment for the individual(s) to be served;</li> <li>○ Complete initial and periodic training provided by HCBS-AMH Provider Agency;</li> <li>○ Pass a criminal background check</li> </ul> </li> <li>● Transportation of individuals must be provided in accordance with applicable state laws;</li> <li>● Direct service providers transporting individuals must have a valid driver’s license and proof of insurance; and</li> <li>● Assisting with tasks delegated by an RN must be in accordance with state law.</li> </ul> |
| <b>Supervised Living</b> | <p>Must comply with the following requirements:</p> <ul style="list-style-type: none"> <li>● Residential settings must meet relevant state and local requirements;</li> <li>● Direct service providers must: <ul style="list-style-type: none"> <li>○ Be at least 18 years of age;</li> <li>○ Have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including the ability to provide the required services as needed by</li> </ul> </li> </ul>   |

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|  | <p>the individual to be served as demonstrated through a written competency-based assessment;</p> <ul style="list-style-type: none"> <li>○ Have at least three personal references from persons not related within three degrees of consanguinity that evidence the ability to provide a safe and healthy environment for the individual(s) to be served;</li> <li>○ Complete initial and periodic training provided by HCBS-AMH Provider Agency; and</li> <li>○ Pass a criminal background check</li> </ul> <ul style="list-style-type: none"> <li>● Transportation of individuals must be provided in accordance with applicable state laws;</li> <li>● Direct service providers transporting individuals must have a valid driver’s license and proof of insurance; and</li> <li>● Assisting with tasks delegated by an RN must be in accordance with state law.</li> </ul>   |
| <p><b>Host Home/Companion Care</b></p>                     | <p>Must comply with the following requirements:</p> <ul style="list-style-type: none"> <li>● Residential settings must meet relevant state and local requirements;</li> <li>● Direct service providers must: <ul style="list-style-type: none"> <li>○ Be at least 18 years of age;</li> <li>○ Have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including the ability to provide the required services as needed by the individual to be served as demonstrated through a written competency-based assessment;</li> <li>○ Have at least three personal references from persons not related within three degrees of consanguinity that evidence the ability to provide a safe and healthy environment for the individual(s) to be served;</li> <li>○ Complete initial and periodic training provided by HCBS-AMH Provider Agency;</li> <li>○ Pass a criminal background check</li> </ul> </li> <li>● Transportation of individuals must be provided in accordance with applicable state laws;</li> <li>● Direct service providers transporting individuals must have a valid driver’s license and proof of insurance; and</li> <li>● Assisting with tasks delegated by an RN must be in accordance with state law.</li> </ul> |
| <p><b>Community Psychiatric Supports and Treatment</b></p> | <p>A direct service provider must be trained, credentialed, and demonstrate competence in the specialized psychotherapy used. Providers of this service must be a Licensed Practitioner of the Healing Arts (LPHA).</p> <p>If direct service provider does not have competence in the specialized psychotherapy used prior to service provision, the provider may provide the psychotherapy in the event they are under the supervision of a fully licensed clinician that meets the criteria to be an (LPHA) and meets the supervisor requirements as outlined by the EBP.</p>  |

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| <p><b>Employment Services</b></p>      | <p>A direct service provider must be at least 18 years of age and meet one of the following qualifications:</p> <ul style="list-style-type: none"> <li>• Have a bachelor’s degree in rehabilitation, business, marketing, or a related human services field, and one year’s paid or unpaid experience providing employment services to people with disabilities;</li> <li>• Have an associate’s degree in rehabilitation, business, marketing, or a related human services field, and two years paid or unpaid experience providing employment services to people with disabilities; or</li> <li>• Have a high school diploma or Certificate of High School Equivalency (GED credentials), and three years paid or unpaid experience providing employment services to people with disabilities.</li> </ul>   |
| <p><b>Peer Support</b></p>             | <p>Must be recognized under a HHSC-approved process for certification Peer Specialists. Individual providers must maintain a HHSC-approved certification for mental health or substance use disorder peer specialists. At minimum, individuals must also be 18 years of age or older and have lived experience as an individual with mental health and/or substance use needs.</p>   |
| <p><b>Home Delivered Meals</b></p>     | <p>Must follow procedures and maintain facilities that comply with all applicable state and local laws and regulations related to fire, health, sanitation, and safety; and food preparation, handling, and service activities</p> <p>All staff and volunteers involved in food preparation have training in:</p> <ul style="list-style-type: none"> <li>• Portion control;</li> <li>• FDA Food Code practices for sanitary handling of food;</li> <li>• Texas food safety requirements; and</li> <li>• Agency safety policies and procedures.</li> </ul> <p>All staff and volunteers having direct contact with an individual have training in:</p> <ul style="list-style-type: none"> <li>• Protecting confidentiality;</li> <li>• How to report concerns, which may include: change of condition; self-neglect, and abuse, to appropriate staff for follow-up; and</li> <li>• When to report to the RM any individuals considered high risk, as a result of the nutrition risk assessment.</li> </ul> |
| <p><b>Minor Home Modifications</b></p> | <p>The agency must comply with the requirements for delivery of minor home modifications, which include requirements as to:</p> <ul style="list-style-type: none"> <li>• Type of allowed modifications;</li> <li>• Time frames for completion;</li> <li>• Specifications for the modification;</li> <li>• Inspections of modifications;</li> <li>• Follow-up on the completion of modifications; and</li> <li>• Qualified building contractors provide minor home modifications in accordance with state and local building codes and other applicable regulations.</li> <li>• Direct service providers must meet applicable laws and regulations for the provision of the approved minor home modification and provide modifications in accordance with applicable state and local building codes.</li> </ul>   |

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| <b>Nursing</b>                                       | Direct service providers must maintain an RN license (or LVN licensed vocational nurse under the supervision of an appropriate Clinical Supervisor registered nurse), registered to practice in the state or otherwise authorized to practice in Texas under the Nurse Licensure Compact.  |
| <b>Recovery Management</b>                           | <p>Direct service providers of recovery management must comply with the following requirements:</p> <ul style="list-style-type: none"> <li>• Have at least 2 years of experience working with people with SMI; <ul style="list-style-type: none"> <li>• Have a master’s degree in human services or related field;</li> <li>• Demonstrate knowledge of issues affecting people with SMI and community-based interventions/resources for this population; and</li> <li>• Complete HHSC-required training in the HCBS-AMH program.</li> </ul> </li> </ul> <p>Direct service providers of recovery management cannot be any of the following:</p> <ul style="list-style-type: none"> <li>• Related by blood or marriage to the individual;</li> <li>• Financially or legally responsible for the individual;</li> <li>• Empowered to make financial or health-related decisions on behalf of the individual; or</li> <li>• Direct service providers of other HCBS-AMH services for the individual, 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 individual chooses to provide the service (See 9212.1 Recovery Management Provider of Last Resort).</li> </ul> |
| <b>HCBS-AMH Psychosocial Rehabilitation services</b> | <p>Direct service providers must comply with the following requirements:</p> <ul style="list-style-type: none"> <li>• Be qualified and demonstrate competency and fidelity to the evidence-based practices (EBPs) used;</li> <li>• Have the level of education and experience required by the evidence-based modality employed; and</li> <li>• At minimum, must have a bachelor’s degree in psychology or a related field; and <ul style="list-style-type: none"> <li>○ Have HHSC-approved training and/or certification in the EBP; and</li> <li>○ Must be supervised by a licensed clinician trained and certified in the EBP.</li> </ul> </li> </ul>  |
| <b>Respite care</b>                                  | <p>Direct service providers must adhere to the following standards:</p> <ul style="list-style-type: none"> <li>• Be 18 years of age or older;</li> <li>• Trained in CPR/first-aid;</li> <li>• Pass criminal history checks;</li> <li>• Not be on a list of Employee Misconduct Registry or Nurse Aide Registry;</li> <li>• Maintain current Texas driver’s license and proof of automobile insurance if transporting individuals; and</li> <li>• Be familiar with individual-specific competencies</li> </ul>  |
| <b>Substance Use Disorder Services</b>               | Direct service providers must be Qualified Credentialed Counselors (QCC) for the provision of SUD as defined by HHSC. Substance Use Disorder (SUD) treatment programs must be licensed by the Texas Department of State Health Services as Chemical Dependency Treatment Programs.   |

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|                                | Direct service providers must be licensed and/or appropriately credentialed to provide services and act within the scope of their licensure and/or credentialing.   |
| <b>Transition Assistance</b>   | Direct service providers of TAS must be 18 years of age or older, pass a criminal background check, and demonstrate knowledge and/or have experience in managing transitions to home and community-based settings. Must demonstrate knowledge of, and history in, successfully serving individuals who require home and community-based services. |
| <b>Transportation Services</b> | Direct service providers must meet the following qualifications: <ul style="list-style-type: none"> <li>• 18 years of age or older;</li> <li>• Valid driver's license;</li> <li>• Proof of insurance; and</li> <li>• Pass a criminal background check</li> </ul>  |

### **9400 Responsibility of the Recovery Manager in Service Provision**

The RM is responsible for assisting individuals in gaining access to needed HCBS-AMH services, as well as medical, social, educational, and other resources, regardless of funding source. The RM is responsible for coordination of services, including coordinating HCBS-AMH services, coordinating with the MCO providing other Medicaid services, and coordinating with third parties providing services. RMs are responsible for monitoring the provision of services included in the IRP to ensure that the individual's needs, preferences, health, and welfare are promoted. The RM:

- Coordinates / leads development of the IRP using a PCRCP which supports the individual;
- Monitor, on a quarterly basis to see if the objectives and outcomes of Employment Services are being met;
- Assists the individual in directing and making informed choices according to the individual's needs and preferences;
- Provides supporting documentation to be considered by HHSC in the independent evaluation and reevaluations;
- Identifies services / providers, brokers to obtain and integrate services, facilitates, and advocates to resolve issues that impede access to needed services;
- Develops / pursues resources to support the individual's recovery goals including non-HCBS Medicaid, Medicare, and/or private insurance or other community resources;
- Assists the individual in identifying and developing natural supports (family, friends, and other community members) and resources to promote the individual's recovery;
- Informs individuals of fair hearing rights;
- Assists individuals with fair hearing requests when needed and upon request;
- Assists individuals with retaining HCBS-AMH and Medicaid eligibility;
- Educates and informs individuals about services, the individual recovery planning process, recovery resources, rights, and responsibilities;
- Actively coordinates with other individuals and/or entities essential to physical and/or behavioral services for the individual (including the individual's MCO) to ensure that other services are integrated and support the individual's recovery goals, health, and welfare;

- Monitors health, welfare, and safety through regular contacts (visits with the individual, paid and unpaid supports, and natural supports) at a minimum frequency required by HHSC;
- Responds to and assesses emergency situations and incidents and assures that appropriate actions are taken to protect the health, welfare, and safety of individuals;
- Reviews provider service documentation and monitors the individual's progress;
- Initiates recovery plan team discussions or meetings when services are not achieving desired outcomes. Outcomes include housing status, employment status, involvement in the criminal justice system, response to treatment and other services, and satisfaction with services; and
- Through the recovery plan monitoring process, solicits input from the individual and/or family, as appropriate, related to satisfaction with services.
- Arranges for modifications in services and service delivery, as necessary;
- Advocates for continuity of services, system flexibility and integration, proper utilization of facilities and resources, accessibility, and beneficiary rights; and
- Participates in any HHSC-identified activities related to quality oversight and provide reporting as required by HHSC.

### **9410 Creation of IRP**

The RM is responsible for facilitating the creation of the initial IRP and updating IRPs not to exceed 90 days from the date of the last IRP: See the following sections for guidance on the creation and development of the IRP.

- 6430 Recovery Manager Meets with Individual;
- 7000 Individual Recovery Plan (IRP);
- 7200 IRP Requirements;
- 7300 Initial IRP;
- 7400 Update IRP; and
- 7700 IRP Approval Process.

### **9420 Service Coordination**

#### **9421 Coordination with Managed Care Organizations**

The Recovery Management Entity provides and obtains updates from the MCO during weekly conference calls. The RM works closely to coordinate services with the MCO. The RM works closely with the individual's assigned MCO coordinator for provision of services, access to benefits and ensuring non-duplication of services (See 20000 Non-Duplication of Services and 2100 Overview of Roles and Responsibilities of the of Recovery Manager and Recovery Management Entity).

#### **9422 Coordination with HCBS-AMH Provider Agency**

After the individual selects the HCBS-AMH Provider Agency the RM notifies the HCBS-AMH Provider Agency and coordinates participation on the development of the IRP. The RM monitors that HCBS-AMH services are initiated within seven business days of authorization of the IRP.

Throughout the duration of services, RM responsibilities shall include but are not limited to the following:

- Continued contact with HCBS-AMH providers to ensure the coordination and provision of services;
- Coordinating and facilitating any IRP meetings with the individual and HCBS-AMH providers;

- Assist in conflict resolution between the individual and HCBS-AMH providers;
- Outreach to individuals after missed scheduled appointment with providers within 24 hours;
- Upon notification by HCBS-AMH provider that individual is not attending scheduled services, the RM schedules and facilitates recovery plan meeting with the individual and/or LAR, and the individual's PCRPs participants within seven business days of this notification to try and re-engage the individual in services. The recovery plan meeting should address the following:
  - Access barriers and issues and concerns with current provider; and
  - Update IRP to reflect any changes in services; and
- If the individual chooses to remain in services, additional updates may be made to the current IRP, if applicable. (See 7400 Update IRP).

### **9423 Coordination with HHSC to Obtain Preauthorization for Recovery Management Conversion Services**

Preauthorization is approval by HCBS-AMH staff for a provider to bill for Recovery Management services prior to the individual's enrollment in HCBS-AMH from a nursing home or another HCBS program. Preauthorization of Recovery Management services allow the RM to work with the individual's HCBS 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 RM Handbook to view preauthorization process located at <https://www.dshs.state.tx.us/mhsa/hcbs-amh/recoverymanager/>. Access the Preauthorization Form located at <https://www.dshs.state.tx.us/mhsa/hcbs-amh/Forms.aspx>.

### **9430 Monitoring the IRP**

The RM is responsible to monitor the IRP through the following;

- Contact with the PCRPs participants identified on the IRP;
- Review of provider service documentation;
- Monitoring the individual's progress toward recovery goals;
- Initiating PCRPs 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;
- Soliciting input from the individual or LAR, as appropriate, 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.

### **9431 Review of the IRP**

The HCBS-AMH services on the IRP are reviewed not to exceed 90 days from the date of the last IRP and as needed. An Update IRP is required as indicated.

### **9432 Updating the Services on the IRP**

The Recovery Manager initiates updates to the IRP in coordination with the members of the individual's PCRCP participants. Modifications to quantity and/or type of services listed on an individual's IRP may occur (See 7400 Update IRP). Reasons for this to occur include but are not limited to the following:

- Quantity of Service and/or Types of Service specified in the most recent IRP are no longer clinically appropriate for the individual. This includes the following:
  - The individual needs a higher level of care
- Quantity of Service and/or Types of Service are adjusted to meet the current treatment needs of the individual as identified by the PCRCP participants;
- The individual transfers to a different HCBS-AMH Provider Agency or Recovery Management Entity (See 10300 Transfer).
- The individual's place of residence changes to an institutional setting for greater than 30 days and services are suspended (See 10200 Suspension) ;
- The individual is discharged from service (See 10100 Discharge);
- The individual has Imminent Health or Safety Risk.

### **9440 Frequency of Recovery Management Service Provision**

#### **9441 Recovery Management Prior to Discharge from State Hospital**

During Recovery Management Transitional services (HCBS-AMH service provided prior to discharge from the state hospital), the RM shall meet with the individual at a minimum of one time every two weeks for RM Transitional Services. RMs providing Recovery Management Transitional Services to individuals in state hospitals at a distance greater than 100 miles from the RM's office building provide a minimum of three in person visits during the duration of Transitional Services provided to the individual in the state hospital. The RM must meet face-to-face with the individual within fourteen calendar days prior to the anticipated date of discharge. The RM is permitted to coordinate and monitor services via teleconference.

#### **9442 Recovery Management Following Discharge from the State Hospital**

The RM shall meet with the individual for the provision of recovery management at an intensive level (minimum of three times per week) during the first three months of an individual's discharge to the community from the state hospital. The RM must provide at least one of these encounters in the individual's residence.

After three months of recovery management at an intensive level, the RM shall convene a meeting with the individual, the individual'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 should be reflected on the IRP.

#### **9443 Recovery Management at an Intensive Level**

The RM is responsible for providing recovery management services at an intensive level (minimum of three times per week) during crisis situations, potential discharge from HCBS-AMH, and transfer of services.

## **9500 Responsibility of the HCBS-AMH Provider Agency**

HCBS-AMH Provider Agencies shall provide 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 HCBS-AMH Provider Agreement and the Provider Manual regardless of whether HCBS-AMH services are provided directly or through subcontractors.

## **10000 Discharge, Suspension, and Transfer**

### **10100 Discharge**

#### **10110 Reasons for Discharge**

In the event an individual is discharged from HCBS-AMH one of the following reasons shall be cited:

| <b>Reason for Discharge</b>   | <b>Justification</b>   |
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| <b>Voluntary:</b>   | The individual, for whom HCBS-AMH continues to be indicated, requests to be discharged from HCBS-AMH and Recovery Management Entity OR the individual chooses to discontinue necessary participation in the HCBS-AMH Program (See 2600 Roles of the Individual) despite engagement efforts by HCBS-AMH Provider. |
| <b>No Clinical Need:</b>  | HCBS-AMH services are no longer required to meet the clinical needs of the individual; OR the individual has not received <i>any</i> HCBS-AMH services for one year.   |
| <b>Higher Clinical Need:</b>  | HCBS-AMH services are no longer appropriate or effective to meet the clinical needs of the individual; OR the clinical needs of the individual place the individual and/or community at risk and cannot be addressed by available HCBS-AMH services.   |
| <b>No Longer Eligible<br/>(for reasons other<br/>than clinical need):</b> | The individual is enrolled in a different HCBS Medicaid program OR no longer meets financial eligibility   |
| <b>Unable to Locate:</b>  | The individual is unable to be located for 90 consecutive days.  |
| <b>Out of Service Area<br/>(and not able to be<br/>transferred):</b>      | The individual permanently moves out of state OR the individual moves to a county where HCBS-AMH does not have a contracted Provider Agency.   |
| <b>Hospitalization<br/>(greater than 180<br/>days):</b>                   | The individual has been hospitalized for a period greater than 180 days and does not receive an extension on suspension of their services.   |
| <b>Incarceration<br/>(greater than 180<br/>days):</b>                     | The individual has been incarcerated in a criminal justice institution greater than 180 days and does not receive an extension on suspension of his/her services.  |
| <b>Individual's Choice<br/>of Setting:</b>                                | The individual chooses to live in a setting that does not meet CFR HCBS 441.710 and is not able to have services.  |
| <b>Services No Longer<br/>Available:</b>                                  | A service critical to the individual's continued community tenure is no longer available to the individual due to no HCBS-AMH provider available in individual's area of residence.  |
| <b>Death:</b>   | The individual has died.   |

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| <b>Non-compliant with Services:</b> | The individual declines to participate in the recovery planning process or address goals essential to their continued health and safety in the community for 90 consecutive days. |
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## **10120 Discharge Procedure**

### **10120.01 Voluntary:**

The Recovery Management Entity and the HCBS-AMH Provider Agency shall not modify, discontinue or refuse services to an individual enrolled in HCBS-AMH unless documented efforts have been made with the individual and/or LAR to resolve the situation that triggers such modification or discontinuation or refusal to provide services.

When an individual requests discharge from services but still requires HCBS-AMH, the RM and HCBS-AMH Providers must do the following:

1. The RM schedules and facilitates an IRP meeting with the individual, LAR, if applicable, and the individual's PCRCP participants within seven business days of the discharge request. The IRP meeting should address the following:
  - Develop a corrective action plan which outlines the following
    - Contributing problems/barriers to treatment;
    - Life changes;
    - Clinical Interventions; and
    - Corrective action plan should be documented in the individual's progress notes
  - Update IRP to reflect services and efforts to re-engage the individual; and
  - Discharge and transition planning, as indicated (i.e. the individual refuses continued HCBS-AMH services and all engagement activities).
2. After IRP authorization of Update IRP, the RM shall document attempts to provide Recovery Management at an intensive level for two weeks, in an attempt to re-engage the individual in HCBS-AMH services.
3. The RM facilitates a follow-up IRP meeting with the individual and/or LAR, and the individual's PCRCP participants. The IRP meeting should address the following:
  - Assess progress and continued barriers, re- evaluate corrective action plan, and document in the individual's progress notes;
  - Provide option of discharge from services or transfer of services to new provider; and
  - Decision on discharge from HCBS-AMH services.
4. If the individual chooses to discharge from HCBS-AMH services, the RM assists the individual in selecting alternate community services, and makes referrals to community resources and has the individual complete release of information. (See 7500 Discharge IRP).
5. The RM submits Discharge IRP to HHSC and supporting documents within three business days of final request for discharge. (See 7500 Discharge IRP and 7740 Submission of Discharge IRP).

6. The RM notifies the individual's HCBS-AMH Provider Agency of discharge from program within three business days of authorization of Discharge IRP.

HHSC issues Determination Letter and the RM distributes the letter to the individual within three business days of authorization of Discharge IRP. The Determination letter should include the following:

- Notification of discharge from HCBS-AMH services;
- Discharge Date (Date Discharge IRP is authorized);
- Re-enrollment process and Medicaid Fair Hearing Process; and
- Contact information of LMHA/LBHA.

#### **10120.02 No Clinical Need:**

If the RM, HCBS-AMH Provider Agency, and the individual agree HCBS-AMH services are no longer necessary to meet the individual's needs, the RM:

1. Submits request to LMHA or authorized assessor for an Update HCBS-AMH UA. UA to re-evaluate need for services is conducted within ten business days of request.
2. The RM reviews UA and gathers supporting documents from other HCBS-AMH providers to support discharge reason within three business of receipt of UA.
3. The RM creates Discharge IRP and submits supporting documents within three business days of receipt of UA to HHSC. (See 7740 Submission of Discharge IRP).
4. The RM notifies the individual's HCBS-AMH Provider Agency of discharge from program within three business days of authorization of Discharge IRP.
5. The RM refers the individual to any additional community supports requested and obtains a signed consent to release information from the individual and/or LAR. Upon the individual and/or LAR's request, a copy of the individual's record is provided.

HHSC issues Determination Letter and the RM distributes the letter to the individual within three business days of authorization of Discharge IRP. The Determination letter should include the following:

- Notification of discharge from HCBS-AMH services;
- Discharge Date (Date Discharge IRP is authorized);
- Re-enrollment process and Medicaid Fair Hearing Process; and
- Contact information of LMHA/LBHA.

#### **10120.03 Higher Clinical Need:**

If it is believed an individual can no longer reside safely in the community with current HCBS-AMH services the RM:

1. Submits request to LMHA/LBHA or authorized independent assessor for an Update UA. UA to re-evaluate need for services is conducted within ten business days of request for discharge.
2. The RM reviews UA and supporting documents. The RM assists the individual with identifying a setting which provides a higher level of care and obtains a signed consent to release information

from the individual and or LAR. The RM makes referral and transfers a copy of the individual's current psychiatric and medical information (See 6230 Transfer of Records).

3. The RM updates and submits Discharge IRP and supporting documents to HHSC within three business days of receipt of UA. (See 7740 Submission of Discharge IRP).
4. The RM notifies the individual's HCBS-AMH Provider Agency of discharge from program within three business days of authorization or Discharge IRP.

HHSC issues Determination Letter and the RM distributes the letter to the individual within three business days of authorization of Discharge IRP. The Determination letter should include the following:

- Notification of discharge from HCBS-AMH services;
- Discharge Date (Date Discharge IRP is authorized);
- Re-enrollment process and Medicaid Fair Hearing Process; and
- Contact information of LMHA/LBHA.

**10120.04 No Longer Eligible (for reasons other than clinical need):**

During participation in HCBS-AMH services, an individual's eligibility status may change. In these instances:

1. The RM obtains a signed consent to release information from the individual and refers the individual to alternate community services. A copy of the individual's record is available upon the individual and/or LAR's request.
2. The RM updates IRP and submits Discharge IRP to HHSC within five business days of notification of ineligibility. (See 7740 Submission of Discharge IRP).
3. HCBS-AMH Recovery Management Entity and HCBS-AMH Provider Agency discharges the individual within two business days of receiving notification of the individual's discharge from HCBS-AMH services.

**10120.05 Unable to Locate:**

1. Recovery Management Entity and HCBS-AMH Provider Agency may discharge or suspend an individual's services for up to 180 days when they have been unable to locate the individual for 90 consecutive days. During these 90 days, Recovery Management Entity must do the following:
  - Check all local inpatient facilities and jails;
  - Outreach to the individual's emergency contact; and
  - Attempt a home visit to the individual's last known address.
2. If Recovery Management Entity and HCBS-AMH Provider Agency choose to suspend the individual's services, the RM must submit an Update IRP requesting a suspension of services (See 10230 Documentation Requirements for Suspension).
3. If an individual's services are placed in suspended status, the RM makes the above listed outreach attempts every thirty days.
4. If the RM and HCBS-AMH Provider Agency discharge the individual, the RM creates Discharge IRP and submits IRP and supporting documentation from the RM and HCBS-AMH providers

showing outreach efforts to HHSC within three business days of the determination. This documentation includes, but is not limited to:

- All phone calls to the individual's emergency contact (if consents provided);
  - Attempted home visits to the last known address; and
  - Outreach letter to the last known address and emergency contact requesting re-engagement in services. Letter should include the following:
    - Request to re-engage in services;
    - Notification of discharge or suspension from program if re-engagement is not made within 90 days of date of notice; and
    - Contact information of HCBS-AMH Provider Agency and Recovery Management Entity.
5. The RM notifies HCBS-AMH Provider Agency and direct service providers of individual's discharge from the program within three business days of authorization or Discharge IRP.
6. HHSC issues Determination Letter and the RM distributes the letter to the individual within three business days of authorization of Discharge IRP. The Determination letter should include the following:
- Notification of discharge from HCBS-AMH services;
  - Discharge Date (Date Discharge IRP is authorized);
  - Re-enrollment process and Medicaid Fair Hearing Process; and
  - Contact information of LMHA/LBHA.

**10120.06 Out of Service Area (and not able to be transferred):**

When an individual relocates to a county within Texas served by the HCBS-AMH Program, the individual remains shall be transferred to another HCBS-AMH Provider Agency and Recovery Management Entity (See 10300 Transfer). However, if the individual moves to a county or service area where there is not yet an HCBS-AMH Provider Agency and Recovery Management Entity, the participant must be discharged from HCBS-AMH. In this circumstance:

1. The RM obtains a signed consent to release information from the individual and makes referral to alternate community services in the individual's new area of residence. A copy of the individual's records are available upon request by the individual and/or LAR.
2. The RM updates IRP and submits Discharge IRP and supporting documentation to HHSC within five business days of request for discharge (See 7740 Submission of Discharge IRP).
3. The RM notifies HCBS-AMH Providers of the individual's discharge from the program within three days of authorization or Discharge IRP.

HHSC issues Determination Letter and the RM distributes the letter to the individual within three business days of authorization of Discharge IRP. The Determination letter should include the following:

- Notification of discharge from HCBS-AMH services;
- Discharge Date (Date Discharge IRP is authorized);
- Re-enrollment process and Medicaid Fair Hearing Process; and
- Contact information of LMHA/LBHA.

**10120.07 Hospitalization (greater than 180 days):**

When an individual is hospitalized, the RM completes and submits critical incident to HHSC within 72 hours of the individual's hospitalization. (See 13530 Critical Incidents Reporting).

Services may be suspended for up to 180 days with the possibility of a 30 day extension. (See 10200 Suspension, 10220.01 Inpatient Psychiatric Hospitalization: 10220.02 Inpatient Medical Hospitalization; and 10221 Extension of Suspended Services).

After the individual's period of service suspension is over:

1. The RM submits Discharge IRP with supporting documents.
2. HHSC issues a Determination Letter and the RM distributes the letter within three business days of HHSC decision. The letter should include the following:
  - Determination of HCBS-AMH services;
  - Discharge date (Date Discharge IRP is authorized by HHSC);
  - Re-enrollment or Medicaid Fair Hearing Process; and
  - Contact information of LMHA/LBHA.
3. The RM notifies HCBS-AMH Provider Agency of the individual's discharge from the program within three business days of authorization of Discharge IRP.

**10120.08 Criminal Justice Involvement (greater than 180 days):**

When an individual is incarcerated, the RM completes and submits critical incident to HHSC within 72 hours of the individual's incarceration. (See 13530 Critical Incidents Reporting).

Services may be suspended may be suspended for up to 180 days with the possibility of a 30 day extension. (See 10200 Suspension, 10220.04 Incarceration: and 10221 Extension of Suspended Services)

After the individual's period of service suspension is over:

1. The RM submits Discharge IRP with supporting documents to HHSC within three business days.
2. HHSC issues a Determination Letter and the RM sends the letter to the individual within three business days of authorization or Discharge IRP. The letter should include the following:
  - Determination of HCBS-AMH services;
  - Discharge date (Date Discharge IRP is authorized by HHSC);
  - Re-enrollment and Medicaid Fair Hearing Process; and
  - Contact information of LMHA/LBHA.
3. The RM notifies HCBS-AMH Provider Agency of the individual's discharge from the program within three business days of authorization of Discharge IRP.

**10120.09 Individual's Choice of Setting:**

During participation in HCBS-AMH services, the individual may choose to move to a setting that is not in compliance with CFR 441.710.

If an individual chooses to live in this type of setting:

1. The RM facilitates an IRP meeting with the individual, LAR, if applicable, and the individual's PCRIP participants within seven business days of notification of the individual selecting a non-HCBS-AMH approved setting. IRP meeting should address the following:
  - The individual's reasons for selection of a non-HCBS-AMH approved setting;
  - Notification of discharge from services if non-HCBS-AMH approved setting is selected; and
  - Alternate housing options which meet HCBS-AMH setting requirements.
2. If an individual chooses to discharge, the RM obtains a signed consent to release information from the individual and makes referral to alternate community services. A copy of the individual's records are available upon request by the individual and/or LAR.
3. The RM updates IRP and submits Discharge IRP and supporting documentation to HHSC. HHSC issues Determination Letter and the RM sends the letter to the last known address of the individual within three business days of authorization of Discharge IRP. The letter should include the following:
  - Notification of discharge from HCBS –AMH services;
  - Discharge Date (Date Discharge IRP is authorized);
  - Re-enrollment and Medicaid Fair Hearing process; and
  - Contact information of LMHA/LBHA.
4. The RM notifies HCBS-AMH Provider Agency of the individual's discharge from the program within three business days of authorization of Discharge IRP.

**10120.10 Services Not Available:**

If a service critical to the individual's continued tenure in the community is no longer available to the individual:

1. The RM submits request to HHSC for Update UA to re-evaluate the individual's service needs within seven business days of request for discharge.
2. The RM reviews UA and supporting documents within three business days of receipt of UA. The RM schedules an IRP meeting with the individual, LAR (if applicable), and the individual's PCRIP participants. The IRP meeting should address the following:
  - Access barriers/problems to remaining in the community;
  - Access alternative ways for the individual to remain in the community; and
  - Provide crisis and safety planning (if necessary, update on IRP and submit to HHSC).
3. If alternative services are identified in the community, the RM and HCBS-AMH provide intensive services for two weeks. After two weeks, a follow up IRP meeting is scheduled. The IRP meeting should address the following:
  - Review progress;
  - Access barriers/problems remaining in community; and
  - Determination on the individual remaining in the community.

4. If no alternative placements are available, the RM obtains a signed consent to release information from the individual and refer the individual to a higher level of care. (See 10120.03 Higher Clinical Need:).
5. The RM submits Discharge IRP and supporting documents to HHSC within three business days. (See 7740 Submission of Discharge IRP and 7500 Discharge IRP).
6. HHSC issues a Determination Letter and the RM distributes the letter to the individual within three business days of authorization of Discharge IRP. The letter should include the following:
  - Determination on HCBS-AMH services;
  - Discharge Date (Date Discharge IRP authorized);
  - Re-enrollment and Medicaid Fair Hearing Process; and
  - Contact information of the LMHA/LBHA
7. Upon discharge approval, the RM notifies HCBS-AMH Provider Agency of the individual's discharge within three business days of authorization or Discharge IRP.

**10120.11 Death:**

Upon the death of an individual enrolled in HCBS-AMH:

1. The RM or HCBS-AMH provider completes critical incident report. The RM submits critical incident report to HHSC within 72 hours of notification of the individual's death. (See 13530 Critical Incidents Reporting);
2. The RM submits Discharge IRP and supporting documents to HHSC within three business days;
3. The RM notifies HCBS-AMH Provider Agency of the individual's death.

**10120.12 Non-Compliant with Services:**

When an individual becomes non-compliant with services, the RM follows the process outlined for a voluntary discharge (See 10120.01 Voluntary:). All efforts to engage the individual and make adaptations to IRP to engage the individual in services must be documented in progress notes and Update IRPs. The individual's participant agreement should be reviewed with the individual and the individual should also be informed that they are in violation of their Participant Agreement and subject to discharge or suspension of their HCBS-AMH services. The individual is notified that continued choice to not engage in IRP planning process will result in discharge or suspension of their HCBS-AMH services.

If an individual remains non-compliant with services for 90 days consecutively, the individual is offered the option to voluntarily discharge from services or have their services suspended for up to 180 days (See 10230 Documentation Requirements for Suspension). If an individual declines to do so:

1. The RM updates the IRP to reflect non-compliance with services and submits Discharge IRP and supporting documents to HHSC within three business days.
2. HHSC issues Determination Letter and the RM sends the letter to the last known address of the individual within three business days of authorization of Discharge IRP. The letter should include the following:
  - Notification of discharge from HCBS –AMH services;

- Discharge Date (Date Discharge IRP is authorized);
- Re-enrollment and Medicaid Fair Hearing process; and
- Contact information of LMHA/LBHA.

3. The RM notifies HCBS-AMH Provider Agency of the individual’s discharge from the program within three business days of HHSC discharge approval.

**10130 Documentation Requirements for Discharge**

The reason for discharge and all agency referrals shall be documented in the individual’s clinical record and the Recovery Management Entity shall submit a Discharge IRP to HHSC within 3 business days. (See 2120 The Recovery Management Entity is responsible to; and 7510 Requirements Specific to the Discharge IRP).

The RM and the HCBS-AMH Provider shall document efforts made with the individual and/or LAR to resolve situations that trigger modification, discontinuation, or refusal to provide services.

**10200 Suspension**

**10210 Reasons for Suspension**

| <b>Reason for Suspension</b>                  | <b>Justification</b>   |
|---|--|
| <b>Inpatient Psychiatric Hospitalization:</b> | The individual is admitted into an inpatient psychiatric facility a period greater than 30 days.   |
| <b>Inpatient Medical Hospitalization:</b>     | The individual is admitted into an inpatient medical hospital for a physical health need greater than 30 days.   |
| <b>Resides in a Nursing Home:</b>             | The individual has been admitted into nursing home greater than 30 days.   |
| <b>Incarceration:</b>                         | The individual has been incarcerated greater than 30 days.   |
| <b>Temporary Living Arrangement:</b>          | Temporary living arrangement: The individual chooses to temporarily reside in a non-HCBS-AMH approved setting that is not a hospital, nursing home, or criminal justice institution.   |
| <b>Imminent Health or Safety Risk</b>         | The individual exhibits behavior that constitutes imminent danger or a threat to the health or safety of the individual or another person including the service provider. Examples include, but are not limited to: <ul style="list-style-type: none"> <li>• Exhibiting weapons;</li> <li>• Making direct or indirect threats of physical harm, force or death;</li> <li>• Physically attacking a person with or without a weapon;</li> <li>• Threatening use of force by self or someone else; and</li> <li>• Sexual harassment or sexual assault.</li> </ul> |

## **10220 Suspension Procedure**

### **10220.01 Inpatient Psychiatric Hospitalization:**

Individuals may need to access temporary inpatient psychiatric services while enrolled in HCBS-AMH. If the situation is temporary but exceeds 30 days the individual may be placed in suspended status. (See 5100 Enrollment Process Definitions), but the individual's eligibility is not affected.

#### Upon admission:

The RM submits and Update IRP within five business days of submission of critical incident report to HHSC. (See 13530 Critical Incidents Reporting).

HHSC issues a Determination Letter and the RM distributes the letter to the individual and/or LAR within three business days of authorization of the Update IRP. The Determination Letter includes the following:

- Determination of suspension of services;
- Reason for suspension of services;
- Medicaid Fair Hearing Process;
- Date of service suspension (30 days from date letter is drafted); and
- Duration of suspension of services.

An individual may be placed in suspended status for up to 180 days, with the option of a 30 day extension. (See 10221 Extension of Suspended Services).

#### Upon discharge from the State Hospital while on Suspended Status:

Prior to discharge from a state hospital, the SHSW should utilize the SSA Pre-Release Agreement, if applicable, to ensure expedited reinstatement of the individual's benefits. (See 14110 Social Security Administration Prerelease Program).

Upon the individual's discharge from the hospital, the RM submits an Update IRP within five business days of submission of the critical incident report and submits the Update IRP to HHSC. (See 13530 Critical Incidents Reporting). The RM notifies the individual through Determination Letter upon individual's discharge from the hospital within three business days. The Determination letter includes the following:

- Determination of services;
- Date services will resume (date Medicaid is reinstated); and
- Contact information of the HCBS-AMH Recovery Management Entity.

### **10220.02 Inpatient Medical Hospitalization:**

Individuals may need to access temporary inpatient services for physical health needs while enrolled in HCBS-AMH. If the situation is temporary but exceeds 30 days the individual's eligibility is not affected.

#### Upon admission:

The RM submits and Update IRP within five business days of submission of critical incident report to HHSC. (See 13530 Critical Incidents Reporting).

HHSC issues a Determination Letter and the RM distributes the letter to the individual and/or LAR within three business days of authorization of the Update IRP. The Determination Letter includes the following:

- Determination of suspension of services;

- Reason for suspension of services;
- Medicaid Fair Hearing Process;
- Date of service suspension (30 days from date letter is drafted); and
- Duration of suspension of services.

An individual may be placed in suspended status for up to 180 days, with the option of a 30 day extension. (See 10221 Extension of Suspended Services).

Upon discharge:

Upon the individual's discharge from the hospital, the RM submits an Update IRP within 5 business days of submission of the critical incident report and submits the Update IRP to HHSC (See 13530 Critical Incidents Reporting). The RM notifies the individual through Determination Letter upon the individual's discharge from the hospital within three business days. The Determination letter includes the following:

- Determination of services;
- Date services will resume (date Medicaid is reinstated); and
- Contact information of the HCBS-AMH Recovery Management Entity.

**10220.03 Resides in a Nursing Home:**

When the RM determines the individual requires care in a nursing home for a period greater than 30 days, the individual may be placed in suspended status.

HCBS-AMH Respite must be considered as an initial option for meeting the individual's need for a Nursing Home. If it is determined that an alternative temporary out-of-home living arrangement is more appropriate to address the current needs of the individual, then the following guidelines apply. This policy does not apply to Temporary Inpatient Hospitalizations.

Prior to admittance into the nursing home, the RM submits an Update IRP indicating need for nursing home care, start date for the temporary out-of-home living arrangement, and a supporting documents as to why the HCBS-AMH covered services are not being utilized.

Upon admission:

Upon authorization of the Update IRP, HHSC issues a Determination Letter and the RM distributes the letter to the individual and/or LAR within three business days. The Determination includes the following:

- Determination of suspension of services;
- Reason for suspension of services;
- Medicaid Fair Hearing Process;
- Date of service suspension (30 days from date letter is drafted); and
- Duration of suspension of services, if known.

An individual may be placed in suspended status for up to 180 days, with the option of a 30 day extension. (See 10221 Extension of Suspended Services).

For individuals suspended for "Resides in an Institution" recovery management must occur on a monthly basis to coordinate and document the individual's plan to transition back to residing in the community.

Upon discharge:

Upon the individual's discharge from the nursing home, the RM submits an Update IRP within five business days of submission of the critical incident report (See 13530 Critical Incidents Reporting). The

RM notifies the individual through Determination Letter upon the individual's discharge from the hospital within three business days. The Determination letter includes the following:

- Determination of services;
- Date services will resume (date Medicaid is reinstated); and
- Contact information of HCBS-AMH Recovery Management Entity.

Upon the individual's discharge from the nursing home, the RM submits an Update IRP within five business days of submission of the critical incident report and submits the Update IRP to HHSC. (See 13530 Critical Incidents Reporting). The RM notifies the individual through a Determination Letter upon the individual's discharge from the hospital within three business days. The Determination letter includes the following:

- Determination of services;
- Date services will resume (date Medicaid is reinstated); and
- Contact information of HCBS-AMH Recovery Management Entity.

#### **10220.04 Incarceration:**

If an individual is incarcerated for a period greater than 30 days, he/she may be placed in suspended status.

##### Upon incarceration:

Upon incarceration the RM updates and submits and Update IRP within five business days of submission of critical incident report. (See 13530 Critical Incidents Reporting). Upon authorization of Update IRP, HHSC issue a Determination Letter and the RM distributes the letter to the individual and/or LAR within three business days. The Determination includes the following:

- Determination on suspension of services;
- Reason for suspension of services;
- Medicaid Fair Hearing Process;
- Date of service suspension (30 days from date letter is drafted); and
- Duration of suspension of services, if known.

An individual may be placed in suspended status for up to 180 days, with the option of a 30 day extension. (See 10221 Extension of Suspended Services).

##### Upon release:

Upon the individual's release, the RM submits an Update IRP within five business days of submission of the critical incident report and submits the Update IRP to HHSC (See 13530 Critical Incidents Reporting). The RM notifies the individual through a Determination Letter upon the individual's discharge from the hospital within three business days. The Determination letter includes the following:

- Determination of services;
- Date services will resume (date Medicaid is reinstated); and
- Contact information of HCBS-AMH Recovery Management Entity

#### **10220.05 Temporary Living Arrangement:**

If the individual chooses to temporarily reside in a non-HCBS-AMH approved setting consistent with the CFR § 441.710, he/she may be placed in suspended status.

Prior to the individual's relocation to this setting, the RM submits an Update IRP with the start date for the temporary out-of-home living arrangement and a rationale as to why the HCBS-AMH covered services are not being utilized.

**10220.05.1 Relocation to the temporary non-HCBS-AMH approved setting:**

Upon relocation to the temporary non-HCBS-AMH approved setting, HHSC issues a Determination Letter and the RM distributes the letter within three business days of notification of suspension of services.

The letter includes the following:

- Determination on suspension of services;
- Reason for suspension of services;
- Medicaid Fair Hearing Process;
- Date of service suspension (30 days from date letter is drafted); and
- Duration of suspension of services, if known.

An individual may be placed in suspended status for up to 180 days, with the option of a 30 day extension. (See 10221 Extension of Suspended Services).

**10220.05.2 Return to HCBS-AMH approved setting:**

Upon notification and verification that the individual has returned to an HCBS-AMH approved setting, HHSC issues a Determination letter and the RM distributes the letter to the individual within two business days of verification of HCBS-AMH setting. This letter includes the following:

- Determination on Services;
- Medicaid Fair Hearing Process; and
- Date services are reinstated (five business days from date letter is drafted)

The RM meets with the individual on date services are reinstated and submits an Update IRP to HHSC within ten business days.

**10220.06 Imminent Health or Safety Risk:**

If the individual poses an imminent health or safety risk he/she may be placed in suspended status and the direct service provider and HCBS-AMH RM must make an immediate referral to:

- Appropriate protective services agency;
- Local law enforcement; and/or
- LMHA/LBHA

The RM or provider must complete and submit a critical incident report within 72 hours of incident to HHSC and Update IRP to HHSC.

Upon authorization of the Update IRP, HHSC issues a Determination Letter to be distributed by the RM to the individual within three business days. The Determination includes the following:

- Determination of suspension of services;
- Reason for suspension of services;
- Medicaid Fair Hearing Process;
- Date of service suspension (Date of IRP Authorization); and
- Duration of suspension of services, if known.

Upon notification by licensed mental health professional that the individual is no longer at imminent risk of danger to themselves or others, the RM meets with the individual and PCRCP participants and updates IRP.

### **10221 Extension of Suspended Services**

An individual may 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 the individual or family member indicates the wish for HCBS-AMH services to resume;
- The RM reviews the reasons for the request to determine if an exception should be submitted to HHSC; and
- If reasons or conditions demonstrate clear and convincing evidence the individual can resume service within 30 days past the 180-day suspension period. Reasons and conditions include:
  - Documentation or verbal communication from a treating professional that demonstrates the individual is able to return to his home in the community within 30 days of exceeding the 180 suspension period;
  - Proof of having a home in the community to live in upon discharge from an institution;
  - Resources in the community (for example, involved family) that are available to help; support the individual when he moves back into the community;
  - Temporarily living or traveling out of state;

The RM requests an exception by encrypted email to HHSC HCBS- AMH mailbox with the subject line “Extension of Suspended Services” outlining request and attaching supporting documents which meet at least one of the criteria listed above.

### **10230 Documentation Requirements for Suspension**

In order to request suspension of services, the RM must submit an Update IRP and supporting documents. The following are suitable forms of supporting documentation:

- Documentation of outreach attempts to locate the individual (See 10120.05 Unable to Locate:);
- Documentation of the individual’s non-compliance with services (See 10120.12 Non-Compliant with Services:);
- Nursing Home Admission documents;
- Legal documents;
- Medical documentation verifying need for extended hospital or nursing home stay;
- Verification of temporary residence in non-HCBS-AMH approved setting; and
- Documentation verifying any of the reasons for extension of suspended services. (See 10221 Extension of Suspended Services).

### **10300 Transfer**

An individual may transfer from one HCBS-AMH Provider Agency or HCBS-AMH Recovery Management Entity to another available HCBS-AMH provider at any time.

### **10310 Reasons for Transfer**

| Reason for Transfer |  |
|---------------------|--|
|---------------------|--|

|  |  |
|--|--|
| <b>Individual Selects Different Provider Agency:</b>             | The individual chooses to transfer to obtain HCBS-AMH services through a different provider agency in the same service area.                             |
| <b>HCBS-AMH Provider Agreement Termination:</b>                  | The HCBS-AMH Provider Agreement is terminated between an HCBS-AMH Provider and HHSC and the individual must be transferred to another HCBS-AMH provider. |
| <b>Individual Relocates Outside the Provider's Service Area:</b> | An individual relocates to a county within Texas that is served by the HCBS-AMH Program but not by the current HCBS-AMH Provider.                        |

### **10320 Transfer Procedure**

The RM is responsible for the coordination of the transfer activities to another HCBS-AMH provider and/or Recovery Management Entity. The Recovery Management Entity initiating the transfer of the individual must do all of the following:

- Obtain a completed HCBS-AMH Provider Selection Form, signed by the individual;
- Conduct an IRP meeting(s) to assess reason for transfer and provide interventions;
- Obtain a release of information from the individual within five business days to facilitate communication and coordination with the new Recovery Management Entity and/or HCBS-AMH Provider Agency;
- Contact the new Recovery Management Entity and/or HCBS-AMH Provider Agency to inform them of the impending transfer;
- Prepare a packet of information to forward to the new Recovery Management Entity and/or HCBS-AMH Provider Agency. This packet must contain the following information (See 6230 Transfer of Records):
  - The individual and/or LAR's contact information;
  - Determination Letter;
  - Progress notes;
  - Current UA;
  - If applicable, any additional functional assessments;
  - Current IRP;
  - HCBS-AMH Provider Selection Form;
  - Notification of Participant's Rights Form;
  - Valid HCBS-AMH consents;
  - Copy of Medicaid Card and valid IDs; and
- Periodically check to ensure the transfer process is proceeding;
- Submit Transfer IRP to HHSC within 3 business days (See 7730 Submission of Transfer IRP); and
- Notify accepting HCBS-AMH provider of HHSC approval of the individual's transfer within two business days of authorization of Transfer IRP and electronically send transfer information packet; and
- Distribute to the individual and/or LAR a Determination Letter within three business days of authorization of Transfer IRP which states the following:
  - Determination of HCBS-AMH services;
  - Date of approved transfer;
  - Medicaid Fair Hearing Process; and
  - Contact information of new HCBS-AMH Provider Agency or Recovery Management Entity.

### **10320.01 Individual Selects Different HCBS-AMH Provider:**

If an individual requests transfer to another HCBS-AMH provider or Recovery Management Entity:

1. The RM schedules and facilitates an IRP meeting with the individual, LAR, if applicable, and the individual's PCRCP participants within seven business days of the discharge request. The IRP meeting should address the following:
  - Contributing problems/barriers to treatment;
  - Life changes;
  - Clinical Interventions;
  - Updates IRP to reflect services;
  - Transition planning, as indicated (i.e. the individual requests immediate transfer); and
  - Complete Corrective Action Plan documented in the individual's progress notes, if applicable
2. The RM facilitates a follow-up IRP meeting with the individual and/or LAR, and the individual's PCRCP participants. The IRP meeting should address the following:
  - Assess progress and continued barriers and re-evaluate corrective action plan (if indicated in previous IRP meeting); and
  - Decision to transfer to another provider.
3. If the individual chooses to remain with the current HCBS-AMH provider, the RM and providers continue to provide services listed on Update IRPs and the RM continues to provide Recovery Management at an intensive level until expiration of Update IRPs.
4. If the individual chooses to transfer HCBS-AMH Provider Agency or HCBS-AMH Recovery Management Entity, the RM works with the individual to complete new HCBS-AMH Provider Selection Form and consents necessary to release information. The RM transfers the following documents (See 6230 Transfer of Records):
  - The individual's and/or LAR contact information;
  - Determination Letter;
  - Progress notes;
  - Current UA, any additional functional assessments (if applicable);
  - Current IRP;
  - HCBS-AMH Provider Selection Form;
  - Notification of Participant's Rights Form, Valid HCBS-AMH consents; and
  - Copy of Medicaid Card, and valid IDs.
5. Upon securing new provider, the RM submits an Update IRP to HHSC within five business days of the individual completing new HCBS-AMH Provider Selection Form. (See 7730 Submission of Transfer IRP).
6. The RM notifies the individual's HCBS-AMH Provider Agency of transfer within three business days of authorization of the Transfer IRP.
7. HHSC issues a Determination Letter to be distributed by the RM within three business days of authorization of Transfer IRP. The letter shall state the following:
  - Determination of HCBS-AMH services;
  - Date of approved transfer;

- Medicaid Fair Hearing Process;
- Contact information of new HCBS-AMH Provider Agency or Recovery Management Entity.

**10320.02 HCBS-AMH Provider Agreement Termination:**

If the HCBS-AMH Provider Agreement is terminated between an HCBS-AMH Provider Agency and HHSC, all individuals that HCBS-AMH Provider Agency is serving must be appropriately transitioned to another HCBS-AMH Provider (if available) prior to the termination. HHSC notifies the individual and/or LAR 30 days prior to termination of the provider agreement. Individuals must choose another HCBS-AMH Provider Agency from which to receive services. The RM shall:

1. Meet with the individual and/or LAR and complete HCBS-AMH Provider Selection Form and have the individual complete consents for release of information.
2. Refer the individual to new provider and transfer the following documents (See 6230 Transfer of Records):
  - The individual and/or LAR’s contact information;
  - Determination Letter;
  - Progress notes;
  - Current UA, any additional functional assessments (if applicable);
  - Current IRP;
  - HCBS-AMH Provider Selection Form;
  - Notification of Participant’s Rights Form, Valid HCBS-AMH consents; and
  - Copy of Medicaid Card, and valid IDs.
3. Upon securing new provider, submit Transfer IRP to HHSC within five business days of the individual completing new HCBS-AMH Provider Selection Form. (See 7730 Submission of Transfer IRP).
4. Notify current and new HCBS-AMH provider of HHSC approval of the individual’s transfer within two business days of authorization of Transfer IRP.
5. Distribute a Determination Letter to the individual and/or LAR within three business days of authorization of Transfer IRP. The letter shall state the following:
  - Determination on HCBS-AMH services;
  - Date of approved transfer;
  - Medicaid Fair Hearing Process; and
  - Contact information of new HCBS-AMH provider or Recovery Management Entity.

**10320.03 Individual Relocates Outside the Provider’s Service Area:**

When an individual relocates to a county or service area within Texas that has an HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity, the individual remains eligible for the program. The RM shall:

1. Meet with the individual and/or LAR and complete HCBS-AMH Provider Selection Form and have the individual complete consents for release of information.

2. Refer the individual to new provider and transfer the following documents (See 6230 Transfer of Records):
  - The individual and/or LAR's contact information;
  - Determination Letter;
  - Progress notes;
  - Current UA, any additional functional assessments (if applicable);
  - Current IRP;
  - HCBS-AMH Provider Selection Form;
  - Notification of Participant's Rights Form, Valid HCBS-AMH consents; and
  - Copy of Medicaid Card, and valid IDs.
3. Upon securing new provider, submit Transfer IRP to HHSC within five business days of the individual completing new HCBS-AMH Provider Selection Form. (See 7730 Submission of Transfer IRP).
4. Notify current and new HCBS-AMH Provider Agency of HHSC approval of the individual's transfer within two business days of authorization of Transfer IRP.
5. Distribute a Determination Letter to the individual and/or LAR within three business days of authorization of Transfer IRP. The letter shall state the following:
  - Determination on HCBS-AMH services;
  - Date of approved transfer;
  - Medicaid Fair Hearing Process; and
  - Contact information of new HCBS-AMH Provider Agency or Recovery Management Entity.

#### **10321 Coordination with New HCBS-AMH Provider**

New providers (HCBS-AMH Recovery Management Entity and/or HCBS-AMH Provider Agency) must do all of the following:

- Review the transfer packet;
- Identify the PCRPs participants;
- Coordinate with the RM, individual, and PCRPs participants to schedule a meeting;
- Work with the PCRPs participants to determine if current IRP will be adopted as written, revised or an Update IRP will be developed;
- If applicable, submit an Update IRP to HHSC; and
- Request an Update HCBS-AMH UA if necessary.

#### **10330 Documentation Requirements for Transfer**

A Transfer IRP must be submitted to HHSC at least fourteen days prior to transition of the individual to another HCBS-AMH Provider Agency. (See 7510 Requirements Specific to the Discharge IRP).

# **11000 Settings Requirements**

## **11100 General HCBS-AMH Settings Requirements**

HCBS-AMH services are provided in “home and community-based settings,” including individual homes, apartments, adult foster homes, assisted living facilities, and small community-based residences. Home and community-based settings meet certain qualifications. In accordance with Code of Federal Regulations §441.710 Home and Community-Based Setting qualifications include:

- The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not enrolled in HCBS-AMH;
- The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the IRP and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board;
- Ensures the individual's rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact; and
- Facilitates individual choice regarding services and supports, and who provides them.

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

All HCBS Setting requirements also apply to provider offices if the individual is receiving services in a provider office.

HCBS-AMH services must:

- Be physically accessible to the individual;
- Be furnished in integrated settings and in a way that fosters the independence of each individual and the realization of the benefits of community living, including opportunities to seek employment and work in competitive integrated settings;
- Be person-driven to the maximum extent possible, treat each individual with dignity and respect, promote individuals' inclusion in community activities, use natural supports and typical community services available and accessible to the same degree as individuals not receiving HCBS-AMH services; and
- Promote social interaction and participation in leisure activities, and improve/maintain daily living and functional living skills.

Home and community-based settings do not include the following:

- 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.

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

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

### **11200 Provider Owned and Operated Housing**

In a provider-owned or controlled residential setting, in addition to the qualities specified above and in Section 11100, the following additional conditions must be met:

1. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual, and the individual 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 must be in place for each individual which provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
2. Each individual has privacy in their sleeping or living unit:
  - Units have entrance doors lockable by the individual. Appropriate staff may have keys to doors if this modification is documented on the IRP;
  - Individuals sharing units have a choice of roommates in that setting; and
  - Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
3. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
4. Individuals are able to have visitors of their choosing at any time.
5. The setting is physically accessible to the individual.
6. Any modification of the additional conditions specified in items 1 through 4 above, must 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 of that have been tried but did not work.
  - 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 individual.
- Include an assurance that interventions and supports will cause no harm to the individual.

## **12000 Utilization Management**

### **12100 HHSC Functions**

HHSC monitors service utilization data in coordination with the approved IRP, as well as all service encounter claims. HHSC conducts UM functions and develops quality indicators.

In order to maintain program cost within the state appropriations, HHSC monitors IRPs and utilization of services by individuals. The total cost of program services may not exceed a maximum amount set by HHSC based on the amount of monies available to HCBS-AMH as authorized in appropriation by the legislature. When the program costs are getting close to the maximum amount as authorized in appropriations by the legislature, HHSC may submit an amendment to amend the HCBS-AMH SPA to CMS requesting changes to the needs-based criteria.

HHSC monitors the HCBS-AMH Provider Agency and Recovery Management Entity on the performance of HCBS-AMH activities and conduct regular data verification via desk review.

HHSC conducts an on-going process of retrospective analysis of the Medicaid utilization data.

### **12200 Utilization Management Guidelines**

Across the HCBS-AMH population served, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate per month. If service utilization is high need, supporting documentation is submitted to HCBS-AMH prior to the authorization of service(s).

As necessary, HHSC coordinates with the individual's RM to request additional information for proposed services and amounts of services that meet the level of need as defined in UM Guidelines table below. When notified by HHSC that a requested service needs additional justification, the RM coordinates with HCBS-AMH Provider Agency and PCRPs participants to obtain justification for a service and reports back to HHSC within 5 business days (See 7200 IRP Requirements)

| <b>Service</b>             | <b>Standard Anticipated Utilization</b> | <b>High Need Utilization</b> |
|----------------------------|---|------------------------------|
| Host Home Companion        | Daily                                   | N/A                          |
| Supported Home Living      | 32-62 units/month                       | 63-186 units/month           |
| Supervised Living Services | Daily                                   | N/A                          |
| Assisted Living            | Daily                                   | N/A                          |

|  |   |   |
|--|---|---|
| HCBS-AMH Psychosocial Rehabilitation Services (Individual) | 20-40 Units/month   | 41-65 units/month   |
| HCBS-AMH Psychosocial Rehabilitation Services (Group)      | 20-40 units per month   | 41-65 units per month   |
| Supported Employment                                       | 10-21 units per month   | 22-38 units per month   |
| Employment Assistance                                      | 8-13 units/ month   | 14-17 units/month   |
| Minor Home Modifications                                   | \$500   | \$1,000   |
| Home-delivered Meals                                       | 20-45 units/month   | 46-62 units/month   |
| Transition Assistance                                      | \$1500-Supported Home Living<br>\$500-Host Home, Supervised Living, Assisted Living | \$2500-Supported Home Living<br>\$1,000-Host Home, Supervised Living, Assisted Living |
| Adaptive Aids  | \$500   | \$1,000   |
| Transportation Services                                    | 303-400miles/month  | 401-500 miles/month   |
| Community Psychiatric Supports and Treatment               | 4-5 units/month (1 hour units)  | 6-8 units/month(1 hour unit)  |
| Peer Support   | 10-20 units/month   | 21-30 units/month   |
| Respite Care (In home)                                     | 1 unit/month  | 3 units/month   |
| Respite Care (Out of home)                                 | 1 unit/month  | 3 units/month   |
| Substance Use Disorder Services (individual)               | 100-145 units/month   | 146-192 units/month   |
| Substance Use Disorder Services (group)                    | 10-20 units/month   | 21-39 units/month   |
| Nursing  | 12-24 units/month   | 25-56 units/month   |
| Recovery Management  | On average<br>24-48 units per week or a maximum of 192 units per month              | On average<br>49-64 units per week or a maximum of 256 units per month                |

### **12300 HCBS-AMH Provider UM Functions**

The HCBS-AMH Provider Agency shall not modify, discontinue or refuse services to an individual unless documented efforts have been made with the individual to resolve the situation that triggers such modification or discontinuation or refusal to provide services.

Due to the limited availability of resources in certain service areas, it may not always be possible to locate the full array of HCBS-AMH services. In these cases, a provider must demonstrate a Good Faith Effort in locating providers through outreach and networking (See 6521 Good Faith Effort Exception).

### **12310 Recovery Management Entity UM Functions**

The Recovery Management Entity performs UM activities that include monitoring service utilization for compliance with the approved IRP for each individual. HHSC assists the RM in UM activities by requesting monthly encounter data from the HCBS-AMH Provider Agencies and provides the RM with HCBS-AMH-specific service encounter data at similar intervals for each individual enrolled in HCBS-AMH.

The HCBS-AMH Recovery Management Entity participates collaboratively in ongoing quality improvement and assurance activities.

HCBS-AMH Recovery Management Entities are required to repay any identified overpayment.

### **12320 HCBS-AMH Provider Agency Functions**

The HCBS-AMH Provider Agency monitors service utilization for compliance with the approved IRP for each individual.

HCBS-AMH Provider Agencies are required to repay any identified overpayment. Encounters are linked to paid claims and any identified invalid services are expected to be repaid by the HCBS-AMH Provider. The HCBS-AMH Provider Agency participates collaboratively in ongoing quality improvement and assurance activities (See 12200 Utilization Management Guidelines).

### **12400 Minimum Amount of Services**

In order for an individual to be determined to need HCBS-AMH services, an individual must require the provision of at least one HCBS-AMH service, as documented in the IRP.

### **12500 Reduction in Services**

During the course of the individual's participation in the program, the intensity of services being provided by the RM and HCBS-AMH Direct Service Providers may change. If it is clinically indicated there needs to be a reduction in services, the RM completes the following:

- Convenes a IRP meeting with the individual/and or LAR, HCBS-AMH Provider, and RM to review a possible reduction in services;
- Completes an Update IRP which reflects which HCBS-AMH services are reduced and the reason for this reductions in services;
- Submits the Update IRP for approval by HHSC within three business days(See 7720 Submission of Update IRP); and
- After approval, notifies the individual and/or LAR as well as HCBS-AMH Provider Agency via the Determination Letter provided by HHSC.

## **13000 Maintenance of Records, Documentation, and Reporting**

The Recovery Management Entity and HCBS-AMH Provider Agency are responsible to adhere to the following guidelines:

- Records should be organized and divided into sections according to a consistent standard allowing for ease of location and referencing;
- Records should be sequential and date ordered;
- Records should be fastened together to avoid loss or being misplaced. No loose papers;
- The HCBS-AMH Recovery Management and HCBS-AMH Provider Agency shall allow HHSC Staff access to all clinical records upon request;

- The individual shall have access to the clinical record in accordance with Texas Health and Safety Code, §611.0045;
- The HCBS-AMH Recovery Management and HCBS-AMH Provider Agency must keep all records required by the Provider Agreement until one of the following occurs, whichever is the latest:
  - Seven years from the date that one of the following events occurs: transfer, death, discharge;
  - Any audit exception or litigation involving the records is resolved;
- Clinical records must be stored in a “double locked” manner (e.g. in a locked filing cabinet located within a locked office). If records must be transported, maintain the “double locked” and safeguarding requirements (e.g. transported in a locked box in a locked vehicle trunk and not left in an unattended vehicle). Electronic Health Records (EHR) must be stored in a password-protected computer located within a locked room.

The exchange or sharing of confidential information, particularly protected health information or other sensitive personal information shall be done in compliance with HIPAA. All parties involved with the HCBS-AMH Program (including HHSC staff, HCBS-AMH Provider Agency and Recovery Management entity direct service staff) shall maintain and protect the confidential information to the extent required by law.

### **13100 HHSC Maintenance of Records**

HHSC Maintains the Following:

- Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by HHSC and the HCBS-AMH provider for a minimum period of three years as required in 45 CFR §92.42;
- Determination Letter;
- Indigent Waitlist;
- Consents;
- Enrollment documents;
- Assessments; and
- Criminal history, Background checks, licensures, and certifications for individuals providing HCBS-AMH services in the state hospital to an enrolled individual.

### **13200 Recovery Management Entity Maintenance of Records**

The Recovery Management Entity shall maintain original forms provided to the individual and LAR in the individual’s clinical record and provide the individual and LAR a copy.

The Recovery Management Entity maintains the following in the clinical record for each individual:

- Demographic and contact information for the individual;
- Determination Letters;
- HCBS-AMH Provider Selection Form;
- Demographic and contact information of individual enrolled in HCBS-AMH;
- Notification of Participant’s Right’s Form;
- Individual Recovery Plans;
- Safety Plans and Crisis Plans;
- Progress Notes for all HCBS-AMH services provided to the individual;
- Critical Incident Reports; and

- Other HCBS-AMH Program documentation.

### **13300 HCBS-AMH Provider Agency Maintenance of Records**

The HCBS-AMH Provider Agency maintains the Following in the Clinical Record for each individual:

- Demographic and contact information for the individual;
- Determination Letters;
- Notification of Participant Rights Form;
- HCBS-AMH Provider Selection Form;
- Individual Recovery Plans;
- Safety Plans and Crisis Plans;
- Respite Provider Form;
- Transportation Log;
- Progress Notes for all HCBS-AMH services provided to the individual;
- Critical Incident Reports;
- Other HCBS-AMH Program documentation; and
- Personnel Records (See 13600 Personnel Records)

### **13400 Documentation Requirements**

HCBS-AMH Provider Agencies and Recovery Management Entities are responsible for keeping accurate and adequate records that document the services provided to the individual. (See HCBS-AMH Billing Guidelines <http://www.dshs.state.tx.us/mhsa/hcbs-amh/billing/> for additional documentation requirements).

#### **13410 Documentation of Provider Choice**

Documentation regarding provider choice is included in the individual's record. Documentation of provider choice includes:

- A completed HCBS-AMH Provider Selection Form, signed by the individual;
- The final selection of an HCBS-AMH Provider Agency and Recovery Management Entity must be documented and retained in the individual's clinical record; and
- The individual's right to choose the service provider extends to the specific HCBS-AMH direct service personnel that provide HCBS-AMH services. The individual and LAR's selection of HCBS-AMH Provider Agency and Recovery Management Entity personnel is documented and retained in the individual's clinical record.

#### **13420 Progress Notes**

Progress notes are required for all services provided to an individual. HHSC may request progress note documentation at any time to verify reimbursed services are being provided in accordance with the requirements of HCBS-AMH. General documentation requirements for progress notes include but are not limited to:

- Progress notes must be written for all individuals and kept in the clinical record;
- Adhere to TAC 412.326
- All entries must be legible;
- Use only ink;
- Every page must have some form of individual identification;

- The name of the individual receiving the service;
- The name of the service and a description of the service provided;
- The date of the contact;
- Start and stop time of the contact;
- The location where the service was provided;
- The individual's response to the services being provided;
- The progress or lack of progress in addressing the individual's outcomes as identified in the Individual Recovery Plan;
- Summary of activities and behaviors which occurs during the provision of the service;
- The signature and credentials of direct service staff;
- All words must be tailored to the changing needs of each individual;
- Correcting errors: Do not use correction tape/fluid, or scribble over; instead, draw a single line through the error & initial, then enter correct material;
- Only original authors may make alterations;
- Reviewers or supervisors may not edit original authors but may supply an addendum with dated signature; and
- Acronyms and abbreviations: Use only universal acronyms and abbreviations.

### **13430 Documentation Specific to Certain Services**

In addition to the general documentation requirements identified above, certain HCBS-AMH services have documentation requirements. (See HCBS-AMH Billing Guidelines <http://www.dshs.state.tx.us/mhsa/hcbs-amh/billing/> for more details).

## **13500 Reporting**

### **13510 HCBS-AMH Service Reporting**

The encounter system and invoice system are linked together in an Excel workbook titled HCBS-AMH Invoice Template

HHSC receives all HCBS-AMH invoices from the Recovery Management Entity and Provider Agency. HHSC conducts quality checks on invoice for accuracy and completeness, and reviews the amounts against the approved IRP. HHSC may collect any information from the provider by accessing other data sources such as TMHP or requesting records from the HCBS-AMH Recovery Management Entity or Provider Agency.

See HCBS-AMH Billing Guidelines for the HCBS-AMH Invoice Template and detailed instructions. The HCBS-AMH Invoice Template can be downloaded at <http://www.dshs.state.tx.us/mhsa/hcbs-amh/billing/>.

The HCBS-AMH Invoice Template shall be submitted via HIPAA compliant encrypted email to the Claims Processing Unit @dshs.state.tx.us with a copy to [mhcontracts@dshs.state.tx.us](mailto:mhcontracts@dshs.state.tx.us) and [HCBS-AMH.services@dshs.state.tx.us](mailto:HCBS-AMH.services@dshs.state.tx.us). The HCBS-AMH Provider must have prior approval by HHSC to submit the HCBS-AMH Invoice Template through a method other than encrypted email.

### **13520 Quarterly and Annual Reports**

The HCBS-AMH Provider shall submit to HHSC quarterly and annual reports utilizing the Quarterly Report Template and Annual Report Template located at <http://www.dshs.state.tx.us/mhsa/hcbs-amh/Reporting-Templates.aspx>.

### **13530 Critical Incidents Reporting**

Critical incident training for HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity direct service staff is by the HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity.

The HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity are responsible for implementing a procedure which ensures the reporting of all critical incidences. Incidences may include, but are not limited to, the following:

- Abuse, neglect, or exploitation of an HCBS-AMH participant (See 13540 Abuse, Neglect, and Exploitation (ANE));
- Psychiatric hospitalizations;
- Extended nursing home placement;
- Incarceration;
- When an individual is either hospitalized or discharged from the hospital, the RM must complete and submit the Critical Incident Reporting Form to HHSC within 72 hours of the date notified of hospitalization, and within 72 hours of the date notified of hospitalization discharge;
- Restraint of an HCBS-AMH participant;
- A slip or fall, medication error, or medical complication; or
- Incidents caused by the member such as verbal and/or physical abuse of staff or other members, destruction or damage of property, contraband, and member self-abuse;
- Eviction from primary residence; or
- Serious injury or death

The HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity are required to report any critical incidents that result in substantial disruption of the program operation involving or potentially affecting individuals enrolled in HCBS-AMH within 72 hours of notification of an incident. (See 13540 Abuse, Neglect, and Exploitation (ANE) for additional ANE reporting requirements). The HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity are responsible for submitting all Critical Incident Reporting Forms to HHSC within 72 hours of notification of an incident report. The Critical Incident Report Form is submitted to HHSC at [HCBS-AMH@dshs.state.tx.us](mailto:HCBS-AMH@dshs.state.tx.us) with the subject line titled "Critical Incident Reporting Form."

The HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity are required to complete a Critical Incident Report Form (See <http://www.dshs.state.tx.us/mhsa/hcbs-amh/Forms.aspx> for access to this form) that includes, but is not limited to, the following information:

- Date, time, and location of incident;
- Individual identifying or demographic information;
- Staff making report, witnesses, and associated contact information;
- Categories of Critical Incidents: ANE, Injury, Medical Emergency, Behavioral or Psychiatric Emergency (including psychiatric hospitalizations), Allegation against client rights, Criminal Activity, Death, Restraint, Medication Error, Participant Departure (missing); and
- Detailed description of the incident.

The HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity shall re-submit to HHSC the Critical Incident Report Form within 72 hours of notification of outcome of the incident with any updated information. If psychiatric hospitalization (or other institutionalization) occurs, the Recovery Management Entity must submit an Update IRP to HHSC within 30 days of discharge from the institution.

In the case of critical incidents, the HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity are expected to take immediate action to resolve, when feasible, and to report to the appropriate state and/or law enforcement entities.

HHSC is responsible for overseeing the reporting of and response to critical incidents that affect individuals enrolled in HCBS-AMH. Critical incidents are managed as part of the contract oversight process by HHSC.

When reviews of the HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity occur, critical incident reports are reviewed. HHSC reports data from critical incident reviews to HHSC on a quarterly basis.

The HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity cooperates with and assists HHSC and any state or federal agency charged with the duty of identifying, investigating, sanctioning or prosecuting suspected fraud and abuse, including the Office of Inspector General at HHSC.

The HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity may not change a confirmed finding made by a DFPS investigator. The HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity may request a review of the finding or the methodology used to conduct the investigation.

The HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity must comply with all applicable state and Federal abuse and other reporting laws. It is the responsibility of the HCBS-AMH Provider to understand and comply with professional and legal requirements within the State of Texas.

### **13540 Abuse, Neglect, and Exploitation (ANE)**

#### **13541 General Policies and Procedures Regarding ANE**

Cases of suspected ANE shall be reported by the HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity to the appropriate investigative authority immediately. The HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity shall cooperate with Adult Protective Services (APS) investigator to ensure APS is able to complete a thorough investigation.

The HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity shall develop, implement and enforce a written policy that includes Screening, Documenting, and Reporting Policy for Contractors/Providers and train all direct service staff on reporting requirements.

The HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity shall retain reporting documentation on site and make it available for inspection by HHSC when requested.

For ANE reports, the HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity are required to submit accurate and timely information to HHSC. The HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity must report any incidents that result in substantial disruption of program operation involving or potentially affecting individuals enrolled in HCBS-AMH within 72 hours of notification on an incident, including allegations of ANE. HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity shall submit a Critical Incident Reporting Form (See <http://www.dshs.state.tx.us/mhsa/hcbs-amh/Forms.aspx> for access to this form) within 72 hours of an alleged ANE report, and within 72 hours of receiving a final investigative report from DFPS. The HCBS-AMH Provider submits the Critical Incident Report Form to HHSC at [HCBS-AMH@dshs.state.tx.us](mailto:HCBS-AMH@dshs.state.tx.us) with the subject line titled "Critical Incident Reporting Form."

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

### **13542 Reports to Department of Family and Protective Services (DFPS)**

When the alleged or suspected abuse involves a person responsible for the care, custody, or welfare of the individual, the report must be made to DFPS.

Reports to DFPS: A person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, is required to report the information immediately to DFPS. (See: Texas Human Resources Code, Title 2, Subtitle D, Chapter 48, Section 48.051 (relating to Reports of Abuse Neglect, or Exploitation: Immunities).

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

The HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity may not change a confirmed finding made by a DFPS investigator. The HCBS-AMH Provider may request a review of the finding or the methodology used to conduct the investigation.

### **13543 Client Abuse and Neglect Reporting System (CANRS) for LMHA/LBHA Providers of HCBS-AMH:**

If the perpetrator or alleged perpetrator is an employee or agent of and LMHA/LBHA, or the perpetrator is unknown, then the Administrator of the HCBS-AMH Provider, or their designee shall ensure that a Client Abuse and Neglect Report (See <http://www.dshs.state.tx.us/mhsa/hcbs-amh/Forms.aspx> for access to this form) is completed. The Client Abuse and Neglect Report must be completed within fourteen calendar days of the receipt of the investigative report or decision made after review or appeal using the CANRS Definitions and the CANRS Classifications; TAC, Ch. 414, subchapter L, §414.558 – Data Reporting Responsibilities. Within one working day after completion of the Client Abuse and Neglect Reporting form, the Administrator of the HCBS-AMH Provider, or their designee shall ensure that:

- the information contained in the completed Client Abuse and Neglect Report is entered into the Client Abuse and Neglect Reporting System (CANRS); or
- if access to CANRS is unavailable, a copy of the completed Client Abuse and Neglect Report is forwarded for data entry to the HHSC Office of Consumer Services and Rights Protection.

### **13544 DFPS Investigations**

DFPS investigates reports of alleged abuse, neglect, or exploitation (ANE) of individuals receiving services from certain providers including elderly individuals, disabled individuals, and children. This includes investigations of:

- Facilities (State Hospitals, State Supported Living Centers, ICF-IIDs, etc.);
- Community Center, Local Mental Health Authority, Local Intellectual and Developmental Disability Authority;
- Person who contracts with HHS agency or MCO to provide HCBS;
- Person who contracts with MCO to provide behavioral health services;
- MCO;
- Officer/employee/agent/contractor/subcontractor of above; and
- Employee/agent/manager/coordinator of an individual participating in the Consumer Directed Services Option

DFPS also investigates children residing in an HCS home as well as all children receiving services from a licensed HCSSA.

DFPS-APS conducts these investigations pursuant to Human Resources Code Chapter 48, as amended by SB 1880 as well as Family Code section 261.404, as amended by SB 1880.

When DFPS receives ANE reports concerning an individual in a facility licensed by another state agency, DFPS forwards the report to the appropriate agency for investigation. DFPS investigates reports of ANE when there is not already an authorized entity to conduct such an investigation.

#### Abuse Hotline for APS Facility Investigations:

1-800-647-7418

Online via secure website and get a response within 24 hours:

<https://www.txabusehotline.org/Login/Default.aspx>

#### Texas Department of Aging and Disability Services (DADS)

DADS regulates nursing homes, assisted living facilities, private ICF/MR, and adult day care

Complaints (reports of abuse):

1-800-458-9858

#### Nursing Home Information:

1-800-252-8016

#### Texas Health and Human Services Commission

HHSC oversees hospitals, psychiatric hospitals (including private psychiatric facilities), and various other medical facilities.

Complaints:

1-888-973-0022

#### Texas Council on Family Violence

##### Domestic Violence Hotline:

1-800-799-7233

(1-800-799-SAFE) 1-800-787-3224 (TDD)

### **13550 Reporting Emergencies**

Call 911 or local law enforcement

### **13600 Personnel Records**

#### **13610 Minimum Standards**

The HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity is required to retain a confidential personnel record for each direct service staff. The HCBS-AMH Provider Agency and Recovery Management Entity is ultimately responsible to verify that direct service staff of subcontracted providers meets stated qualifications, criminal history, and registry checks. Personnel records at minimum should include:

1. Current Criminal Background Check;
2. Completion of HHSC required training;
3. Completion of training required for competence of the service delivered;
4. Certification records for employees and subcontractors;
5. Certification or Registration with the state and federal government, as required by applicable state and federal Laws;
6. Current copy of Professional Licensure, Certification or Registration with the state and federal government, as required by applicable state and federal Laws;
7. Educational history;
8. Work history;
9. Prior or pending malpractice litigation;
10. Professional liability claims history;
11. Criminal convictions;
12. Individual complaints received by facilities or state agency;
13. Any disciplinary action initiated against the provider by state board or other agency;
14. Any curtailing, suspension, or termination of staff privileges at any medical or treatment facility or program;
15. Any sanctions imposed by an insurance company or CMS, including sanctions relating to the provider's participation in Medicaid or Medicare programs;
16. Evidence of adequate malpractice or liability insurance;
17. For physicians, information on the practitioner from the National Practitioner's Data Bank and the following: current and valid license from the Texas Board of Medical Examiners; current and valid Drug Enforcement Administration (DEA) certificate, and evidence of graduation from medical school and completion of residency, or board eligibility/ certification, if applicable;
18. History, education, and ability to provide services to covered lives;
19. History or previous training in providing the covered services;
20. A statement by the applicant regarding:
  - a. Any physical or behavioral health problems that may affect the provider's ability to provide services;
  - b. History and current status of licensure and felony convictions.
  - c. History and current status of privileges, including limitations, or disciplinary actions by the appropriate licensing agency or facilities, and
  - d. An attestation to the correctness and completeness of the application.

The HCBS-AMH Provider Agency and Recovery Management Entity shall allow HHSC Staff access to personnel records when conducting QM reviews, invoicing verifications and for other requests.

### **13620 Credentialing for Service Provision within the State Hospitals**

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

| <b>Service</b>                            |     |                              |
|---|-----|------------------------------|
| Recovery Management                       | Yes | Master's Degree              |
| Psychiatric Supports and Treatment        | Yes | License                      |
| Substance Use Disorder (SUD) Services     | Yes | Degree or License            |
| HCBS-Psychosocial Rehabilitation Services | Yes | Bachelor's Degree or License |
| Peer Support                              | Yes | Certification                |

The HCBS-AMH Provider Agency and Recovery Management Entity are required to maintain personnel records of direct service staff providing services (see 13600 Personnel Records).

The HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity shall provide the following electronically to HHSC for direct service staff providing services in the state hospital at [HCBS-AMH@dshs.state.tx.us](mailto:HCBS-AMH@dshs.state.tx.us) and use the subject line "Hospital Credentialing."

- 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 state hospital point of contact (POC) HHSC; and as applicable; proof of degree, license, or certification for each direct service provider providing HCBS-AMH services inside a state hospital.

HCBS-AMH Provider Agencies and HCBS-AMH Recovery Management Entities shall send notification via email identifying any changes/updates to HCBS-AMH direct service staff that are authorized to work in a state hospital to [HCBS-AMH@dshs.state.tx.us](mailto:HCBS-AMH@dshs.state.tx.us). HCBS-AMH direct service providers shall not provide HCBS-AMH services to any individual inside a state hospital until credentialing process is complete.

### **13621 Credentialing Procedure for the Recovery Manager**

The Recovery Management Entity shall receive notification through the HCBS-AMH Provider Selection Form that the Recovery Management Entity has been selected by an individual residing in a SH. In the notification a POC at the identified SH shall be listed. The RM shall contact the SH POC and work collaboratively to schedule a fingerprinting appointment. Once the appointment is complete and verified by the SH POC, the RM may schedule initial IRP meeting with the individual in the SH.

### **13622 Credentialing Procedure for the Comprehensive Service Provider**

Upon completion of the Initial IRP, the RM and the individual identify if an approved HCBS-AMH Provider Agency (See 13620 Credentialing for Service Provision within the State Hospitals) is required to meet goals identified on the IRP while an individual is residing in a SH. Goals identified in the first three

to six months of enrollment for an individual is residing in a SH are identified to ensure successful transition to the community. If a service provider is identified, The RM shall:

1. Inform SH POC and approved HCBS-AMH service provider;
2. Coordinate a time for the SH POC and HCBS-AMH service provider to schedule a fingerprinting appointment;
3. Follow-up with SH POC and HCBS-AMH service provider to ensure the individual is cleared to work in a SH; and
4. Schedule a meeting to complete an update IRP to include additional HCBS-AMH service providers.

## **14000 Benefits, Entitlements and Financial Resources**

### **14100 Social Security and Medicaid Application**

The Social Security Administration (SSA) through Supplemental Security Income (SSI) or HHSC determines if an individual is eligible for Medicaid. When an individual has been identified as eligible for HCBS-AMH services, SHSW or referring entity begins the SSI application process.

### **14110 Social Security Administration Prerelease Program**

Through and Interagency Agreement with the Social Security Administration (SSA), DSHS is able to utilize SSA's Prerelease Program. This expedited application process is for individuals 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 the hospital at the time of enrollment HCBS-AMH eligibility determination, the SHSW assists the individual with the SSI application process through the Social Security Administration Prerelease program.

An application filed before release allows SSA to make a determination based on what the situation will be after the institution releases the individual. This allows the HCBS-AMH eligible individual to receive SSI or Social Security payments shortly after they re-enter the community.

### **14120 Community Applications for SSI Benefits**

Individuals currently residing in the community while HCBS-AMH eligibility is determined work with their referring entity to submit an application for SSI benefits.

For more information on the application process and appeals, see <http://www.socialsecurity.gov/disabilityssi/apply.html>.

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 on SSA's Compassionate Allowance Condition. A list of these disorders can be found at <http://www.socialsecurity.gov/compassionateallowances/>.

If an individual is denied SSI benefits, see <http://www.ssa.gov/appeals/> for appeals process.

### **14130 Recovery Managers Role in Obtaining and Maintaining Benefits**

When applicable, it is the responsibility of the RM to coordinate with the SHSW to ensure the Social Security prerelease application process has been completed. The RM is responsible for monitoring the

status of the individual's benefits and providing guidance and assistance to help the individual obtain and maintain benefits.

### **14140 Qualified Income Trust**

If an individual's income exceeds the HCBS-AMH financial eligibility requirements (150% of the FPL), then an option is available for the individual to set up a Qualified Income Trust (QIT) in order to meet the financial requirements. It is the responsibility of the individual and LAR to set up a QIT.

### **14200 Medicaid**

If an individual is **not** currently Medicaid Eligible, staff from the referring entity submits an application for Medicaid eligibility. This **only** applies to the Long Term Hospitalization population.

### **14210 SSI and Medicaid Eligibility**

Eligibility determinations for Medicaid are performed as described under the Texas Medicaid State Plan. HHSC makes the final determination of eligibility for the 1915(i) state plan option. In accordance with the Social Security Act §1902(a)(5), the determination of eligibility for medical assistance under the plan shall be made by HHSC or, for individuals qualifying for Supplemental Security Income (SSI), by the agency or agencies administering the supplemental security income program. Individuals approved for SSI Benefits receive Medicaid without an additional application process.

### **14220 Non-SSI Eligible Medicaid Eligibility**

Non-SSI eligible individuals must complete a Medicaid eligibility determination by submitting an application to HHSC Medicaid Eligibility (HHSC ME). This process involves an investigation of the applicant's financial status, proof of citizenship, and ends with a decision of approval or denial.

### **14230 Application for Medicaid**

The referring entity assists the individual and/or the LAR in obtaining and completing an application for Medicaid Eligibility.

- Application and submission process can be found on <https://www.yourtexasbenefits.com/ssp/SSPHome/ssphome.jsp>
- Tips to submit 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 twelve months is preferable;
  - Provide copy of the individual's Birth Certificate
  - Provide copy of the individual's Private Insurance Card, front and back (if applicable); include policy values; and
  - All resources must be listed (i.e. bank accounts), financial verification (i.e. 3 consecutive monthly bank statements dated to first of month of application date complete with ending balance and account holder names) must also accompany the application or will be requested by HHSC.

NOTE: Information from other sources may also help show the extent to which an individual's impairment(s) affects his or her 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.

### **14331 Medicaid Appeal Process**

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

- Denial of benefits
- Reduction of benefits
- 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
- Submitting a written request via mail to:

HHSC  
PO Box 15100  
Midland, TX 79711-990710

### **14332 Additional Resources if Medicaid Eligibility is Denied**

The following is a list of application options in the situation that 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 <http://www.dads.state.tx.us/forms/H1010/>. This is an integrated application for requesting additional programs/services outside the scope of Medicaid Aged and Disabled (i.e. SNAP, TANF).

### **14300 Dual-Eligibility**

Individuals are eligible for HCBS-AMH services if they are receiving both Medicaid and Medicare (dual-eligibility). In cases of dual-eligibility, the individual's HCBS-AMH services are covered under Medicaid and acute care services are billed to Medicare.

### **14400 STAR+PLUS**

STAR+PLUS is a Medicaid managed care program of the Texas Health and Human Services Commission in which individuals are automatically enrolled in if they have a physical or mental disability and are able to get 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, the individual is defaulted into a STAR+PLUS MCO.

STAR+PLUS enrollees have the opportunity to 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.

The STAR and STAR+PLUS plans:

- Offers 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
- Extra services offered by the health plan

NOTE: Dual Eligible individuals enrolled in long-term services and supports through STAR+PLUS and basic medical services through Medicare.

### **14500 Federal Insurance Exchange**

If an individual's income is more than 100% of the FPL, an individual is able to purchase a private health insurance plan in the Marketplace and may be eligible for premium subsidies based on his/her household size and income.

To assist an individual in enrolling in the Texas Health Insurance Exchange Marketplace, use the official website [www.HealthCare.gov](http://www.HealthCare.gov) or call 800-318-2596 to apply for coverage, compare plans, and enroll.

### **14600 Texas Supplemental Nutrition Assistance Program (SNAP)**

SNAP, commonly known as food stamp benefits, is a government run program to assist individuals and families with food costs. SNAP Benefits allow individuals and families to purchase food items at an authorized retail store.

For questions about SNAP and the application process, see <https://www.yourtexasbenefits.com/sfp/SSPHome/ssphome.jsp>.

### **14700 Comprehensive Energy Assistance Program (CEAP)**

CEAP is a federally funded program that issues heating benefits to supplement a household's annual energy cost.

To apply for CEAP, call toll free at (877) 399-8939 between 8 a.m. and 5 p.m., Monday through Friday. The toll free number directly connects with the CEAP service provider in the county from which the call originates.

## **14800 County Indigent Health Care Program (CIHCP)**

Individuals who are deemed indigent may be enrolled in HCBS-AMH. Indigent individuals may also receive additional services through the CIHCP.

See Appendix A: Training Requirements for additional information on training on CIHCP and the services available.

## **15000 Quality Management (QM)**

Quality Management (QM) activities are performed by HHSC and locally by the HCBS-AMH Provider.

The foremost responsibility of any service system is to ensure the health, welfare and safety of individuals being served. Within Texas' Mental Health service delivery system, protocols are in place to ensure that health and welfare standards are continuously met and that Medicaid services, including those funded through HCBS-AMH implemented in accordance with Medicaid statute, HCBS-AMH requirements and programmatic standards. Components of the HCBS-AMH QM system include:

- Development and review of the IRP;
- Annual required reviews of each HCBS-AMH 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 critical incident reports;
- Collection and analysis of critical incident data to identify trends and initiate quality improvement strategies;
- The individual receiving service satisfaction; and
- Setting Requirements

The HCBS-AMH Provider Agency and Recovery Management Entity participates collaboratively with HHSC in ongoing quality improvement and assurance activities. The HCBS-AMH Provider Agency, Recovery Manager, or HHSC may identify issues and suggest potential remedies.

## **15100 HCBS-AMH Provider Agency and Recovery Management Entity QM**

### **Responsibilities**

HCBS-AMH Provider Agency and Recovery Management Entity must allow representatives of HHSC, DFPS, Office of Attorney General Medicaid Fraud, and United States Department of Health and Human Services full and free access to direct service staff, individuals enrolled in HCBS-AMH, and all locations where the HCBS-AMH Provider Agency direct service staff or subcontractors and Recovery Management Entity recovery managers perform activities related to the HCBS-AMH program.

HCBS-AMH Provider Agency and Recovery Management Entity are obligated to verify on an ongoing basis that these qualifications are achieved, maintained, and documented. HHSC conducts annual review to verify these requirements continue to be met after the provider and HHSC enter into an agreement.

## **15200 HHSC Responsibilities**

HHSC is responsible for the oversight of the HCBS-AMH Provider Agencies and Recovery Management Entities. HHSC conducts, quarterly desk reviews and annual site reviews of compliance with the functions delegated in the approved HCBS-AMH Provider Agreement. These reviews examine HCBS-AMH 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 criminal history and registry checks. HCBS-AMH Program aggregates the data annually and reports to HHSC.

HHSC conducts quarterly desk reviews and annual on-site reviews of each HCBS-AMH Provider Agency and Recovery Management Entity to evaluate compliance with the HCBS-AMH policies. The reviews include an evaluation of clinical records of individuals enrolled in HCBS-AMH to ensure that the HCBS-AMH Provider is providing adequate oversight and that the HCBS-AMH Provider Agency and Recovery Management Entity is responsive to findings. These reviews monitor HCBS-AMH Provider Agency and Recovery Management Entity compliance with requirements for criminal history and abuse registry checks in accordance with Texas Administrative Code (TAC) Chapter 414 Subchapter K Criminal History and Registry Clearances. Part of HHSC's annual review of each HCBS-AMH Provider Agency and Recovery Management Entity consists of a comparison of the billed services to the services documented in the individual's clinical record.

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

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

HHSC also 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 must meet state licensure or program certification requirements that may pertain to each setting.

HHSC includes medication management review as part of its annual review of contracted HCBS-AMH Provider Agency and Recovery Management Entity's. HHSC is responsible for monitoring the performance of providers administering medications to the individual. HHSC enforces requirements through annual assessment and review of critical incidents.

HHSC oversees providers to ensure individual choice and independence is not compromised. HHSC reviews and approve the individual's IRP before the provision of services.

HHSC annually reviews contractors who complete evaluations, reevaluations, assessments, and IRPs to ensure that they do not have an interest in or are under the control of a provider on the IRP.

In addition, HHSC annually reviews 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, intermittent reviews may be conducted if a pattern of unresolved complaints, critical incidents, an HCBS-AMH Provider Agency and Recovery Management Entity's past performance, or other findings warrants more frequent review.

HHSC conducts quarterly data verification via desk review. This process can generate a Plan of Improvement if deficiencies are discovered.

HHSC conducts quarterly 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 HCBS-AMH Provider Agency and Recovery Management Entity. These data verification reviews include verification of diagnosis, treatment plan, demographic, clinical and financial eligibility, server credentials, as well as service documentation.

HHSC identifies inefficiencies and barriers to desired outcomes and makes recommendations to the HCBS-AMH Provider Agency and Recovery Management Entity and/or HHSC for program and administrative modifications.

DFPS provide HHSC copies of each investigation of ANE allegations involving an individual enrolled in HCBS-AMH. Regardless of the investigation findings, HHSC reviews each investigative report.

HHSC develops, implements, and monitors compliance with rules, policies, procedures, and other guidance governing the HCBS-AMH Program.

HHSC may conduct interviews with individuals enrolled in HCBS-AMH to verify the individual's satisfaction and verify the delivery of services.

The Quality Management Plan delineates specific indicators related to each sub-assurance. Data from these reviews are reported to HHSC via these indicators and associated reports. HHSC coordinates with HHSC to discuss findings and trends and, when necessary to develop and monitor remediation plans.

HHSC conducts surveys and monitors HCBS-AMH Provider Agency and Recovery Management Entity's for compliance with licensing and certification requirements. When harmful or non-compliant practices are identified, corrective action is taken to bring the facility back into compliance. HHSC analyzes 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.

HHSC includes medication management review as part of its quarterly risk review of contracted HCBS-AMH Provider Agency and Recovery Management Entity's. HHSC is responsible for monitoring the performance of providers administering medications to the individual. HHSC enforces requirements through quarterly risk assessment and review of critical incidents. In the case of medication management, remediation plans involve communication and other technical assistance to HCBS-AMH

Provider Agency and Recovery Management Entity's about issues and trends identified through the quality process.

All monitoring/reviews of HCBS-AMH Provider Agencies and HCBS-AMH Recovery Management Entities are subject to possible generation a Plan of Improvement if deficiencies are identified by HHSC staff.

### **15300 Recovery Management Entity QM Activities**

Recovery Management Entities are specifically responsible for the following QM activities:

- Informing HHSC of concerns or known issues with HCBS-AMH Provider Agency and Recovery Management Entity's and the implementation of services identified in any individual's IRP; and
- Implementing QM operating practices for HCBS-AMH services and activities such as monitoring that the required contacts occur, modifying each IRP as necessary, and ensuring that the documentation generated by the RM provides evidence of compliance with requirements.

The Recovery Management Entity should extend the standard QM practices to services and activities that are carried out by the RM. HHSC and the Recovery Management Entity collaborate on identifying, developing, and implementing utilization management, quality assurance & improvement activities specific to the HCBS-AMH Program.

### **15400 HCBS-AMH Provider Agency QM Activities**

HHSC performs QM oversight of the HCBS-AMH Provider Agency and Recovery Management Entity Agencies through encounter data reporting and regular desk and on-site reviews. HCBS-AMH Provider Agency and Recovery Management Entity allow HHSC access to records related to HCBS-AMH services. HCBS-AMH Provider Agency and Recovery Management Entity must participate in Quality Improvement activities as identified by HHSC.

The HCBS-AMH Provider Agency is specifically responsible for the following QM activities:

- Informing HHSC of concerns or known issues with HCBS-AMH Provider Agency and Recovery Management Entity and the implementation of services identified in any individual's IRP;
- Implementing QM operating practices for HCBS-AMH services and activities such as monitoring that the documentation generated by the provider provides evidence of compliance with requirements.

HHSC and the HCBS-AMH Provider Agency collaborate on identifying, developing, and implementing utilization management, quality assurance & improvement activities specific to the HCBS-AMH Program.

## **16000 Health and Safety**

### **16100 Suicide Prevention and Intervention Protocol**

Information on policies and procedures associated with suicide prevention/ intervention as well as information on available trainings can be accessed at <http://www.texasuicideprevention.org/>. For additional information on training requirements for suicide prevention and intervention (See Appendix A: Training Requirements).

## **16200 Use of Restrictive Interventions**

HCBS-AMH Provider Agency and Recovery Management Entity shall comply with TAC Chapter 415, Subchapter F. regarding Interventions in Mental Health Services. Per TAC §415.254, except as provided by this subchapter, the use of restraint or seclusion is prohibited during the course of the delivery of HCBS-AMH services. TAC §415.253 defines restraint as, “The use of any personal restraint or mechanical restraint that immobilizes or reduces the ability of the individual to move his or her arms, legs, body, or head freely.” Restraint is used only as last resort after less restrictive measures have been found to be ineffective or are judged unlikely to protect the individual or others from harm. The intervention is used for the shortest period possible and terminated as soon as the individual demonstrates the release behaviors specified by the ordering physician.

Individuals must provide informed consent regarding the potential use of restrictive intervention. This potential must be included on the individual’s safety plan and modification section of the IRP. This includes understanding of their rights, how to report abuse, neglect, and exploitation (See 7250 Deviations from Service Standards and 7200 IRP Requirements).

Direct staff shall:

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

The use of restrictive interventions (personal restraint) is permissible on the provider’s property or for transportation of an individual only if implemented:

- In accordance with state law regarding interventions in mental health services TAC Chapter 415, Subchapter F, regarding Interventions in Mental Health Services
- When less restrictive interventions (such as those listed in the safety plan if there is one) are determined ineffective to protect other individuals, the individual, staff members, or others from harm;
- In accordance with, and using only those safe and appropriate techniques as determined by the provider’s written policies or procedures and training program;
- In connection with applicable evaluation and monitoring;
- In accordance with any alternative strategies and special considerations documented in the IRP;
- When the type or technique of restrictive intervention used is the least restrictive intervention that are effective to protect the other individuals, the individual, staff members, or others from harm; and
- Is discontinued at the earliest possible time.

The HCBS-AMH Provider Agency and Recovery Management Entity must take into consideration information that could contraindicate or otherwise affect the use of personal restraint, including information obtained during the UA or intake. This information includes, but is not limited to:

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

An individual held in restraint shall be under continuous direct observation. The HCBS-AMH Provider Agency and Recovery Management Entity 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.

### **16210 Documentation and Reporting of Restrictive Interventions**

The use of personal restraint must be documented as a critical incident by the HCBS-AMH Provider Agency and Recovery Management Entity and follow the procedures for Critical Incident Reporting. Unauthorized use of restrictive interventions are detected by record review and through complaints.

The HCBS-AMH Provider Agency and Recovery Management Entity shall record the following information in the clinical record within 24 hours:

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

The LAR must be notified each time restraint is used according to the following:

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

The RM shall review convene the individual's PCRP team and document alternative strategies for dealing with behaviors in each of the following circumstances and update the IRP and safety plan accordingly:

- In any case in which behaviors have necessitated the use of restrictive interventions for the same individual more than two times during any 30-day period; and

- When two or more separate episodes of restrictive interventions of any duration have occurred within the same 12 hour period.

HHSC is responsible for overseeing the use of restrictive interventions, including the use of personal restraints, with individuals enrolled in HCBS-AMH.

The use of restrictive interventions are reported as critical incidents and managed as part of the contract oversight process by HHSC.

HHSC's oversight of the use of personal restraints by HCBS-AMH Provider Agency and Recovery Management Entity is accomplished through annual risk assessment conducted by HHSC. Unauthorized use of restraint is detected by record review, site reviews, and through complaints.

### **16220 Prohibited Restrictive Interventions**

The use of chemical restraints and mechanical restraints are prohibited by HCBS-AMH Comprehensive Provider. The use of seclusion is prohibited. The use of personal restraints are prohibited except in a behavioral health emergency.

Other forms of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ other aversive methods to modify behavior are not allowable.

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

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

Restrictive interventions shall not be used:

- As a means of discipline, retaliation, punishment, or coercion;
- For the purpose of convenience of staff members or other individuals;
- 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 individual or imminent physical harm to another, and less restrictive methods have been tried and failed.

HCBS-AMH Provider Agency and Recovery Management Entity shall not use more force than is necessary to prevent imminent harm and shall ensure the safety, well-being, and dignity of individuals who are personally restrained, including attention for personal needs.

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

- Obstructs the individual's airway, including a procedure that places anything in, on, or over the individual's mouth or nose;
- Impairs the individual's breathing, including applying pressure to the individual's torso or neck;
- Restricts circulation;

- Secures an individual to a stationary object while the individual is in a standing position;
- Causes pain to restrict an individual's movement (pressure points or joint locks);
- Inhibits, reduces, or hinders the individual's ability to communicate;
- Are protective or supportive devices that are not easily removable by the individual without assistance;
- Is a protective or supportive device that is not easily removable by the individual without a staff member's assistance; and
- Functions as a protective device for wound healing, after a wound has healed.

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

### **16230 Training Requirements Regarding Restrictive Interventions**

HCBS-AMH Comprehensive Providers and Recovery Management Entities shall ensure that direct service members are informed of their roles and responsibilities and are trained and demonstrate competence accordingly.

The training program shall:

- Target the specific needs of the HCBS-AMH 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, which shall include evaluation to ensure that the training program, as planned and as 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 individuals 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 job duties involving direct care responsibilities, and at least annually thereafter, direct service staff must receive training and demonstrate competence in at least the following knowledge and applied skills that shall be specific and appropriate to the target population of HCBS-AMH:

- The use of restraint, including how to perform the restraint;
- Identifying the causes of aggressive or threatening behaviors of individuals who need mental health services, including behavior that may be related to an individual's non-psychiatric medical condition;
- Identifying underlying cognitive functioning and medical, physical, and emotional conditions;
- Identifying medications and their potential effects;
- Identifying how age, weight, cognitive functioning, developmental level or functioning, gender, culture, ethnicity, and elements of trauma-informed care, including history of abuse or trauma and prior experience with restraint or seclusion, may influence behavioral emergencies and affect the individual's response to physical contact and behavioral interventions;
- Explaining how the psychological consequences of restraint or seclusion and the behavior of staff members can affect an individual's behavior, and how the behavior of individuals can affect a staff member;

- Applying knowledge and effective use of communication strategies and a range of early intervention, de-escalation, mediation, problem-solving, and other non-physical interventions, such as clinical timeout and quiet time; and
- Recognizing and appropriately responding to signs of physical distress in individuals who are restrained or secluded, including the risks of asphyxiation, aspiration, and trauma.

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

- Safe and appropriate initiation and use of restraint as a last resort in a behavioral emergency;
- Safe and appropriate initiation and application, and use of personal restraint as a last resort in a behavioral emergency; 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, a registered nurse or a physician assistant who is authorized to:

- Perform assessments of individuals who are in restraint shall receive training, which shall include a demonstration of competence in:
  - monitoring cardiac and respiratory status and interpreting their relevance to the physical safety of the individual 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 individuals 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 an individual for an emergency medical condition.
- Conduct evaluations of individuals, including face-to-face evaluations pursuant to §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 a registered nurse, individuals during restraint shall receive training, which shall include a demonstration of competence in:

- Monitoring respiratory status;
- Recognizing nutritional and hydration needs;
- Checking circulation in, and range of motion of, the extremities;

- Providing for hygiene and elimination;
- Addressing physical and psychological status and comfort, including signs of distress;
- Assisting individuals in de-escalating, including through identification and removal of stimuli, if known.
- Recognizing when continuation of restraint is no longer justified by a behavioral emergency;
- Recognizing when to contact a registered nurse; and
- See Appendix A: Training Requirements and Resources.

## **16300 Medication Safety and Management**

### **16310 Medication Management General Standards**

HCBS-AMH Comprehensive Provider must adhere to the TAC Chapter 415, Subchapter A in the provision of medication management. HCBS-AMH Comprehensive Provider are responsible for monitoring participant medication regimens, for individuals enrolled in HCBS-AMH who cannot self-administer and/or require oversight of self-administration of medications. (See 7250 Deviations from Service Standards).

- At least annually, The HCBS-AMH Provider Agency must assure that staff administering medications be qualified under their scope of practice.
- HCBS-AMH Provider Agency must comply with TAC Title 22, Chapter 225 when delegating nursing tasks to unlicensed caregivers.
- The HCBS-AMH Provider Agency must assure that staff delegated the authority to administer medications or oversight of individuals who self-administer medications receive instruction in medication administration and monitoring from a practitioner with delegation authority. Staff delegated to administer medications are trained and have knowledge of each medication, what is prescribed for, and the adverse reactions side effects before assuming their duties and as indicated by changes in the client's condition or medication regimen.
- The HCBS-AMH Provider Agency must monitor staff that have been delegated authority to administer medications or oversight of individuals who self-administer medications.
- If applicable, the LAR must sign an authorization for the HCBS-AMH Provider Agency to administer each medication according to label directions.
- The medication must be in the original container labeled with the expiration date and the individual's full name.
- The HCBS-AMH Provider Agency must administer the medication according to the label directions or as amended by a physician.
- The HCBS-AMH must administer the medication only to the individual for whom it is intended.
- The HCBS-AMH Provider Agency must not administer the medication after its expiration date.
- If applicable, the HCBS-AMH Provider Agency may provide non-prescription medications if the HCBS-AMH Provider Agency obtains LAR consent prior to administration of the medication. Consent may be given over the phone and documented as such by the HCBS-AMH Comprehensive Provider.
- At least quarterly, or more frequently if indicated by the individual's condition, medication regimen or changes to the regimen, HCBS-AMH Comprehensive Providers shall review medication administration records to ensure that medications are correctly administered.

### **16320 Self-Administration of Medications**

If the individual requires supervision for self-administration of medications, the HCBS-AMH direct service staff must ensure:

- If applicable, the LAR has signed an authorization for the individual to self-administer each medication according to label directions;
- The medication must be in the original container labeled with the individual's full name and expiration date;
- The individual administers the medication in amounts according to the label directions or as amended by a physician;
- The individual must administer the medication only to him or herself;
- The individual must not administer the medication after its expiration date; and
- If applicable, the individual may provide self-administration of non-prescription medications if the HCBS-AMH Provider Agency obtains consent from the LAR prior to the self-administration of the medication. Consent may be given over the phone and documented as such by the HCBS-AMH Comprehensive Provider.

### **16330 Medication Errors**

Any errors must be reported to HHSC as critical incidents, and a Critical Incident Reporting Form (See <http://www.dshs.state.tx.us/mhsa/hcbs-amh/Forms.aspx> for access to this form) must be completed and emailed to the HHSC HCBS-AMH within 72 hours of notification of the incident.

The HCBS-AMH Provider Agency direct service staff that is responsible for medication administration are required to both record and report medication errors to HHSC. Medication errors that occur, the HCBS-AMH Comprehensive Providers are required to record are as follows:

- 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.

### **16340 Required Medication Documentation**

All medication records must be kept for three months after administering the medication. All medication must be documented upon entry into HCBS-AMH on the Perpetual Medication Record and ongoing on the individual's Medication Administration Record (MAR).

The HCBS-AMH Provider Agency must document the following on the Perpetual Medication Record upon the individual's enrollment into HCBS-AMH:

- Full name of the individual to whom the medication was given;
- Name of the medication and quantity; and
- Direct service staff obtaining information

The HCBS-AMH Provider Agency 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 individual to whom the medication was given;

- Name of the medication;
- Date, time, and amount of medication given;
- Full name of direct service staff administering the medication; and
- Outcome of medication administration (i.e. individual refused or medication discontinued)

### **16350 Storing Medications**

If the HCBS-AMH Provider Agency is responsible to store the individual's medications, the provider must store medications as follows:

- Out of reach of children or 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 individual's home if authorized by the individual and/or LAR, including pill packs properly labeled in advance by the client or pharmacy and pharmacy-labeled pill bottles.

Prescribed medications must be inventoried by nursing/designated staff upon receipt from the pharmacy or the client. Medications held at the site for the individual to access (such as pillboxes) or for staff to transport to the individual's home, must be inventoried and kept locked.

### **16360 Destruction of Medication and Empty Prescription Bottles**

If the HCBS-AMH Provider Agency is responsible to store the individual's medications, the provider must abide by TAC, Title 22, and Rule 303.1 regarding destruction of medication.

Empty bottles contain protected health information and must be disposed of appropriately.

## **17000 Consumer Rights**

Individuals shall be notified of his/her rights prior to enrollment into the HCBS-AMH Program. This shall be verified through completion of the Notification of Participant Rights Form.

This Notification of Participant Rights Form:

- Informs the individual of the contact information for HHSC Office of Consumer Services and Rights Protection, DFPS, and the Office of the Ombudsman;
- Informs the individual of his/her right to a Fair Hearing regarding the HCBS-AMH Program; and
- Informs the individual of the process for reporting allegations of ANE and the toll free number for DFPS.

The HCBS-AMH Provider Agency and Recovery Management Entity must also give this information to the individual and LAR when requested, and when a need is identified or thought to exist.

The name, telephone number, and mailing address of the HCBS-AMH Provider Agency and Recovery Management Entity's rights protection officer must be prominently posted in every area that is frequented by HCBS-AMH participants. Individuals desiring to contact the rights protection officer must be allowed access to the HCBS-AMH Provider Agency and Recovery Management Entity's telephones to do so.

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 is documented on the Notification of Participant Rights Form bearing the date and signatures of the individual enrolled in HCBS-AMH and/or LAR and the staff person who explained the rights. The Notification of Participant Rights Form is filed in the individual's clinical record.

### **17100 Medicaid Fair Hearing**

The HCBS-AMH Provider Agency must implement procedures to give notice of the right to a timely and objective appeal process for all individuals receiving HCBS-AMH services. For individuals eligible for Medicaid, HCBS-AMH Comprehensive Providers must implement procedures that provide notice of the right to request a fair hearing, as described in TAC Title 1, Chapter 357, Subchapter A (relating to Uniform Fair Hearing Rules), to an individual whose service or benefits are denied, reduced, suspended, or terminated. The procedures regarding notice of the right to a Medicaid fair hearing must comply with HHSC policy, which may be included in contract provisions.

The Determination Letter informs the individual of the right to continue to receive services while the Medicaid Fair Hearing is pending and the actions the individual must take for services to continue. When HHSC receives a request for a fair hearing, HHSC notifies the HCBS-AMH Provider Agency of such request and the date that the request was received. HCBS-AMH Provider Agency shall review the basis of its decision to deny, terminate, reduce, or suspend services. The HCBS-AMH Provider Agency shall continue services until the hearing officer makes a final decision.

The RM shall assist the individual with the fair hearing process if needed, including the preparation and submission of documentation.

### **17110 Conditions for Requesting a Fair Hearing**

The conditions under which the individual may request a Fair Hearing include, but are not limited to:

- An individual is denied participation in the HCBS-AMH Program;
- An individual is denied continued participation in the HCBS-AMH Program;
- An individual's HCBS-AMH Program services are denied, reduced, suspended, or terminated; or
- The individual's request for eligibility for the HCBS-AMH Program is not acted upon with reasonable promptness.

### **17120 Requirements for Notification**

The individual is informed of the right to a fair hearing during enrollment through the Notification of Participant Rights Form (See <http://www.dshs.state.tx.us/mhsa/hcbs-amh/Forms.aspx> for access to this form). Additional notifications occur for any reduction, termination, suspension or denial of a service.

The following requirements for notification requirements apply:

- The individual may elect to receive notifications electronically;
- The individual's election to receive notices electronically shall be confirmed by regular mail;
- The individual shall be informed of his or her right to change such election to receive notices through regular mail;
- Notices shall be posted to the individual's electronic account within 1 business day of notice generation;
- Email or other electronic communication alerting the individual that a notice has been posted to his or her account shall be sent. Confidential information shall not be included in the email or electronic alert;
- Notice shall be sent by regular mail within three business days of the date of a failed electronic communication if an electronic communication is undeliverable; and
- Any notice posted to the individual's electronic account shall be provided through regular mail, at the individual's request.

### **17130 Fair Hearing Process**

#### **17131 Requesting a 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 a Fair Hearing must be made to the HHSC Office of Consumer Services and Rights Protection. An authorized representative of the appellant may make the request for a Fair Hearing by completing the steps outlined in the Determination Letter or by calling the Office of Consumer Services and Rights Protection.

Once an appeal is filed, only the appellant or the appellant's representative may withdraw the request. The appellant must make the request in writing to the hearings officer or the local office and give the reason for requesting to withdraw.

#### **Contact Information:**

**Texas Health and Human Services Commission (HHSC)  
Office of Consumer Services and Rights Protection  
Mail Code 2018  
8317 Cross Park, Suite 175  
Austin, TX 78754**

**Toll Free Number: 1-800-252-8154  
Local Number: 512-206-5760  
Relay Texas, Voice: 1-800-735-2988  
Relate Texas, TTY: 1-800-735-2989**

#### **17132 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 must 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 individual of his/her right to continue to receive services while the hearing is pending and the actions the individual must take for services to continue.

### **17133 Notification of Fair Hearing**

The HHSC Office of Consumer Services and Rights Protection receive and enter the formal request for a Fair Hearing into the TIERS database, and HHSC provides notification of a scheduled hearing date no less than fourteen days prior to the Fair Hearing.

### **17134 Decision by Fair Hearing's Officer**

A decision by the Fair Hearing's officer must be made by 90 days from the date the appeal request is received. All Fair Hearings are conducted according to the rules in TAC, Title 1, Chapter 357, Subchapter A (relating to Uniform Fair Hearing Rules).

## **17200 Complaints**

### **17210 HCBS-AMH Provider Agency and Recovery Management Entity Policy**

HCBS-AMH Provider Agency and Recovery Management Entities shall be responsible for implementing a procedure which ensures the reporting of a complaint against an agency or its personnel by a member or interested party.

HCBS-AMH Provider Agency and Recovery Management Entity shall ensure availability of their policies and procedures to staff, individuals, LAR or family members or any other interested parties. HCBS-AMH Provider Agency and Recovery Management Entity policies and procedures may be subject to review by HHSC.

### **17220 HHSC Consumer Services and Rights Protection Unit**

HHSC Consumer Services and Rights Protection Unit staff operates a toll free phone line with TTY (telecommunication device for the deaf) capabilities from 8:00am – 5:00pm Monday - Friday.

Complaints can also be submitted via email or written correspondence.

- Complaints may be anonymous.
- There is no restriction on the types of complaints that individuals enrolled in HCBS-AMH may register.
- All complaints are acted upon immediately. Given the variety of complaints, there is no mandated time line for resolution to the complaint.
- Consumer Rights and Protection Staff have access to all departments and units to resolve the individual's complaint.

### **Contact Information:**

**Texas Health and Human Services Commission (HHSC)**

**Office of Consumer Services and Rights Protection**

**Mail Code 2018**

**8317 Cross Park, Suite 175**

**Austin, TX 78754**

**Toll Free Number: 1-800-252-8154**  
**Local Number: 512-206-5760**  
**Relay Texas, Voice: 1-800-735-2988**  
**Relate Texas, TTY: 1-800-735-2989**

### **17230 Complaints involving allegations of Abuse, Neglect and Exploitation**

Complaints involving allegations of Abuse, Neglect and Exploitation are referred immediately to the Department of Family and Protective Services (DFPS) the department with statutory responsibility for investigation of such allegations. (See 13540 Abuse, Neglect, and Exploitation (ANE)).

### **17240 HHSC's Office of the Ombudsman**

When HHSC's complaint process cannot or does not satisfactorily resolve an issue, individuals have the option of contacting the Office of the Ombudsman directly. The Ombudsman'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 individuals are treated fairly, respectfully and with dignity; and
- Making referrals to other agencies as appropriate.

The process to assist with complaints and issues is as follows:

1. Member of the public, individual, or provider makes first contact with HHSC or with HHSC to request assistance with an issue or complaint.
2. If not able to resolve the issue or complaint, the Office of the Ombudsman may be contacted.
3. The Office of the Ombudsman provides an impartial review of actions taken by the program or department.
4. 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.

#### **Contact Information:**

**Texas Health and Human Services Commission**  
**Office of the Ombudsman**  
**Mail Code: H-700**  
**P. O. Box 85200**  
**Austin, TX 78708**

**Phone: 877-787-8999**  
**Fax: 512-706-7130 (not toll free)**  
**E-mail: [contact@hhsc.state.tx.us](mailto:contact@hhsc.state.tx.us)**

## **17300 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.

**Note:** Texas law allows an option for a person'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 Recovery Management Entity may utilize the following forms:

### **17310 Declaration for Mental Health Treatment**

The Declaration for Mental Health Treatment is a legal document which 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 this declaration are followed only if a court believes that the individual is incapacitated to make treatment decisions. Otherwise, the individual is considered able to give or withhold consent for the treatments.

### **17320 Directives to Physicians, Family or Surrogates**

Directive to Physicians, Family or Surrogates communicates an individual's wishes about medical treatment at some time in the future when they are unable to make their wishes known because of illness or injury.

### **17330 Medical Power of Attorney**

Medical Power of Attorney is a legal document gives an agent the authority to make any and all health care decisions for an individual in accordance with their wishes, including their religious and moral beliefs, when they are no longer capable of making those decisions.

### **17340 Out-of-Hospital Do Not Resuscitate**

This legal document instructs emergency medical personnel and other health care professionals to forgo resuscitation attempts. This order does **NOT** affect the provision of other emergency care including comfort care and is not applicable once an individual is in a hospital.

### **17350 Statutory Durable Power of Attorney**

Statutory Durable Power of Attorney is a legal form is for designating an agent who is empowered to take certain actions regarding an individual's property. It does not authorize anyone to make medical and other healthcare decisions for an individual.

These forms are available at:

[http://www.dads.state.tx.us/news\\_info/publications/handbooks/advancedirectives.html](http://www.dads.state.tx.us/news_info/publications/handbooks/advancedirectives.html)

## **18000 Clinical Management for Behavioral Health Services**

### **(CMBHS)**

The HCBS-AMH Provider Agency and Recovery Management Entity shall utilize CMBHS to submit IRPs and claims when CMBHS is made available. HHSC or an independent qualified agent shall utilize CMBHS to process UAs and authorize IRPs. When CMBHS has the capacity to support these functions, submission of information is as otherwise outlined by HHSC.

CMBHS shall be used to meet the following standards:

1. Verification of the individual's enrollment status;
2. Verification of the provision of HCBS-AMH services;
3. Authorization of the IRP;
4. Complete and accurate upload and entry of all data elements required by the Department in a timely manner;
5. Verification when service delivery begins and when and where the delivery is completed each time services are delivered to an individual. This is to be completed in a manner prescribed by the Department; and
6. When requested by the Department, service delivery documentation is immediately available for review.

## **19000 Managing Conflicts of Interest**

### **19100 Conflict of Interest Standards**

#### **19110 Standards**

The HCBS-AMH Provider Agency and Recovery Management Entity shall establish clear and easily accessible means for individuals 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.

HCBS-AMH Provider Agencies and Recovery Management Entities shall be transparent in their communications about agency decisions that directly affect the interests of the individual, including the process and criteria for the selection of subcontracted HCBS-AMH service providers.

The HCBS-AMH Provider Agency and Recovery Management Entity shall regularly review relationships and agreements with direct service providers and/or RMs to ensure they are in keeping with prevailing laws, agency policies, professional standards and the best interests of the individuals they serve.

RMs and providers of the HCBS-AMH services, except a Host Home/Companion Care provider (See 9205 Host Home/Companion Care), shall not be related by blood or marriage to the individual; to any of the individual's paid caregivers; or to anyone financially responsible for the individual or empowered to make financial or health-related decisions on the individual's behalf.

Agencies that are both a Recovery Management Entity and an HCBS-AMH Provider Agency must have a clear administrative firewall that separates the two service entities. For example, supervision or administrative oversight of HCBS-AMH Provider Agency or subcontractors by any HCBS-AMH RM staff is not allowed.. As such, supervision or administrative oversight of HCBS-AMH RM staff by HCBS-AMH Provider Agency or subcontractors is also not allowed. (See 19200 Administrative Firewall for Providers of Last Resort).

### **19120 Ensuring Individual Choice**

The individual, LAR, and PCRPs participants shall be presented with options of Recovery Management Entities and HCBS-AMH Provider Agencies available in the individual's community of choice. Additionally, during IRP meetings the individual verifies if they wish to continue being assisted by their current RM and provider, or if they wish to choose an alternative.

The opportunity to choose among all qualified HCBS-AMH Provider Agency and Recovery Management Entity is documented on the HCBS-AMH Provider Agency and Recovery Management Entity Selection Form. The selection of the HCBS-AMH Provider Agency and Recovery Management Entity is documented in the IRP Form in addition to the HCBS-AMH Provider Agency and Recovery Management Entity Selection Form.

Additional documentation may be required if the selected HCBS-AMH is also providing Recovery Management Services to that individual (See 19200 Administrative Firewall for Providers of Last Resort).

### **19121 Overview of Recovery Management Entities**

The overview of Recovery Management Entities provided by HHSC or referring entity to the individual shall include the following information:

- How long the provider has been in business; and
- Location of provider; and
- Specialization of services

### **19122 Overview of HCBS-AMH Provider Agencies**

The overview of Comprehensive Providers provided by HHSC or referring entity to the individual shall include but is not limited to the following information:

- How long the provider has been in business;
- Location of provider; and
- Specialization of services

## **19200 Administrative Firewall for Providers of Last Resort**

### **19210 Agency Roles and Responsibilities**

Agencies providing both Recovery Management and all other HCBS-AMH services to the same individual must establish administrative separation between direct service staff providing recovery management and direct service staff delivering HCBS-AMH Comprehensive Services on the IRP other than Recovery Management.

These agencies shall have separate administrative structures which provide oversight over direct service staff providing recovery management and direct service staff providing all other HCBS-AMH services.

This separate administrative structure should ensure that recovery management decisions are be subject to influence or revision by those providing or administering other HCBS-AMH services.

### **19220 Agency Policies**

Agencies providing both Recovery Management and all other HCBS-AMH services have clear agency policies that provide an additional layer of protection regarding conflict of interest. These policies outline staff's fiscal and ethical responsibilities with regard to the interests of the agency and the individuals served. These policies should include a process for disclosing conflicts to HHSC, and a process for reviewing and acting upon those disclosures within seven business days.

This includes but is not limited to:

- 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 HCBS-AMH Provider Agency is also providing Recovery Management Services to the same individual. This includes documentation that the RM is not rewarded or penalized based on amount of services listed on an IRP.**

## **20000 Non-Duplication of Services**

HCBS-AMH Medicaid participants are enrolled in Medicaid managed care and are eligible to receive traditional state plan services in addition to HCBS-AMH services.

Because of this, duplication of services can occur. This service duplication happens when an HCBS-AMH participant receives similar services from two different programs (i.e. Adult Mental Health and HCBS-AMH) at the same time.

### **20100 RM's Role in Non-Duplication of Medicaid Services**

The RM is required to identify the potential for service duplication and to prevent the occurrence of duplication. The RM is required to coordinate care, including the development of an IRP, with the participant's MCO Service Coordinator and any additional providers designated by HHSC to ensure comprehensive, coordinated, unduplicated services.

The RM certifies that the individual has exhausted all applicable state plan resources before the following HCBS-AMH services are submitted on the IRP:

- Adaptive Aids
- Non-Medical Transportation
- Peer Support
- Substance Use Disorder Services (unless clinically indicated)

Note: If the assessment indicates the HCBS-AMH participant needs an HCBS-AMH service in lieu of the state plan services, it must be documented on the IRP.

Additionally, the RM must ensure that HCBS-AMH Psychosocial Rehabilitation is 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.

## **20200 RM's Role in Non-Duplication of Services for HCBS-AMH Individuals 18-21**

HCBS-AMH Medicaid individuals under age 21 will be enrolled in STAR Kids or STAR Health (for foster children).

- STAR Kids is tailored to the needs of youth with disabilities. The program provides 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 Department of Family and Protective Services (DFPS) conservatorship and young adults in DFPS paid placement.

Through STAR Kids and STAR Health, individuals have access to traditional state plan services and additional benefits which maybe duplicative of HCBS-AMH services.

To avoid duplication of services, for HCBS-AMH participants under 21 years of age in DFPS conservatorship (foster children), RMs ensure that 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 (Note: If the individual is in a Foster Care Residential Placement, the individual may remain in their placement and receive HCBS-AMH services; and
- Respite

Additionally, the RM certifies that the individual 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 (EPSDT)

Note: If the assessment indicates the HCBS-AMH participant needs an HCBS-AMH service in lieu of the state plan services, it must be documented on the IRP.

See the RM Handbook and the Non-Duplication Checklist located at <https://www.dshs.state.tx.us/mhsa/hcbs-amh/recoverymanager/> for additional information on non-duplication of services.

## **Appendix A: Training Requirements and Resources**

The HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity must 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 individuals to whom they deliver services and are knowledgeable of acts that constitute abuse, neglect, or exploitation of an individual and methods to prevent the occurrence of abuse, neglect, and exploitation.

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

All direct service staff shall be trained on program philosophy, policies and procedures, including identifying, preventing, and reporting of critical incidents and ANE.

All direct service staff shall be trained in the safe use of personal restraint, if applicable.

The HCBS-AMH Provider Agency and Recovery Management Entity hire direct service staff that meet or exceed the minimum skills and training required to provide the assigned HCBS-AMH service and to meet the primary objective of protecting and promoting the health, safety and well-being of individuals.

The HCBS-AMH Provider Agency and Recovery Management Entity may identify Training and Technical Assistance needs to HHSC at any time by contacting the HCBS-AMH staff. The HCBS-AMH Provider Agency and Recovery Management Entity or HHSC may identify issues and suggest potential remedies.

All HCBS-AMH Provider Agency and Recovery Management Entity direct service staff attend and satisfactorily complete the relevant HCBS-AMH specific training prior to the provision of HCBS-AMH services or within designated timeframe. HCBS-AMH Provider Agency and Recovery Management Entity must maintain training documentation in personnel files.

| <b>Service</b>        | <b>Required</b>  | <b>Recommended</b>  |
|-----------------------|--|---|
| Supported Home Living | <ul style="list-style-type: none"> <li>• Restrictive Interventions -prior to service provision</li> <li>• Opioid Overdose Prevention — prior to service provision</li> <li>• Ask About Suicide (ASK) -prior to provision of services</li> <li>• Co-Occurring Psychiatric and Substance Use Disorder (COPSD)- prior to service provision</li> </ul> | <ul style="list-style-type: none"> <li>• Person-Centered Recovery Planning (online modules only)</li> <li>• Harm Reduction</li> <li>• Motivational Interviewing I and II</li> </ul> |
| Assisted Living       | <ul style="list-style-type: none"> <li>• Restrictive Interventions -prior to service provision</li> <li>• Opioid Overdose Prevention – prior to service provision</li> </ul>   | <ul style="list-style-type: none"> <li>• Person-Centered Recovery Planning (online modules only)</li> <li>• Harm Reduction</li> </ul>   |

|  |   |   |
|--|---|---|
|  | <ul style="list-style-type: none"> <li>• Ask About Suicide (ASK) - prior to provision of services</li> <li>• Co-Occurring Psychiatric and Substance Use Disorder (COPSD)- prior to service provision</li> </ul>   | <ul style="list-style-type: none"> <li>• Motivational Interviewing I and II</li> </ul>  |
| Supervised Living Services                   | <ul style="list-style-type: none"> <li>• Restrictive Interventions-prior to service provision</li> <li>• Opioid Overdose Prevention – prior to service provision</li> <li>• Ask About Suicide (ASK)-prior to service provision</li> <li>• Co-Occurring Psychiatric and Substance Use Disorder (COPSD)- prior to service provision</li> </ul>  | <ul style="list-style-type: none"> <li>• Person-Centered Recovery Planning (online modules only)</li> <li>• Harm Reduction</li> <li>• Motivational Interviewing I and II</li> </ul>   |
| Host-Home/Companion Care                     | <ul style="list-style-type: none"> <li>• Restrictive Interventions - prior to service provision</li> <li>• Opioid Overdose Prevention– prior to service provision</li> <li>• Ask About Suicide (ASK) - prior to service provision</li> <li>• Co-Occurring Psychiatric and Substance Use Disorder (COPSD)- prior to service provision</li> </ul>   | <ul style="list-style-type: none"> <li>• Person-Centered Recovery Planning</li> <li>• Harm Reduction</li> <li>• Motivational Interviewing I and II</li> </ul>   |
| Community Psychiatric Supports and Treatment | <ul style="list-style-type: none"> <li>• Harm Reduction – within three months of service provision</li> <li>• Restrictive Interventions -prior to service provision</li> <li>• Person-Centered Recovery Planning (online modules) –prior to service provision</li> <li>• Ask About Suicide (ASK)-prior to service provision</li> <li>• Competency in at least one of the following. Initial training must be completed prior to service provision. Competency must be obtained within one year of service provision): <ul style="list-style-type: none"> <li>○ Cognitive Behavioral Therapy</li> <li>○ Dialectical Behavior Therapy (DBT)</li> <li>○ Cognitive Behavioral Therapy for Psychosis (CBTp)</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>• Cognitive Processing Therapy;</li> <li>• Motivational Interviewing I and II;</li> <li>• Illness Management Recovery</li> <li>• Seeking Safety</li> <li>• Cognitive Behavioral Therapy for Psychosis (CBTp) (if provider already holds a competency in DBT or CBT)</li> </ul> |

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| Employment Services             | <ul style="list-style-type: none"> <li>• Individual Placement and Support (Supported Employment) – prior to service provision</li> <li>• Restrictive Interventions - prior to service provision</li> <li>• Person-Centered Recovery Planning (online modules) - prior to service provision</li> </ul>  | <ul style="list-style-type: none"> <li>• Motivational Interviewing I and II</li> </ul>  |
| Substance Use Disorder Services | <ul style="list-style-type: none"> <li>• Required training for the provision of any EBP (See Section 9215 Substance Use Disorder Services)</li> <li>• Harm Reduction – within three months of service provision;</li> <li>• Motivational Interviewing – Motivational Interviewing I completed within three months of service provision. Motivational Interviewing II and III completed within one year of service provision.</li> <li>• Restrictive Interventions</li> <li>• Person-Centered Recovery Planning (online modules) – prior to service provision</li> <li>• Co-Occurring Psychiatric and Substance Use Disorder (COPSD)- prior to service provision</li> <li>• Opioid Overdose Prevention- prior to the provision of services</li> </ul> | <ul style="list-style-type: none"> <li>• Illness Management Recovery</li> <li>• Seeking Safety – w</li> <li>• Cognitive Processing Therapy Cognitive Behavioral Therapy for Psychosis (CBTp) –</li> </ul> |
| Peer Support                    | <ul style="list-style-type: none"> <li>• Peer Support Specialist Certification – prior to service provision</li> <li>• Restrictive Interventions – prior to service provision</li> <li>• Person-Centered Recovery Planning (online modules) – prior to service provision</li> <li>• Opioid Overdose Prevention- prior to the provision of services</li> <li>• Ask About Suicide (ASK) - prior to provision of services</li> <li>• Co-Occurring Psychiatric and Substance Use Disorder (COPSD)- prior to service provision</li> </ul>   | <ul style="list-style-type: none"> <li>• Peer Specialist Whole Health and Resiliency</li> <li>• Advanced Peer Practices Illness Management Recovery</li> </ul>  |

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| Nursing                                   | <ul style="list-style-type: none"> <li>• Restrictive Interventions - prior to service provision</li> <li>• Person-Centered Recovery Planning (online modules) – prior to service provision</li> <li>• Opioid Overdose Prevention Training- prior to service provision</li> <li>• Co-Occurring Psychiatric and Substance Use Disorder (COPSD)- prior to service provision</li> </ul>   | <ul style="list-style-type: none"> <li>• Harm Reduction –</li> </ul>  |
| HCBS Psychosocial Rehabilitation Services | <ul style="list-style-type: none"> <li>• At least one of the following – prior to service provision (if provider does not already hold competency in an EBT): <ul style="list-style-type: none"> <li>○ Illness Management Recovery;</li> <li>○ Seeking Safety;</li> <li>○ Cognitive Adaptive Therapy</li> </ul> </li> <li>• Person-Centered Recovery Planning (online modules) – prior to service provision</li> <li>• Ask About Suicide (ASK)-prior to provision of services</li> </ul>  | <ul style="list-style-type: none"> <li>• Motivational Interviewing –</li> <li>• Harm Reduction</li> <li>• Illness Management and Recovery (if provider hold a certificate in EBT Illness in CAT or Seeking Safety)</li> </ul>   |
| Recovery Management                       | <ul style="list-style-type: none"> <li>• Person-Centered Recovery Planning (online modules) – prior to service provision</li> <li>• Person-Centered Recovery Planning (in person) – within 3 months of service provision</li> <li>• Supplemental Security Income (SSI) – prior to service provision</li> <li>• Restrictive Interventions -prior to service provision</li> <li>• Ask About Suicide (ASK)-prior to service provision</li> <li>• Opioid Overdose Prevention Training-prior to service provision</li> <li>• Co-Occurring Psychiatric and Substance Use Disorder (COPSD)- prior to service provision</li> <li>• Adult Needs and Strengths Assessment(ANSA)-prior to service provision</li> </ul> | <ul style="list-style-type: none"> <li>• Permanent Supportive Housing</li> <li>• Illness Management Recovery</li> <li>• Harm Reduction</li> <li>• Motivational Interviewing I and II</li> <li>• County Indigent Health Care Program Training Course</li> <li>• Certified Application Counselor Training (Required if the HCBS-AMH participant is utilizing the Health Exchange)</li> <li>• SOAR Training</li> </ul> |

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| Respite Care | <ul style="list-style-type: none"> <li>Restrictive Interventions -prior to service provision</li> </ul> | <ul style="list-style-type: none"> <li>Harm Reduction</li> </ul> |
|--------------|---|--|

Many of these trainings are available online or in person at Texas Centralized Training Infrastructure for Evidence Based Practices (CTI-EBP).

**The HCBS-AMH Provider Agency and HCBS-AMH Recovery Management Entity must pass the HCBS-AMH Open Enrollment Application desk and site review before accessing HCBS-AMH trainings located at the CTI.**

The trainings that are not available through the CTI-EBP can be accessed by other means. Some trainings are the responsibility of the contracted HCBS-AMH Provider Agency or HCBS-AMH Recovery Management Entity. HHSC reviews personnel records to verify completion of these trainings.

All required trainings must be completed within the time frames specified. The web-based trainings produce a certificate upon completion of the training which must be available in personnel records for review by HHSC at quarterly desk/annual site reviews. The need for training and technical assistance may be identified through results of HHSC HCBS-AMH Provider Agency and Recovery Management Entity monitoring, technical assistance contacts, and the use of quality indicators.

## Training Resources

| Training                                    | Description  | Resource  |
|---|--|---|
| Adult Needs and Strengths Assessment (ANSA) | ANSA training and annual certification.  | <a href="http://www.canstraining.com">www.canstraining.com</a>  |
| Ask About Suicide (ASK)                     | Suicide prevention training.   | <a href="http://www.texasuicideprevention.org/training/video-training-lessons-guides/">http://www.texasuicideprevention.org/training/video-training-lessons-guides/</a>                               |
| Cognitive Adaptive Training (CAT)           | Teaches in-home environmental supports to help individuals bypass problems in motivation and thinking in order to organize their home environments and live independently.               | <a href="https://tango.uthscsa.edu/cttesting/">https://tango.uthscsa.edu/cttesting/</a>   |
| Certified Application Counselor             | 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. | <a href="https://marketplace.cms.gov/technical-assistance-resources/training-materials/training.html">https://marketplace.cms.gov/technical-assistance-resources/training-materials/training.html</a> |
| Cognitive Behavioral Therapy (CBT)          | Reviews the core principles of CBT and how to implement CBT practices in service provision.  | <a href="https://tango.uthscsa.edu/cttesting/">https://tango.uthscsa.edu/cttesting/</a> .   |

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| Cognitive Behavioral Therapy for Psychosis (CBTp)               | Outlines how to utilize CBT when working with individuals diagnosed with psychosis-related disorders.  | <a href="https://tango.uthscsa.edu/cttesting/">https://tango.uthscsa.edu/cttesting/</a> .                                   |
| Co-Occurring Psychiatric And Substance Use Disorder (COPSD)     | Offers information on how to integrate mental health and substance use disorder services. The training stresses a multi-view point approach to recovery when working with individuals with co-occurring disorders.           | <a href="https://tango.uthscsa.edu/cttesting/">https://tango.uthscsa.edu/cttesting/</a>                                     |
| County Indigent Health Care Program Training Course (CIHCP)     | Educates providers on the services offered through the CIHCP and how to access these services for individuals.   | <a href="http://www.dshs.state.tx.us/cihcp">http://www.dshs.state.tx.us/cihcp</a>   |
| Dialectical Behavioral Therapy (DBT)                            | 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. | <a href="https://tango.uthscsa.edu/cttesting/">https://tango.uthscsa.edu/cttesting/</a>                                     |
| Harm Reduction  | Introduces the concept of harm reduction and explores how it is used in a broader framework when working with individuals diagnosed with a substance use disorder.   | <a href="https://tango.uthscsa.edu/cttesting/">https://tango.uthscsa.edu/cttesting/</a>                                     |
| Illness Management and Recovery (IMR)                           | Offers a variety of different information, strategies, and skills on IMR to help individuals make informed decisions in their treatment and become empowered in their own recovery.  | <a href="https://tango.uthscsa.edu/cttesting/">https://tango.uthscsa.edu/cttesting/</a>                                     |
| Individual Placement and Support (Supported Employment)         | Teaches providers how to support individuals with a diagnosis of SMI in obtaining supported employment and competitive employment.   | <a href="https://tango.uthscsa.edu/cttesting/">https://tango.uthscsa.edu/cttesting/</a>                                     |
| Motivational Interviewing                                       | Teaches the provider how to utilize motivational practices to help elicit change in the individual.  | <a href="https://tango.uthscsa.edu/cttesting/">https://tango.uthscsa.edu/cttesting/</a>                                     |
| Peer Support Specialist/Peer Specialist Advanced Practices/Peer | Peer providers, who are currently in recovery, who help educate participants on how to use their recovery story to aid other individuals in their own recovery journey.  | <a href="http://www.viahope.org/programs/training-certification">http://www.viahope.org/programs/training-certification</a> |

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| Specialist Whole Health and Resiliency         |   |  |
| Person Centered Recovery Planning (PCRP)       | Provides a comprehensive approach to assessment and services which empower individuals to be leaders in their own recovery.   | <a href="https://tango.uthscsa.edu/cttesting/">https://tango.uthscsa.edu/cttesting/</a>  |
| Permanent Supportive Housing                   | Outlines the essential components of supportive housing in working with individuals with mental illness.  | <a href="https://tango.uthscsa.edu/cttesting/">https://tango.uthscsa.edu/cttesting/</a>  |
| Opioid Overdose Prevention                     | Provides information on overdose prevention.  | This training is given through the provider entity. The materials for this training can be accessed at:<br><a href="http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2016/SMA16-4742">http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2016/SMA16-4742</a> . |
| Restrictive Interventions                      | Outlines the roles and responsibilities of providers in the use of restrictive interventions. Must be in compliance with the requirement of this section and 25 TAC Chapter 415 Subchapter F (See 16230 Training Requirements Regarding Restrictive Interventions). | This training is administered by the provider entity in accordance with TAC regulations.   |
| Seeking Safety                                 | Shows how to implement Seeking Safety therapy to help individuals who have Post Traumatic Stress Disorder (PTSD) and substance use.   | <a href="https://tango.uthscsa.edu/cttesting/">https://tango.uthscsa.edu/cttesting/</a>  |
| SSI/SSDI Outreach, Access, and Recovery (SOAR) | Educates providers on how to help individuals with a disability and at risk of homelessness to apply for SSA benefits.  | <a href="https://soarworks.prainc.com/course/ssissdi-outreach-access-and-recovery-soar-online-training">https://soarworks.prainc.com/course/ssissdi-outreach-access-and-recovery-soar-online-training</a>  |
| Social Security Income (SSI)                   | Outlines the SSA application process.   | <a href="https://tango.uthscsa.edu/cttesting/">https://tango.uthscsa.edu/cttesting/</a> .  |

## **Appendix B: Definition of Forms**

HCBS-AMH forms listed below can be accessed at <http://www.dshs.state.tx.us/mhsa/hcbs-amh/Forms.aspx>.

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| Appeals Form   | The Appeals Form is completed by an individual and/or LAR when requesting a fair hearing to appeal an agency action.   |
| Critical Incident Reporting Form                                       | The Critical Incident Reporting Form is used to report to any critical incidents as required by policy.  |
| Client Abuse and Neglect Report  | If the perpetrator or alleged perpetrator of ANE is an employee or agent of the HCBS-AMH Provider Agency or Recovery Management Entity, or the perpetrator is unknown, then the Administrator of the HCBS-AMH Provider Agency or Recovery Management Entity, or their designee shall ensure that a Client Abuse and Neglect Reporting form is completed.       |
| Crisis Plan Form   | A version of the Crisis Plan that is accessible to the individual and others as identified by the individual and/ or indicated on the crisis plan.   |
| Good Faith Effort Form   | The Good Faith Effort Form is completed by the HCBS-AMH Provider Agency and Recovery Management Entity and/or the RM when they are unable to serve an individual because of their inability to locate a necessary service that meets the individual's needs identified on the individual's Uniform Assessment that ensures their safety in the community.      |
| IRP Individual Recovery Form   | The template utilized by Recovery Management Entities to complete independent assessments of individuals referred to HCBS-AMH for services, initiating changes in services or discontinuing services.  |
| Notification of Participant's Rights                                   | Notifies the individual of his/her rights.   |
| Preauthorization Request Form  | The RM completes the preauthorization form to obtain approval from HHSC to provide recovery management services to an individual while they are dis-enrolling from another HCBS program into HCBS-AMH or when the RM is assisting an individual residing in a correctional facility or nursing facility successfully discharge and transition to the community |
| HCBS-AMH Provider Agency and Recovery Management Entity Selection Form | Documents the selection of the HCBS-AMH Recovery Management Entity and HCBS-AMH Provider Agency by the individual.   |
| Respite Relative Provider Form   | Used to document the provision of any respite services in which a relative is the direct service staff.  |
| Safety Plan Form   | A version of the Safety Plan that is accessible to the individual and others as identified by the individual and/or indicated on the safety plan.  |