



TO: Medical Care Advisory Committee
DATE: August 11, 2022
FROM: Dana Williamson
Director of Program Policy

SUBJECT: Home and Community-based Services Program

Agenda Item No.:

Repeal and New Rules: The proposal repeals §§9.151, 9.152, 9.154 - 9.170, 9.186, and 9.189 - 9.192 in Texas Administrative Code (TAC) Title 40, Part 1, Chapter 9, Subchapter D, relating to the Home and Community-based Services (HCS) Program and proposes new rules in 26 TAC Chapter 263, relating to Home and Community-based Services and Community First Choice (CFC) Services.

BACKGROUND: ☒ Federal Requirement ☒ Legislative Requirement ☐ Other:
(e.g., Program Initiative)

The Texas Health and Human Services Commission proposes the repeal of Sections 9.151, 9.152, 9.154 - 9.170, 9.186, and 9.189 - 9.192 in Texas Administrative Code (TAC) Title 40, Part 1, Chapter 9, Subchapter D, relating to the Home and Community-based Services (HCS) Program and proposes new rules in 26 TAC Chapter 263, relating to Home and Community-based Services (HCS) Program and Community First Choice (CFC).

The HCS Program is a Medicaid waiver program approved by the Centers for Medicare & Medicaid Services (CMS) under §1915(c) of the Social Security Act. This waiver program provides community-based services and supports to eligible individuals as an alternative to services provided in an institutional setting. One purpose of the proposal is to move certain HCS Program rules from 40 TAC Chapter 9, Subchapter D to 26 TAC Chapter 263.

This rule proposal does not include program provider certification principles that are currently in §§9.173 - 9.180, and §§9.181 - 9.183 and reviewed through the survey process. Rules containing the certification standards for the HCS Program will be proposed in 26 TAC Chapter 565 in a future issue of the *Texas Register*.

Another purpose of the proposed new rules is to ensure that the HCS Program complies with the requirements in Title 42, Code of Federal Regulations (CFR), Chapter IV, Subchapter C, Part 441, Subpart G, §441.301(c)(1) - (5). In 2014, CMS amended this regulation to establish new requirements for Home and Community-Based Services (HCBS) Medicaid programs, including requirements for HCBS program settings and person-centered planning. CMS has given states until March 2023 to be in full compliance with the requirements in §441.301(c)(1) - (5). The proposed new rules will also ensure compliance with the requirements in 42 CFR, Chapter IV, Subchapter C, Part 441, Subpart K, §441.530, regarding Home and Community-Based Settings, §441.535, regarding Assessment of functional

need and §441.540, regarding the Person-centered service plan, for Community First Choice (CFC) services because CFC services are available in the HCS Program. Additional purposes of the proposed new rules are described below.

The proposed new rules implement Texas Government Code §531.02161(b)(4) which requires HHSC to ensure that, if cost effective, clinically effective, and allowed by federal law, a Medicaid recipient has the option to receive certain services, including occupational therapy, physical therapy, and speech-language pathology as a telehealth service.

The proposed new rules require the initial HCS eligibility assessments to be conducted in person and the CFC personal assistance services/habilitation (PAS/HAB) Assessment to be completed in person unless certain conditions exist in which case the assessment may be completed by telehealth, telephone, or video conferencing. These requirements help ensure the assessments are thorough and accurate.

The proposed new rules include provisions regarding the denial, suspension, reduction, or termination of an individual's HCS Program services to explain HHSC's process in taking one of these actions. The proposed new rules change the existing service coordination monitoring requirement during suspension from 90 days to 30 days during an individual's suspension.

The proposed new rules require a program provider and local intellectual and disability authority (LIDDA) to submit a translation of non-English documentation submitted to HHSC. The purpose of the proposed new rule is to help ensure that HHSC's reviews of documentation are efficient.

The proposed new rules require a registered nurse to complete a comprehensive nursing assessment of an individual in person under specified circumstances. This requirement is included so that the entire comprehensive nursing assessment is completed when necessary to help ensure the health and safety of an individual. The proposed new rules codify HHSC's current practice of increasing a level of need (LON) 1, 5, or 8 to the next LON because of an individual's high medical needs if the individual meets certain criteria. The proposed new rule also codifies current practice related to individuals transferring to another program provider or choosing a different service delivery option in the HCS Program.

The proposed new rules provide that HHSC may allow program providers and service coordinators to use one or more of the exceptions specified in the rule while an executive order or proclamation declaring a state of disaster under Texas Government Code §418.014 is in effect. This provision is added to help ensure that providers and service coordinators are able to provide services effectively during a disaster.

ISSUES AND ALTERNATIVES:

HHSC anticipates that stakeholders may express opposition to the proposed rule allowing a program provider to evict an individual from a three-person residence or four-person residence and a service provider of host home/companion care to evict an individual from the service provider's residence if the individual or legally authorized representative (LAR) does not pay room or board required by the

residential agreement. HHSC included this provision in the proposed rules to comply with federal regulation and state landlord-tenant laws. Stakeholders may also express opposition to the proposed rule that allows HHSC to deny residential services to an individual who has been evicted by a program provider or service provider of host home/companion care until the individual pays the delinquent room or board. This provision was included to help ensure that program providers are not required to provide room and board to individuals without compensation and to prevent an individual who has been evicted from transferring from one provider to another and not paying the delinquent room or board.

Stakeholders may express concerns about the costs associated with HHSC allowing an individual to have the choice of a private bedroom in a three or four-person residence or host home/companion care residential setting and requiring a program provider to pay for and install an operable lock on an individual's bedroom door. HHSC did not consider any alternatives to these provisions because they were included to comply with federal regulation.

Stakeholders may express concerns about the administrative burden and costs associated with HHSC's requirement for a program provider and a LIDDA to submit a translation of non-English documentation submitted to HHSC. This requirement was included to avoid delays in HHSC utilization reviews and, therefore, the provision of services to individuals, because of time needed to obtain translation of information to English.

Stakeholders may express concern about HHSC not including the eligibility criteria in 40 TAC §9.155(a)(5)(H) describing a prohibited residential setting in proposed new §263.101 regarding eligibility criteria and, instead, including provisions in proposed new §263.501 consistent with 42 CFR §441.301(c)(5)(v) regarding settings that are presumed to have the qualities of an institution.

Further, stakeholders may express concerns about the administrative burden associated with HHSC's requirement to conduct the initial determination of intellectual disability, the initial Inventory for Client and Agency Planning assessment, and an initial and annual comprehensive nursing assessment of an individual in person. This requirement was included because HHSC determined that conducting these assessments in person helps ensure the assessments are thorough, accurate, and complete.

STAKEHOLDER INVOLVEMENT:

The draft rules were posted on HHSC's website for informal comment from March 11, 2022 – April 1, 2022. HHSC received approximately 1006 comments and questions from 752 stakeholders. HHSC reviewed and considered the comments and questions.

Several hundred commenters (74 percent of comments received) expressed that the provision in the HCS Program eligibility criteria describing a prohibited residential setting, specifically, a setting in which two or more dwellings create a distinguishable residential area, is more restrictive than the federal HCBS settings requirements and makes individuals living in intentional communities, farmsteads, or campus settings ineligible for HCS Program Services. The commenters consisted of intentional community organizations, persons who work at intentional communities, family members and friends of individuals who live in intentional

communities, and other advocates of intentional communities. Many of these commenters expressed support for and may have been mobilized by one or more intentional communities. In response to these comments, HHSC removed the provision from the eligibility criteria and, instead, included provisions in proposed §263.501 consistent with 42 CFR §441.301(c)(5)(v) regarding settings that are presumed to have the qualities of an institution and that address a heightened scrutiny review conducted by CMS.

Several commenters expressed concerns that a residential agreement is considered a “lease” subject to state law governing residential tenancies, even though several requirements in the HCS rules are contrary to the requirements in the Texas Property Code. In response to these comments, HHSC clarified that when a provision of the residential agreement contradicts a provision of state law, the provision of the residential agreement governs to the extent allowed by law. A commenter expressed concern that an individual may begin living in a three-person residence, four-person residence, or a residence in which host home/companion care is provided before the residential agreement is fully executed. In response to this comment, HHSC added a provision clarifying that a residential agreement must be fully executed before an individual begins living in one of these residences, except in the event of an emergency. HHSC also made changes to the draft rules in response to requests from commenters to define the purpose of the person-centered planning process and to clarify definitions of some terms in the definition section and the descriptions of some HCS Program services.

Some commenters requested that HHSC remove the individual plan of care cost limit and the service limits for some HCS Program services. HHSC did not make changes in response to these comments because implementing the recommendation requires additional funding. Some commenters requested changes to the supporting documentation requirements for HHSC to increase an individual’s LON to the next LON due to an individual’s dangerous behavior or high medical needs, and to assign a LON 9 for high medical needs. HHSC did not make changes in response to these comments because implementing these recommendations would require additional research.

A few commenters requested that the person-centered planning process involve the individual and LAR. HHSC did not make changes in response to this comment because in some situations, an LAR is granted broad authority under state law to make decisions related to an individual’s care and support. Some commenters requested that HHSC update the proposed rule regarding permanency planning to reflect current permanency planning processes and tools, instruction manuals, Client Assignment and Registration screens, and technical assistance guides. HHSC did not make changes in response to these comments but will consider the commenters’ suggestions for a future rule proposal.

FISCAL IMPACT:

☐ None (if none, delete the table) ☒ Yes (if yes, fill out the following table)

	SFY 22	SFY 23	SFY 24	SFY 25	SFY 26

State	2081	2081	2081	2081	2081
Federal	3105	3105	3105	3105	3105
Total	5186	5186	5186	5186	5186

HHSC anticipates additional fiscal impact to state government but lacks sufficient information to provide an estimate of the cost.

RULE DEVELOPMENT SCHEDULE:

August 11, 2022	Present to the Medical Care Advisory Committee
August 18, 2022	Present to HHSC Executive Council
September 2022	Publish proposed rules in <i>Texas Register</i>
December 2022	Publish adopted rules in <i>Texas Register</i>
December 2022	Effective date

REQUESTED ACTION: (*Check appropriate box*)

☒ The MCAC recommends approval of the proposed rules for publication.

☐ Information Only

TITLE 40 SOCIAL SERVICES AND ASSISTANCE
PART 1 DEPARTMENT OF AGING AND DISABILITY SERVICES
CHAPTER 9 INTELLECTUAL DISABILITY SERVICES--MEDICAID STATE
 OPERATING AGENCY RESPONSIBILITIES
SUBCHAPTER D HOME AND COMMUNITY-BASED SERVICES (HCS) PROGRAM
 AND COMMUNITY FIRST CHOICE (CFC)

PROPOSED PREAMBLE

As required by Texas Government Code §531.0202(b), the Department of Aging and Disability Services (DADS) was abolished effective September 1, 2017, after all of its functions were transferred to the Texas Health and Human Services Commission (HHSC) in accordance with Texas Government Code §531.0201 and §531.02011. Rules of the former DADS are codified in Texas Administrative Code (TAC), Title 40, Part 1, and will be repealed or administratively transferred to 26 TAC, Health and Human Services, as appropriate. Until such action is taken, the rules in Title 40, Part 1 govern functions previously performed by DADS that have transferred to HHSC. Texas Government Code §531.0055, requires the Executive Commissioner of HHSC to adopt rules for the operation and provision of services by the health and human services system, including rules in Title 40, Part 1. Therefore, the Executive Commissioner of HHSC proposes the repeal of §§9.151, 9.152, 9.154 - 9.170, 9.186, and 9.189 - 9.192 in 40 TAC Chapter 9, Subchapter D related to the Home and Community-based Services (HCS) Program and Community First Choice (CFC).

BACKGROUND AND PURPOSE

The purpose of the proposal is to repeal obsolete rules for the HCS Program, a Medicaid waiver program authorized under §1915(c) of the Social Security Act that provides services to individuals with intellectual disabilities. The rules in 40 TAC Chapter 9, Subchapter D govern the provision of HCS Program services. HHSC is proposing new rules regarding the HCS Program in 26 TAC Chapter 263 elsewhere in this issue of the *Texas Register*. The proposed rules address certain aspects of the HCS Program, including eligibility criteria; the maintenance of the HCS interest list; the process for the enrollment of applicants in the HCS Program; renewal and revision of an individual plan of care; requirements for reimbursement of a program provider; and requirements for a local intellectual and developmental disability authority in providing service coordination; and permanency planning requirements. Therefore, the rules in 40 TAC Chapter 9, Subchapter D that address the topics covered by the proposed new rules in 26 TAC Chapter 263 are no longer needed.

SECTION-BY-SECTION SUMMARY

The proposed repeal of §§9.151, 9.152, 9.154 - 9.170, 9.186, and 9.189 - 9.192 removes rules covering topics that are addressed in new proposed rules.

FISCAL NOTE

Trey Wood, HHSC Chief Financial Officer, has determined that for each year of the first five years that the repeals will be in effect, enforcing or administering the repeals does not have foreseeable implications relating to costs or revenues to state or local governments.

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years that the sections will be repealed:

- (1) the proposed repeals will not create or eliminate a government program;
- (2) implementation of the proposed repeals will not affect the number of HHSC employee positions;
- (3) implementation of the proposed repeals will result in no assumed change in future legislative appropriations;
- (4) the proposed repeals will not affect fees paid to HHSC;
- (5) the proposed repeals will not create new rules;
- (6) the proposed repeals will repeal existing rules;
- (7) the proposed repeals will not change the number of individuals subject to the repeals; and
- (8) the proposed repeals will not affect the state's economy.

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT ANALYSIS

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities required to comply with the proposed repeals. The proposed repeals do not impose any additional costs on small businesses, micro-businesses, or rural communities that are required to comply with the repealed rules.

LOCAL EMPLOYMENT IMPACT

The proposed repeals will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to the proposed repeals because the repeals do not impose a cost on regulated persons.

PUBLIC BENEFIT AND COSTS

Stephanie Stephens, State Medicaid Director, has determined that for each year of the first five years the repeals are in effect, the public will benefit from clearer rules that explain the policies and requirements of the HCS Program.

Trey Wood has also determined that for the first five years the repeals are in effect, there are no anticipated economic costs to persons who are required to comply with the proposed repeals because the repeals will not require these persons to alter their current business practices.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Texas Government Code §2007.043.

PUBLIC HEARING

A public hearing to receive comments on this proposal will be held via GoToWebinar on September 26, 2022 at 1:00 p.m. (central time). The link to register for the GoToWebinar meeting is <https://attendee.gotowebinar.com/register/5797564706801514763>.

Persons requiring further information, special assistance, or accommodations should contact Olu Oguntade at (512)438-4478.

PUBLIC COMMENT

Written comments on the proposal may be submitted to Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin, Texas 78711-3247, or street address 4900 North Lamar Boulevard, Austin, Texas 78751; or emailed to HHSRulesCoordinationOffice@hhsc.state.tx.us.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the Texas Register. Comments must be: (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 21R058" in the subject line.

STATUTORY AUTHORITY

The repeals are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services system; Texas Human Resources Code §32.021, which authorizes the Executive Commissioner of HHSC to adopt rules necessary for the proper and efficient operation of the Medicaid program, including the HCS Program.

The repeals affect Texas Government Code §531.0055 and Texas Human Resources Code §32.021.

This agency hereby certifies that this proposal has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

ADDITIONAL INFORMATION

For further information, please call: (512) 438-4478.

Legend:

Single Underline = Proposed new language

~~[Strikethrough and brackets]~~ = Current language proposed for deletion

Regular print = Current language (No change.) = No changes are being considered for the designated subdivision

TITLE 40	SOCIAL SERVICES AND ASSISTANCE
PART 1	DEPARTMENT OF AGING AND DISABILITY SERVICES
CHAPTER 9	INTELLECTUAL DISABILITY SERVICES--MEDICAID STATE OPERATING AGENCY RESPONSIBILITIES
SUBCHAPTER D	HOME AND COMMUNITY-BASED SERVICES (HCS) PROGRAM AND COMMUNITY FIRST CHOICE (CFC)

~~[§9.151. Purpose.~~

~~The purpose of this subchapter is to describe:~~

- ~~—(1) the HCS Program eligibility criteria for applicants and individuals;~~
- ~~—(2) the CFC service eligibility criteria for applicants and individuals;~~
- ~~—(3) the process for enrollment of applicants in the HCS Program;~~
- ~~—(4) requirements for reimbursement of a program provider;~~
- ~~—(5) the responsibilities of a program provider;~~
- ~~—(6) the process for certifying and sanctioning a program provider in the HCS Program; and~~
- ~~—(7) the responsibilities of a LIDDA in providing service coordination.]~~

~~[§9.152. Application.~~

~~This subchapter applies to:~~

- ~~—(1) LIDDAs;~~
- ~~—(2) program providers;~~
- ~~—(3) applicants and their LARs; and~~
- ~~—(4) individuals and their LARs.]~~

~~[§9.154. Description of the HCS Program and CFC.~~

~~(a) The HCS Program is a Medicaid waiver program approved by CMS pursuant to~~

~~§1915(c) of the Social Security Act. It provides community-based services and supports to eligible individuals as an alternative to the ICF/IID Program. The HCS Program is operated by DADS under the authority of HHSC.~~

~~(b) Enrollment in the HCS Program is limited to the number of individuals in specified target groups and to the geographic areas approved by CMS.~~

~~(c) HCS Program services listed in this subsection are selected for inclusion in an individual's IPC to ensure the individual's health, safety, and welfare in the community, supplement rather than replace that individual's natural supports and other community services for which the individual may be eligible, and prevent the individual's admission to institutional services. The following HCS Program services are defined in Appendix C of the HCS Program waiver application approved by CMS and found at www.dads.state.tx.us. Services available under the HCS Program are:~~

~~—(1) TAS;~~

~~—(2) professional therapies provided by appropriately licensed or certified professionals as follows:~~

~~——(A) physical therapy, including a pre-enrollment minor home modifications assessment;~~

~~——(B) occupational therapy, including a pre-enrollment minor home modifications assessment;~~

~~——(C) speech and language pathology;~~

~~——(D) audiology;~~

~~——(E) social work;~~

~~——(F) behavioral support, including a pre-enrollment minor home modifications assessment;~~

~~——(G) dietary services; and~~

~~——(H) cognitive rehabilitation therapy;~~

~~—(3) nursing provided by an RN or LVN;~~

~~—(4) residential assistance, excluding room and board, provided in one of the following three ways:~~

~~——(A) host home/companion care;~~

~~——(B) supervised living; or~~

~~——(C) residential support;~~

~~——(5) supported home living, which is not a reimbursable service for individuals receiving host home/companion care, supervised living, or residential support;~~

~~——(6) respite, which includes room and board when provided in a setting other than the individual's home, but is not a reimbursable service for individuals receiving host home/companion care, supervised living, or residential support;~~

~~——(7) day habilitation, provided exclusive of any other separately funded service, including public school services, rehabilitative services for persons with mental illness, other programs funded by DADS, or programs funded by DARS;~~

~~——(8) employment assistance;~~

~~——(9) supported employment;~~

~~——(10) adaptive aids;~~

~~——(11) minor home modifications, including pre-enrollment minor home modifications;~~

~~——(12) dental treatment; and~~

~~——(13) if the individual's IPC includes at least one HCS Program service to be delivered through the CDS option;~~

~~——(A) FMS; and~~

~~——(B) support consultation.~~

~~(d) A program provider may only provide and bill for supported home living if the activity provided is transportation as described in §9.174(a)(33)(C) of this subchapter (relating to Certification Principles: Service Delivery).~~

~~(e) CFC is a state plan option governed by Code of Federal Regulations, Title 42, Chapter 441, Subchapter K, regarding Home and Community Based Attendant Services and Supports State Plan Option (Community First Choice) that provides the following services to individuals:~~

~~——(1) CFC PAS/HAB;~~

~~——(2) CFC ERS; and~~

~~——(3) CFC support management for an individual receiving CFC PAS/HAB.~~

~~(f) DADS has grouped Texas counties into geographical areas, referred to as "local~~

~~service areas," each of which is served by a LIDDA. DADS has further grouped the local service areas into "waiver contract areas." A list of the counties included in each local service area and waiver contract area is found at www.dads.state.tx.us.~~

~~—(1) A program provider may provide HCS Program services and CFC services only to persons residing in the counties specified for the program provider in DADS automated enrollment and billing system.~~

~~—(2) A program provider must have a separate contract for each waiver contract area served by the program provider.~~

~~—(3) A program provider may have a contract to serve one or more local service areas within a waiver contract area, but the program provider must serve all of the counties within each local service area covered by the contract.~~

~~—(4) A program provider may not have more than one contract per waiver contract area.~~

~~(g) A program provider must comply with:~~

~~—(1) all applicable state and federal laws, rules, and regulations, including Chapter 49 of this title (relating to Contracting for Community Services); and~~

~~—(2) DADS Information Letters regarding the HCS Program found at www.dads.state.tx.us.~~

~~(h) The CDS option is a service delivery option, described in Chapter 41 of this title (relating to Consumer Directed Services Option), in which an individual or LAR employs and retains service providers and directs the delivery of a service through the CDS option, as described in §41.108 of this title (relating to Services Available Through the CDS Option).]~~

~~[§9.155. Eligibility Criteria and Suspension of HCS Program Services and of CFC Services.~~

~~(a) An applicant or individual is eligible for HCS Program services if he or she:~~

~~—(1) meets the financial eligibility criteria as described in Appendix B of the HCS Program waiver application approved by CMS and found at www.dads.state.tx.us;~~

~~—(2) meets one of the following criteria:~~

~~——(A) based on a determination of an intellectual disability performed in accordance with THSC, Chapter 593, Subchapter A and as determined by DADS in accordance with §9.161 of this subchapter (relating to LOC Determination), qualifies for an ICF/IID LOC I as defined in §9.238 of this chapter (relating to ICF/MR Level of Care I Criteria);~~

~~—— (B) as determined by DADS in accordance with §9.161 of this subchapter, qualifies for an ICF/IID LOC I as defined in §9.238 of this chapter or ICF/IID LOC VIII as defined in §9.239 of this chapter (relating to ICF/MR Level of Care VIII Criteria), and has been determined by DADS:~~

~~—— (i) to have an intellectual disability or a related condition;~~

~~—— (ii) to need specialized services; and~~

~~—— (iii) to be inappropriately placed in a Medicaid-certified nursing facility based on an annual resident review conducted in accordance with the requirements of Chapter 17 of this title (relating to Preadmission Screening and Resident Review (PASRR)); or~~

~~—— (C) meets the following criteria:~~

~~—— (i) based on a determination of an intellectual disability performed in accordance with THSC, Chapter 593, Subchapter A and as determined by DADS in accordance with §9.161 of this subchapter, qualifies for one of the following levels of care:~~

~~—— (I) an ICF/IID LOC I as defined in §9.238 of this chapter; or~~

~~—— (II) an ICF/IID LOC VIII as defined in §9.239 of this chapter;~~

~~—— (ii) meets one of the following:~~

~~—— (I) resides in a nursing facility immediately prior to enrolling in the HCS Program; or~~

~~—— (II) is at imminent risk of entering a nursing facility as determined by DADS; and~~

~~—— (iii) is offered HCS Program services designated for a member of the reserved capacity group "Individuals with a level of care I or VIII residing in a nursing facility" included in Appendix B of the HCS Program waiver application approved by CMS and found at www.dads.state.tx.us;~~

~~—— (3) has an IPC cost that does not exceed:~~

~~—— (A) \$167,468 for an applicant or individual with an LON 1, LON 5, or LON 8;~~

~~—— (B) \$168,615 for an applicant or individual with an LON 6; or~~

~~—— (C) \$305,877 for an applicant or individual with an LON 9;~~

~~—— (4) is not enrolled in another waiver program and is not receiving a service that~~

~~may not be received if the individual is enrolled in the HCS Program as identified in the Mutually Exclusive Services table in Appendix II of the HCS Handbook available at www.dads.state.tx.us;~~

~~—(5) does not reside in:~~

~~——(A) an ICF/IID;~~

~~——(B) a nursing facility;~~

~~——(C) an assisted living facility licensed or subject to being licensed in accordance with THSC, Chapter 247;~~

~~——(D) a residential child care operation licensed or subject to being licensed by DFPS unless it is a foster family home or a foster group home;~~

~~——(E) a facility licensed or subject to being licensed by the Department of State Health Services (DSHS);~~

~~——(F) a facility operated by DARS;~~

~~——(G) a residential facility operated by the Texas Juvenile Justice Department, a jail, or a prison; or~~

~~——(H) a setting in which two or more dwellings, including units in a duplex or apartment complex, single family homes, or facilities listed in subparagraphs (A)–(G) of this paragraph, excluding supportive housing under Section 811 of the National Affordable Housing Act of 1990, meet all of the following criteria:~~

~~——(i) the dwellings create a residential area distinguishable from other areas primarily occupied by persons who do not require routine support services because of a disability;~~

~~——(ii) most of the residents of the dwellings are persons with an intellectual disability; and~~

~~——(iii) the residents of the dwellings are provided routine support services through personnel, equipment, or service facilities shared with the residents of the other dwellings; and~~

~~—(6) requires the provision of:~~

~~——(A) at least one HCS Program service per month or a monthly monitoring visit by a service coordinator as described in §9.190(e)(41) of this subchapter (relating to LIDDA Requirements for Providing Service Coordination in the HCS Program); and~~

~~——(B) at least one HCS Program service per IPC year.~~

~~(b) For applicants or individuals with spouses who live in the community, the income and resource eligibility requirements are determined according to the spousal impoverishment provisions in §1924 of the Social Security Act and as specified in the Medicaid State Plan.~~

~~(c) Except as provided in subsection (d), an applicant or individual is eligible for a CFC service under this subchapter if the applicant or individual:~~

~~——(1) meets the criteria described in subsection (a) of this section;~~

~~——(2) requires the provision of the CFC service; and~~

~~——(3) is not receiving host home/companion care, supervised living, or residential support.~~

~~(d) To be eligible for a CFC service under this subchapter, an applicant or individual receiving MAO Medicaid must, in addition to meeting the eligibility criteria described in subsection (c) of this section, receive an HCS Program service at least monthly, as required by 42 CFR §441.510(d), which may not be met by a monthly monitoring visit by a service coordinator as described in §9.190(e)(41) of this subchapter.~~

~~(e) If an individual is temporarily admitted to one of the following settings, the individual's HCS Program services and CFC services are suspended during that admission:~~

~~——(1) a hospital;~~

~~——(2) an ICF/IID;~~

~~——(3) a nursing facility;~~

~~——(4) a residential child care operation licensed or subject to being licensed by DFPS;~~

~~——(5) a facility licensed or subject to being licensed by the DSHS;~~

~~——(6) a facility operated by DARS;~~

~~——(7) a residential facility operated by the Texas Juvenile Justice Department, a jail, or a prison; or~~

~~——(8) an assisted living facility licensed or subject to being licensed in accordance with THSC, Chapter 247.]~~

~~[§9.156. Calculation of Co-payment.~~

~~(a) Individuals and eligible couples determined to be financially eligible based on the special institutional income limit may be required to share in the cost of HCS Program services. The method for determining the individual's or couple's co-payment is described in subsections (b) and (c) of this section and documented on the HHSC Waiver Program Co-Pay Worksheet.~~

~~(b) The co-payment amount as determined by HHSC is the individual's or couple's remaining income after all allowable expenses have been deducted. The co-payment amount is applied only to the cost of home and community-based services funded through the HCS Program and specified on each individual's IPC. The co-payment must not exceed the cost of services actually delivered. The co-payment must be paid by the individual or couple, authorized representative, or trustee directly to the program provider in accordance with the HHSC determination. When calculating the co-payment amount for an individual or a couple whose income exceeds the maximum personal needs allowance, the following are deducted:~~

~~—(1) the cost of the individual's or couple's maintenance needs, which must be equivalent to the special institutional income limit for eligibility under the Texas Medicaid program;~~

~~—(2) the cost of the maintenance needs of the individual's or couple's dependent children, which is an amount equivalent to the TANF basic monthly grant for children or a spouse with children, using the recognizable needs amounts in the TANF Budgetary Allowances Chart; and~~

~~—(3) the costs incurred for medical or remedial care that are necessary but are not subject to payment by Medicare, Medicaid, or any other third party, which include the costs of health insurance premiums, deductibles, and co-insurance.~~

~~(c) When calculating the co-payment amount for individuals with community spouses, HHSC determines the amount of the recipient's income applicable to payment in accordance with §1924 of the Social Security Act and 42 CFR §435.726.]~~

~~[§9.157. HCS Interest List.~~

~~(a) A LIDDA must maintain an up-to-date interest list of applicants interested in receiving HCS Program services for whom the LIDDA is the applicant's designated LIDDA in DADS data system.~~

~~(b) A person may request that an applicant's name be added to the HCS interest list by contacting the LIDDA serving the Texas county in which the applicant or person resides.~~

~~(c) If a request is made in accordance with subsection (b) of this section, a LIDDA~~

~~must add an applicant's name to the HCS interest list:~~

~~—(1) if the applicant resides in Texas; and~~

~~—(2) with an interest list request date of the date the request is received.~~

~~(d) DADS adds an applicant's name to the HCS interest list with a request date as follows:~~

~~—(1) for an applicant under 22 years of age and residing in an ICF/IID or nursing facility located in Texas, based on the date of admission to the ICF/IID or nursing facility; or~~

~~—(2) for an applicant determined diagnostically or functionally ineligible for another DADS waiver program, one of the following dates, whichever is earlier:~~

~~——(A) the request date of the interest list for the other waiver program; or~~

~~——(B) an existing request date for the HCS Program for the applicant.~~

~~(e) DADS or the LIDDA removes an applicant's name from the HCS interest list if:~~

~~—(1) the applicant or LAR requests in writing that the applicant's name be removed from the interest list, unless the applicant is under 22 years of age and residing in an ICF/IID or nursing facility;~~

~~—(2) the applicant moves out of Texas, unless the applicant is a military family member living outside of Texas:~~

~~——(A) while the military member is on active duty; or~~

~~——(B) for less than one year after the former military member's active duty ends;~~

~~—(3) the applicant declines the offer of HCS Program services or, as described in §9.158(f) of this subchapter (relating to Process for Enrollment of Applicants), an offer of HCS Program services is withdrawn, unless:~~

~~——(A) the applicant is a military family member living outside of Texas:~~

~~——(i) while the military member is on active duty, or~~

~~——(ii) for less than one year after the former military member's active duty ends; or~~

~~——(B) the applicant is under 22 years of age and residing in an ICF/IID or nursing facility;~~

~~—(4) the applicant is a military family member living outside of Texas for more than one year after the former military member's active duty ends;~~

~~—(5) the applicant is deceased; or~~

~~—(6) DADS has denied the applicant enrollment in the HCS Program and the applicant or LAR has had an opportunity to exercise the applicant's right to appeal the decision in accordance with §9.169 of this subchapter (relating to Fair Hearing) and did not appeal the decision, or appealed and did not prevail.~~

~~(f) If DADS or the LIDDA removes an applicant's name from the HCS interest list in accordance with subsection (e)(1) — (4) of this section and, within 90 calendar days after the name was removed, the LIDDA receives an oral or written request from a person to reinstate the applicant's name on the interest list:~~

~~—(1) the LIDDA must notify DADS of the request; and~~

~~—(2) DADS:~~

~~——(A) reinstates the applicant's name to the interest list based on the original request date described in subsection (c) or (d) of this section; and~~

~~——(B) notifies the applicant or LAR in writing that the applicant's name has been reinstated to the interest list in accordance with subparagraph (A) of this paragraph.~~

~~(g) If DADS or the LIDDA removes an applicant's name from the HCS interest list in accordance with subsection (e)(1) — (4) of this section and, more than 90 calendar days after the name was removed, the LIDDA receives an oral or written request from a person to reinstate the applicant's name on the interest list:~~

~~—(1) the applicant's name is placed on the interest list:~~

~~——(A) by the LIDDA based on the date the LIDDA receives the oral or written request; or~~

~~——(B) by DADS based on the original request date described in subsection (c) or (d) of this section because of extenuating circumstances as determined by DADS; and~~

~~—(2) DADS notifies the applicant or LAR in writing that the applicant's name has been added to the interest list in accordance with paragraph (1) of this subsection.~~

~~(h) If DADS or the LIDDA removes an applicant's name from the HCS interest list in accordance with subsection (e)(6) of this section and the LIDDA subsequently receives an oral or written request from a person to reinstate the applicant's name on the interest list:~~

~~—(1) the LIDDA must add the applicant's name to the interest list based on the date the LIDDA receives the oral or written request; and~~

~~—(2) DADS notifies the applicant or LAR in writing that the applicant's name has been added to the interest list in accordance with paragraph (1) of this subsection.]~~

~~[§9.158. Process for Enrollment of Applicants:~~

~~(a) DADS notifies a LIDDA, in writing, of the availability of HCS Program services in the LIDDA's local service area and directs the LIDDA to offer HCS Program services to an applicant:~~

~~—(1) whose interest list request date, assigned in accordance with §9.157(c)(2) and (d) of this subchapter (relating to HCS Interest List), is earliest on the statewide interest list for the HCS Program as maintained by DADS; or~~

~~—(2) who is a member of a target group identified in the approved HCS waiver application.~~

~~(b) Except as provided in subsection (c) of this section, the LIDDA must make the offer of HCS Program services in writing and deliver it to the applicant or LAR by regular United States mail or by hand delivery.~~

~~(c) The LIDDA must make the offer of HCS Program services to an applicant described in subsection (a)(2) of this section in accordance with DADS procedures.~~

~~(d) The LIDDA must include in a written offer that is made in accordance with subsection (a)(1) of this section:~~

~~—(1) a statement that:~~

~~——(A) if the applicant or LAR does not respond to the offer of HCS Program services within 30 calendar days after the LIDDA's written offer, the LIDDA withdraws the offer; and~~

~~——(B) if the applicant is currently receiving services from the LIDDA that are funded by general revenue and the applicant or LAR declines the offer of HCS Program services, the LIDDA terminates those services that are similar to services provided under the HCS Program; and~~

~~—(2) information regarding the time frame requirements described in subsection (f) of this section using the Deadline Notification form, which is found at www.dads.state.tx.us.~~

~~(e) If an applicant or LAR responds to an offer of HCS Program services, the LIDDA must:~~

~~—(1) provide the applicant, LAR, and, if the LAR is not a family member, at least one family member (if possible) both an oral and written explanation of the services and supports for which the applicant may be eligible, including the ICF/IID Program (both state supported living centers and community based facilities), waiver programs under §1915(c) of the Social Security Act, and other community based services and supports. The LIDDA must use the Explanation of Services and Supports document, which is found at www.dads.state.tx.us;~~

~~—(2) using a DADS form, provide the applicant and LAR both an oral and a written explanation of all HCS Program services and CFC services; and~~

~~—(3) give the applicant or LAR the Verification of Freedom of Choice Form, Waiver Program which is found at www.dads.state.tx.us, to document the applicant's choice regarding the HCS Program and ICF/IID Program.~~

(f) The LIDDA must withdraw an offer of HCS Program services made to an applicant or LAR if:

~~—(1) within 30 calendar days after the LIDDA's offer made to the applicant or LAR in accordance with subsection (a)(1) of this section, the applicant or LAR does not respond to the offer of HCS Program services;~~

~~—(2) within seven calendar days after the applicant or LAR receives the Verification of Freedom of Choice, Waiver Program form from the LIDDA in accordance with subsection (e)(3) of this section, the applicant or LAR does not document the choice of HCS Program services over the ICF/IID Program using the Verification of Freedom of Choice, Waiver Program form;~~

~~—(3) within 30 calendar days after the applicant or LAR receives the contact information for all program providers in the LIDDA's local service area in accordance with subsection (j)(3) of this section, the applicant or LAR does not document the choice of a program provider using the Documentation of Provider Choice form; or~~

~~—(4) the applicant or LAR does not complete the necessary activities to finalize the enrollment process and DADS has approved the withdrawal of the offer.~~

(g) If the LIDDA withdraws an offer of HCS Program services made to an applicant, the LIDDA must notify the applicant or LAR of such action, in writing, by certified United States mail.

(h) If the applicant is currently receiving services from the LIDDA that are funded by general revenue and the applicant declines the offer of HCS Program services, the LIDDA must terminate those services that are similar to services provided under the HCS Program.

(i) If the LIDDA terminates an applicant's services in accordance with subsection

~~(h) of this section, the LIDDA must notify the applicant or LAR of the termination, in writing, by certified United States mail and provide an opportunity for a review in accordance with §2.46 of this title (relating to Notification and Appeals Process).~~

~~(j) If the applicant or LAR accepts the offer of HCS Program services, the LIDDA must compile and maintain information necessary to process the request for enrollment in the HCS Program.~~

~~—(1) If the applicant's financial eligibility for the HCS Program must be established, the LIDDA must initiate, monitor, and support the processes necessary to obtain a financial eligibility determination.~~

~~—(2) The LIDDA must complete an ID/RC Assessment in accordance with §9.161 and §9.163 of this subchapter (relating to LOC Determination and LON Assignment, respectively).~~

~~——(A) The LIDDA must:~~

~~————(i) perform or endorse a determination that the applicant has an intellectual disability in accordance with Chapter 5, Subchapter D of this title (relating to Diagnostic Eligibility for Services and Supports—Intellectual Disability Priority Population and Related Conditions); or~~

~~————(ii) verify that the applicant has been diagnosed by a licensed physician as having a related condition as defined in §9.203 of this chapter (relating to Definitions).~~

~~——(B) The LIDDA must administer the ICAP and recommend an LON assignment to DADS in accordance with §9.163 and §9.164 of this subchapter (relating to DADS Review of LON).~~

~~——(C) The LIDDA must electronically transmit the completed ID/RC Assessment to DADS for approval in accordance with §9.161(a) and §9.163(a) of this subchapter and, if applicable, submit supporting documentation as required by §9.164(c) of this subchapter.~~

~~—(3) The LIDDA must provide names and contact information to the applicant or LAR for all program providers in the LIDDA's local service area.~~

~~—(4) The LIDDA must assign a service coordinator who, together with other members of the applicant's service planning team, must:~~

~~——(A) develop a PDP;~~

~~——(B) if CFC PAS/HAB is included on the PDP, complete DADS HCS/TxHmL CFC PAS/HAB Assessment form to determine the number of CFC PAS/HAB hours the applicant needs; and~~

~~——(C) develop a proposed initial IPC in accordance with §9.159(c) of this subchapter (relating to IPC);~~

~~——(5) A service coordinator must discuss the CDS option with the applicant or LAR in accordance with §9.168(a) and (b) of this subchapter (relating to CDS Option);~~

~~(k) The service coordinator must:~~

~~——(1) arrange for meetings and visits with potential program providers as requested by the applicant or LAR;~~

~~——(2) review the proposed initial IPC with potential program providers as requested by the applicant or LAR;~~

~~——(3) ensure that the applicant's or LAR's choice of a program provider is documented on the Documentation of Provider Choice Form and signed by the applicant or LAR;~~

~~——(4) negotiate and finalize the proposed initial IPC and the date services will begin with the selected program provider, consulting with DADS if necessary to reach agreement with the selected program provider on the content of the proposed initial IPC and the date services will begin;~~

~~——(5) determine whether the applicant meets the following criteria:~~

~~——(A) is being discharged from a nursing facility, an ICF/IID, or a GRO; and~~

~~——(B) anticipates needing TAS;~~

~~——(6) if the service coordinator determines that the applicant meets the criteria described in paragraph (5) of this subsection:~~

~~——(A) complete, with the applicant or LAR and the selected program provider, DADS Transition Assistance Services (TAS) Assessment and Authorization form found at www.dads.state.tx.us in accordance with the form's instructions, which includes:~~

~~——(i) identifying the TAS the applicant needs; and~~

~~——(ii) estimating the monetary amount for each TAS identified, which must be within the service limit described in §9.192(a)(5) of this subchapter (relating to Service Limits);~~

~~——(B) submit the completed form to DADS to determine if TAS is authorized;~~

~~——(C) send the form authorized by DADS to the selected program provider; and~~

~~———(D) include the TAS and the monetary amount authorized by DADS on the applicant's proposed initial IPC;~~

~~——(7) determine whether an applicant meets the following criteria:~~

~~———(A) is being discharged from a nursing facility, an ICF/IID, or a GRO;~~

~~———(B) has not met the maximum service limit for minor home modifications as described in §9.192(a)(3)(A) of this subchapter; and~~

~~———(C) anticipates needing pre-enrollment minor home modifications and a pre-enrollment minor home modifications assessment;~~

~~——(8) if the service coordinator determines that an applicant meets the criteria described in paragraph (7) of this subsection:~~

~~———(A) complete, with the applicant or LAR and selected program provider, DADS Home and Community-based Services (HCS) Program Pre-enrollment MHM Authorization Request form found at www.dads.state.tx.us in accordance with the form's instructions, which includes:~~

~~———(i) identifying the pre-enrollment minor home modifications the applicant needs;~~

~~———(ii) identifying the pre-enrollment minor home modifications assessments conducted by the program provider as required by §9.174(h)(1)(A) of this subchapter (relating to Certification Principles: Service Delivery);~~

~~———(iii) based on documentation provided by the program provider as required by the *HCS Program Billing Guidelines*, stating the cost of:~~

~~———(I) the pre-enrollment minor home modifications identified on the form, which must be within the service limit described in §9.192(a)(3)(A) of this subchapter; and~~

~~———(II) the pre-enrollment minor home modifications assessments conducted;~~

~~———(B) submit the completed form to DADS to determine if pre-enrollment minor home modification and pre-enrollment minor home modifications assessments are authorized;~~

~~———(C) send the form authorized by DADS to the selected program provider; and~~

~~———(D) include the pre-enrollment minor home modifications, pre-enrollment minor home modifications assessments, and the monetary amount for these services authorized by DADS on the applicant's proposed initial IPC;~~

~~—(9) if an applicant or LAR chooses a program provider to deliver supported home living, nursing, host home/companion care, residential support, supervised living, respite, employment assistance, supported employment, day habilitation, or CFC PAS/HAB, ensure that the initial proposed IPC includes a sufficient number of RN nursing units for a program provider nurse to perform an initial nursing assessment unless, as described in §9.174(c) of this subchapter:~~

~~———(A) nursing services are not on the proposed IPC and the individual or LAR and selected program provider have determined that an unlicensed service provider will not perform a nursing task as documented on DADS form "Nursing Task Screening Tool"; or~~

~~———(B) an unlicensed service provider will perform a nursing task and a physician has delegated the task as a medical act under Texas Occupations Code, Chapter 157, as documented by the physician;~~

~~—(10) if an applicant or LAR refuses to include on the initial proposed IPC a sufficient number of RN nursing units to perform an initial nursing assessment as required by paragraph (9) of this subsection:~~

~~———(A) inform the applicant or LAR that the refusal:~~

~~—————(i) will result in the applicant not receiving nursing services from the program provider; and~~

~~—————(ii) if the applicant needs host home/companion care, residential support, supervised living, supported home living, respite, employment assistance, supported employment, day habilitation, or CFC PAS/HAB from the program provider, will result in the individual not receiving that service unless, as described in §9.174(d)(2) of this subchapter:~~

~~—————(I) the program provider's unlicensed service provider does not perform nursing tasks in the provision of the service; and~~

~~—————(II) the program provider determines that it can ensure the applicant's health, safety, and welfare in the provision of the service; and~~

~~———(B) document the refusal of the RN nursing units on the proposed IPC for an initial assessment by the program provider's RN in the applicant's record;~~

~~—(11) ensure that the applicant or LAR signs and dates the proposed initial IPC;~~

~~—(12) ensure that the selected program provider signs and dates the proposed IPC, demonstrating agreement that the services will be provided to the applicant;~~

~~—(13) sign and date the proposed initial IPC, which indicates that the service coordinator agrees that the requirements described in §9.159(c) of this subchapter~~

~~have been met;~~

~~—(14) using a DADS form, provide an oral and written explanation to the applicant or LAR of:~~

~~——(A) the eligibility requirements for HCS Program services as described in §9.155(a) of this subchapter (relating to Eligibility Criteria and Suspension of HCS Program Services and of CFC Services); and~~

~~——(B) if the applicant's PDP includes CFC services:~~

~~————(i) the eligibility requirements for CFC services as described in §9.155(c) of this subchapter to applicants who do not receive MAO Medicaid; and~~

~~————(ii) the eligibility requirements for CFC services as described in §9.155(d) of this subchapter to applicants who receive MAO Medicaid; and~~

~~—(15) inform the applicant or LAR, orally and in writing:~~

~~——(A) that HCS Program services may be terminated if:~~

~~————(i) the individual no longer meets the eligibility criteria described in §9.155(a) of this subchapter;~~

~~————(ii) the individual or LAR requests termination of HCS Program services; and~~

~~——(B) if the applicant's PDP includes CFC services, that CFC services may be terminated if:~~

~~————(i) the individual no longer meets the eligibility criteria described in §9.155(c) or (d) of this subchapter; or~~

~~————(ii) the individual or LAR requests termination of CFC services.~~

~~(l) A LIDDA must conduct permanency planning in accordance with §9.167(a) of this subchapter (relating to Permanency Planning).~~

~~(m) After the proposed initial IPC is finalized and signed in accordance with subsection (k) of this section, the LIDDA must:~~

~~—(1) electronically transmit the proposed initial IPC to DADS and:~~

~~——(A) keep the original proposed initial IPC in the individual's record; and~~

~~——(B) ensure the electronically transmitted proposed initial IPC contains information identical to that on the original proposed initial IPC; and~~

~~—(2) submit other required enrollment information to DADS.~~

~~(n) DADS notifies the applicant or LAR, the selected program provider, the FMSA, if applicable, and the LIDDA of its approval or denial of the applicant's enrollment. When the enrollment is approved, DADS authorizes the applicant's enrollment in the HCS Program through the DADS data system and issues an enrollment letter to the applicant that includes the effective date of the applicant's enrollment in the HCS Program.~~

~~(o) Prior to the applicant's service begin date, the LIDDA must provide to the selected program provider and FMSA, if applicable, copies of all enrollment documentation and associated supporting documentation, including relevant assessment results and recommendations, the completed ID/RC Assessment, the proposed initial IPC, and the applicant's PDP, and, if CFC PAS/HAB is included on the PDP, the completed DADS HCS/TxHmL CFC PAS/HAB Assessment form.~~

~~(p) Except for the provision of TAS, pre-enrollment minor home modifications, and a pre-enrollment minor home modifications assessment, as required by §9.174(g) and (h) of this subchapter, the selected program provider must not initiate services until notified of DADS approval of the applicant's enrollment.~~

~~(q) The selected program provider must develop:~~

~~—(1) an implementation plan for:~~

~~——(A) HCS Program services, except for transportation as a supported home living activity, that is based on the individual's PDP and IPC; and~~

~~——(B) CFC services, except for CFC support management, that is based on the individual's PDP, IPC, and if CFC PAS/HAB is included on the PDP, the completed DADS HCS/TxHmL CFC PAS/HAB Assessment form; and~~

~~—(2) a transportation plan, if transportation as a supported home living activity is included on the PDP.~~

~~(r) The LIDDA must retain in the applicant's record:~~

~~—(1) the Verification of Freedom of Choice, Waiver Program form documenting the applicant's or LAR's choice of services;~~

~~—(2) the Documentation of Provider Choice form documenting the applicant's or LAR's choice of a program provider, if applicable;~~

~~—(3) the Deadline Notification form; and~~

~~—(4) any other correspondence related to the offer of HCS Program services.~~

~~(s) Copies of the following forms referenced in this section are available at www.dads.state.tx.us:~~

- ~~—(1) Verification of Freedom of Choice, Waiver Program form;~~
- ~~—(2) Documentation of Provider Choice form;~~
- ~~—(3) Deadline Notification form;~~
- ~~—(4) Transition Assistance Services (TAS) Assessment and Authorization form;~~
~~and~~
- ~~—(5) Home and Community-based Services (HCS) Program Pre-enrollment MHM Authorization Request form.]~~

~~[§9.159. IPC.~~

~~(a) A service coordinator must initiate development of a proposed initial IPC for an applicant as required by §9.158(j)(4)(C) of this subchapter (relating to Process for Enrollment of Applicants).~~

~~(b) A program provider must initiate development of a proposed renewal and proposed revised IPC for an individual as required by §9.166 of this subchapter (relating to Renewal and Revision of an IPC).~~

~~(c) An IPC must be based on the PDP and specify the type and amount of each HCS Program service and CFC service to be provided to an individual, except for CFC support management, as well as non-HCS Program and non-CFC services and supports to be provided during the IPC year. The type and amount of each HCS Program service and CFC service in the IPC:~~

- ~~—(1) must be necessary to protect the individual's health and welfare in the community;~~
- ~~—(2) must not be available to the individual through any other source, including the Medicaid State Plan, other governmental programs, private insurance, or the individual's natural supports;~~
- ~~—(3) must be the most appropriate type and amount to meet the individual's needs;~~
- ~~—(4) must be cost effective;~~
- ~~—(5) must be necessary to enable community integration and maximize independence;~~
- ~~—(6) if an adaptive aid or minor home modification, must:~~

~~—— (A) be included on DADS approved list in the *HCS Program Billing Guidelines*; and~~

~~—— (B) be within the service limit described in §9.192 of this subchapter (relating to Service Limits);~~

~~—— (7) if an adaptive aid costing \$500 or more, must be supported by a written assessment from a licensed professional specified by DADS in the *HCS Program Billing Guidelines*;~~

~~—— (8) if a minor home modification costing \$1,000 or more, must be supported by a written assessment from a licensed professional specified by DADS in the *HCS Program Billing Guidelines*;~~

~~—— (9) if dental treatment, must be within the service limit described in §9.192 of this subchapter;~~

~~—— (10) if respite, must be within the service limit described in §9.192 of this subchapter;~~

~~—— (11) if TAS, must be:~~

~~—— (A) supported by a Transition Assistance Services (TAS) Assessment and Authorization form authorized by DADS; and~~

~~—— (B) within the service limit described in §9.192(a)(5)(A) or (B) of this subchapter;~~

~~(12) if pre-enrollment minor home modifications, must be:~~

~~—— (A) supported by a written assessment from a licensed professional if required by the *HCS Program Billing Guidelines*;~~

~~—— (B) supported by a Home and Community-based Services (HCS) Program Pre-enrollment MHM Authorization Request form authorized by DADS;~~

~~—— (C) within the service limit described in §9.192(a)(3)(A) of this subchapter;~~

~~(13) if a pre-enrollment minor home modifications assessment, must be supported by a Home and Community-based Services (HCS) Program Pre-enrollment MHM Authorization Request form authorized by DADS; and~~

~~—— (14) if CFC PAS/HAB, must be supported by the DADS HCS/TxHmL CFC PAS/HAB Assessment form.~~

~~(d) If an applicant's or individual's IPC includes only CFC PAS/HAB to be delivered through the CDS option, the service coordinator must include in the IPC:~~

~~—(1) CFC FMS instead of FMS; and~~

~~—(2) if the applicant or individual will receive support consultation, CFC support consultation instead of support consultation.]~~

~~[§9.160. DADS Review of a Proposed IPC.~~

~~(a) DADS reviews a proposed IPC to determine whether to authorize the IPC.~~

~~(b) The service coordinator's agreement or disagreement, as required by §9.166(e)(3) of this subchapter (relating to Renewal and Revision of an IPC), with the proposed renewal or revised IPC will be considered in DADS review of the proposed IPC.~~

~~(c) DADS may review supporting documentation specified in §9.159(c) of this subchapter (relating to IPC) at any time to determine if the type and amount of HCS Program services and CFC services specified in a proposed IPC are appropriate. If requested by DADS:~~

~~—(1) the LIDDA must submit to DADS documentation supporting a proposed initial IPC; and~~

~~—(2) the program provider must submit to DADS documentation supporting a proposed renewal or revised IPC.~~

~~(d) Before authorizing a proposed IPC that exceeds 100 percent of the estimated annualized average per capita cost for ICF/IID Program services, DADS reviews the IPC to determine if the type and amount of HCS Program services and CFC services specified in the proposed IPC are appropriate and supported by documentation specified in §9.159(c) of this subchapter. A proposed IPC with such an IPC cost must be submitted to DADS with documentation supporting the IPC, as described in §9.159(c) of this subchapter, before the electronic transmission of the IPC. After reviewing the supporting documentation, DADS may request additional documentation. DADS reviews any additional documentation submitted in accordance with its request and, for an applicant or individual who is eligible for the HCS Program, electronically authorizes the proposed IPC or sends written notification that the proposed IPC has been authorized with modifications.]~~

~~[§9.161 LOC. Determination.~~

~~(a) A LIDDA must request an LOC from DADS for an applicant at the time the applicant is enrolled into the HCS Program. The LOC is requested by electronically transmitting a completed ID/RC Assessment to DADS, indicating the recommended LOC, signed and dated by the service coordinator. The electronically transmitted ID/RC Assessment must contain information identical to the information on the signed and dated ID/RC Assessment.~~

~~(b) A program provider must request an LOC for an individual from DADS in accordance with this subsection:~~

~~—(1) Before the expiration of an ID/RC Assessment, the program provider must electronically transmit to DADS a completed ID/RC Assessment, indicating the recommended LOC, that is signed and dated by the program provider.~~

~~—(2) The program provider must ensure the electronically transmitted ID/RC Assessment contains information that is identical to the information on the signed and dated ID/RC Assessment.~~

~~—(3) The program provider must, within three calendar days after transmission, provide the service coordinator with a paper copy of the signed and dated ID/RC Assessment.~~

~~(c) For an LOC requested in accordance with subsection (b) of this section, within seven calendar days after the ID/RC Assessment is electronically transmitted by the program provider, the service coordinator must review the ID/RC Assessment in the DADS data system and:~~

~~—(1) enter the service coordinator's name and date in the DADS data system;~~

~~—(2) enter in the DADS data system whether the service coordinator agrees or disagrees with the ID/RC Assessment; and~~

~~—(3) if the service coordinator disagrees with the ID/RC Assessment, notify the individual, LAR, DADS, and the program provider of the service coordinator's disagreement in accordance with DADS instructions.~~

~~(d) The service coordinator's agreement or disagreement will be considered in DADS review of an ID/RC Assessment transmitted in accordance with subsection (b) of this section.~~

~~(e) For an LOC requested under subsection (a) or (b) of this section, DADS makes an LOC determination in accordance with §9.238 of this chapter (relating to ICF/MR Level of Care I Criteria) and §9.239 of this chapter (relating to ICF/MR Level of Care VIII Criteria) based on DADS review of information reported on the applicant's or individual's ID/RC Assessment.~~

~~(f) Information on the ID/RC Assessment must be supported by current data obtained from standardized evaluations and formal assessments that measure physical, emotional, social, and cognitive factors. The signed and dated ID/RC Assessment and documentation supporting the recommended LOC must be maintained in the individual's record.~~

~~(g) DADS approves the LOC or sends written notification:~~

~~—(1) to the applicant, individual, or LAR that the applicant or individual is not eligible for HCS Program services or CFC services and provides the applicant, individual, or LAR with an opportunity to request a fair hearing in accordance with §9.169 of this subchapter (relating to Fair Hearing); and~~

~~—(2) to the LIDDA and program provider that the LOC has been denied.~~

~~(h) An LOC determination is valid for 364 calendar days after the LOC effective date determined by DADS.~~

~~(i) If the LON of an individual receiving HCS Program services changes from a LON 5, LON 8, LON 6, or LON 9 to a LON 1, DADS notifies the LIDDA of the change using DADS Form 1597, HCS Level of Care Redetermination Cover Sheet.~~

~~—(1) The LIDDA must, within 30 business days after receiving the notification:~~

~~——(A) assess the individual in person and complete a new Determination of Intellectual Disability (DID) in accordance with Chapter 5, Subchapter D of this title (relating to Diagnostic Eligibility for Services and Supports—Intellectual Disability Priority Population and Related Conditions);~~

~~——(B) complete the LIDDA section of DADS Form 1597, HCS Level of Care Redetermination Cover Sheet, and return the form to DADS; and~~

~~——(C) submit a copy of the results of the new DID and any other pertinent information regarding the reassessment of the individual to DADS.~~

~~—(2) If the LIDDA is unable to complete the requirements described in paragraph (1) of this subsection within the 30 business day timeframe, the LIDDA must notify DADS of the reasons for the delay.~~

~~—(3) DADS reviews the information submitted by the LIDDA regarding the redetermination and notifies the LIDDA and the HCS Program provider of the review decision using DADS Form 1597, HCS Level of Care Redetermination Cover Sheet.]~~

~~[§9.162. Lapsed LOC.~~

~~(a) DADS does not pay the program provider for HCS Program services or CFC services provided during a period of time in which the individual's LOC has lapsed unless a reinstatement of the LOC determination is requested and granted in accordance with this section. DADS does not grant a request for reinstatement of an LOC determination to:~~

~~—(1) establish program eligibility;~~

~~—(2) renew an LOC determination;~~

~~—(3) obtain an LOC determination for a period of time for which an LOC has been denied;~~

~~—(4) revise an LON; or~~

~~—(5) obtain an LON determination for a period of time for which an individual's IPC is not current.~~

~~(b) The program provider must request reinstatement of an LOC determination in accordance with this subsection.~~

~~—(1) The program provider must:~~

~~—(A) complete an ID/RC Assessment signed and dated by the program provider;~~

~~—(B) include on the ID/RC Assessment an end date of the LOC period that is not later than 365 calendar days after the end date of the previously authorized LOC period; and~~

~~—(C) within 180 calendar days after the end date of the previously authorized LOC period, electronically transmit to DADS the completed ID/RC Assessment.~~

~~—(2) The program provider must ensure that the electronically transmitted ID/RC Assessment contains information that is identical to the information on the signed and dated ID/RC Assessment.~~

~~—(3) The program provider must, within three calendar days after submission, provide the service coordinator with a paper copy of the signed and dated ID/RC Assessment.~~

~~(c) Within seven calendar days after the ID/RC Assessment is electronically transmitted by the program provider, the service coordinator must review the ID/RC Assessment in the DADS data system and:~~

~~—(1) enter the service coordinator's name and date in the DADS data system;~~

~~—(2) enter in the DADS data system whether the service coordinator agrees or disagrees with the ID/RC Assessment; and~~

~~—(3) if the service coordinator disagrees with the ID/RC Assessment, notify the individual, LAR, DADS, and the program provider of the service coordinator's disagreement in accordance with DADS instructions.~~

~~(d) The service coordinator's agreement or disagreement is considered in DADS review of an ID/RC Assessment transmitted in accordance with subsection (b) of this section.~~

~~(e) DADS notifies the program provider of its decision to grant or deny the request for reinstatement of an LOC determination within 45 calendar days after DADS receives the ID/RC Assessment from the program provider in accordance with subsection (b)(1) of this section.~~

~~(f) If DADS grants a reinstatement, the period of reinstatement will be for a period of not more than 180 calendar days after the end date of the previously authorized LOC period.]~~

~~[§9.163. LON Assignment.~~

~~(a) A LIDDA must request an LON for an applicant from DADS at the time an applicant is enrolled into the HCS Program. The LON is requested by electronically transmitting to DADS a completed ID/RC Assessment, indicating the recommended LON, that is signed and dated by the service coordinator. The electronically transmitted ID/RC Assessment must contain information identical to the information on the signed and dated ID/RC Assessment.~~

~~(b) A program provider must request an LON for an individual from DADS in accordance with this subsection.~~

~~—(1) Before the expiration of an ID/RC Assessment, the program provider must electronically transmit to DADS a completed ID/RC Assessment, indicating the recommended LON, that is signed and dated by the program provider.~~

~~—(2) The program provider must ensure the electronically transmitted ID/RC Assessment contains information that is identical to the information on the signed and dated ID/RC Assessment.~~

~~—(3) The program provider must, within three calendar days after submission, provide the service coordinator with a paper copy of the signed and dated ID/RC Assessment.~~

~~—(4) If applicable, the program provider must submit supporting documentation to DADS as required by §9.164(c) of this subchapter (relating to DADS Review of LON).~~

~~(c) For an LON requested in accordance with subsection (b) of this section, within seven calendar days after the ID/RC Assessment is electronically transmitted by the program provider, the service coordinator must review the ID/RC Assessment in DADS data system and:~~

~~—(1) enter the service coordinator's name and date in DADS data system;~~

~~—(2) enter in DADS data system whether the service coordinator agrees or disagrees with the ID/RC Assessment; and~~

~~—(3) if the service coordinator disagrees with the ID/RC Assessment, notify the individual, LAR, DADS, and the program provider of the service coordinator's disagreement in accordance with DADS instructions.~~

~~(d) The service coordinator's agreement or disagreement is considered in DADS review of an ID/RC Assessment transmitted in accordance with subsection (b) of this section.~~

~~(e) The program provider must maintain documentation supporting the recommended LON in the individual's record.~~

~~(f) DADS assigns an LON to an individual based on the individual's ICAP service level score, information reported on the individual's ID/RC Assessment, and required supporting documentation. Documentation supporting a recommended LON must be submitted to DADS in accordance with DADS guidelines.~~

~~(g) DADS assigns one of five LONs as follows:~~

~~—(1) an intermittent LON (LON 1) is assigned if the individual's ICAP service level score equals 7, 8, or 9;~~

~~—(2) a limited LON (LON 5) is assigned if the individual's ICAP service level score equals 4, 5, or 6;~~

~~—(3) an extensive LON (LON 8) is assigned if the individual's ICAP service level score equals 2 or 3;~~

~~—(4) a pervasive LON (LON 6) is assigned if the individual's ICAP service level score equals 1; and~~

~~—(5) regardless of an individual's ICAP service level score, a pervasive plus LON (LON 9) is assigned if the individual meets the criteria set forth in subsection (i) of this section.~~

~~(h) An LON 1, 5, or 8, determined in accordance with subsection (g) of this section, is increased to the next LON by DADS, due to an individual's dangerous behavior, if supporting documentation submitted to DADS proves that:~~

~~—(1) the individual exhibits dangerous behavior that could cause serious physical injury to the individual or others;~~

~~—(2) a written behavior support plan has been implemented that meets DADS guidelines and is based on ongoing written data, targets the dangerous behavior with individualized objectives, and specifies intervention procedures to be followed when the behavior occurs;~~

~~—(3) more service providers are needed and available than would be needed if the~~

~~individual did not exhibit dangerous behavior;~~

~~—(4) service providers are constantly prepared to physically prevent the dangerous behavior or intervene when the behavior occurs; and~~

~~—(5) the individual's ID/RC Assessment is correctly scored with a "1" in the "Behavior" section.~~

~~(i) DADS assigns an LON 9 if supporting documentation submitted to DADS proves that:~~

~~—(1) the individual exhibits extremely dangerous behavior that could be life threatening to the individual or to others;~~

~~—(2) a written behavior support plan has been implemented that meets DADS guidelines and is based on ongoing written data, targets the extremely dangerous behavior with individualized objectives, and specifies intervention procedures to be followed when the behavior occurs;~~

~~—(3) management of the individual's behavior requires a service provider to exclusively and constantly supervise the individual during the individual's waking hours, which must be at least 16 hours per day;~~

~~—(4) the service provider assigned to supervise the individual has no other duties during such assignment; and~~

~~—(5) the individual's ID/RC Assessment is correctly scored with a "2" in the "Behavior" section.~~

~~(j) A program provider must re-administer the ICAP to an individual under a circumstance described in paragraphs (1) — (3) of this subsection and must submit a completed ID/RC Assessment to DADS recommending a revision of the individual's LON assignment if the ICAP results and the ID/RC Assessment indicate a revision of the individual's LON assignment may be appropriate. The ICAP must be re-administered:~~

~~—(1) within three years after the individual's enrollment and every third year thereafter;~~

~~—(2) if changes in the individual's functional skills or behavior occur that are not expected to be of short duration or cyclical in nature; or~~

~~—(3) if the individual's skills and behavior are inconsistent with the individual's assigned LON.]~~

~~[§9.164. DADS' Review of LON.~~

~~(a) DADS may review a recommended or assigned LON at any time to determine if it is appropriate. If DADS reviews an LON, documentation supporting the LON must be submitted to DADS in accordance with DADS' request. DADS may modify an LON and recoup or deny payment based on its review.~~

~~(b) Before assigning an LON, DADS reviews documentation supporting the recommended LON if:~~

~~—(1) an LON is requested that is an increase from the individual's current LON;~~

~~—(2) an LON is requested in accordance with §9.163(i) of this subchapter (relating to LON Assignment); or~~

~~—(3) an LON is requested in accordance with §9.163(h) of this subchapter.~~

~~(c) Documentation supporting a recommended LON described in subsection (b) of this section must be submitted to DADS and received by DADS within seven calendar days after electronically transmitting the recommended LON.~~

~~—(1) Within 21 calendar days after receiving the supporting documentation:~~

~~——(A) DADS requests additional documentation;~~

~~——(B) electronically approves the recommended LON; or~~

~~——(C) sends written notification that the recommended LON has been denied.~~

~~—(2) DADS reviews any additional documentation submitted in accordance with DADS' request and:~~

~~——(A) electronically approves the recommended LON; or~~

~~——(B) sends written notification that the recommended LON has been denied to the program provider, the service coordinator, and the individual or LAR.]~~

~~[§9.165. Reconsideration of LON Assignment.~~

~~(a) If the program provider disagrees with an LON assignment, the program provider may request that DADS reconsider the assignment.~~

~~(b) The program provider may receive reconsideration only if the program provider submitted documentation supporting the recommended LON as required by §9.164(c) of this subchapter (relating to DADS' Review of LON).~~

~~(c) To request reconsideration of an LON assignment, the program provider must submit a written request for reconsideration to DADS within 10 calendar days after receipt of the notice that the recommended LON was denied. A program provider~~

~~may send DADS documentation, in addition to that required by §9.164(c) of this subchapter, to support the request for reconsideration of an LON assignment.~~

~~(d) Within 21 calendar days after receipt of a request for reconsideration, DADS electronically approves the recommended LON or sends written notification that the recommended LON has been denied to the program provider, the service coordinator, and the individual or LAR.]~~

~~[§9.166. Renewal and Revision of an IPC.~~

~~(a) Renewal of the IPC. At least annually and before the expiration of an individual's IPC, the individual's IPC must be renewed in accordance with this subsection and with DADS instructions.~~

~~—(1) At least 60 but no more than 90 calendar days before the expiration of an individual's IPC, the service coordinator must:~~

~~——(A) notify the service planning team that the individual's PDP must be reviewed and updated; and~~

~~——(B) convene the service planning team to:~~

~~————(i) review and update the individual's PDP; and~~

~~————(ii) if CFC PAS/HAB is included on the PDP, complete DADS HCS/TxHmL CFC PAS/HAB Assessment form to determine the number of CFC PAS/HAB hours the individual needs.~~

~~—(2) The service coordinator, within 10 calendar days after the PDP is updated, must send the program provider and FMSA, if applicable, a copy of:~~

~~——(A) the updated PDP; and~~

~~——(B) if CFC PAS/HAB is included on the PDP, a copy of the completed DADS HCS/TxHmL CFC PAS/HAB Assessment form.~~

~~—(3) The program provider must ensure that a meeting between the service planning team and the program provider occurs at least 30 but no more than 60 calendar days before the expiration of the individual's IPC to:~~

~~——(A) review the PDP and, if CFC PAS/HAB is included on the PDP, the completed DADS HCS/TxHmL CFC PAS/HAB Assessment form; and~~

~~——(B) develop the proposed renewal IPC in accordance with §9.159(c) of this subchapter (relating to IPC), including completion of the CDS option portion of the proposed renewal IPC, if applicable, and the non-HCS Program services and non-CFC services.~~

~~—(4) The program provider must develop, before the effective date of the proposed renewal IPC:~~

~~——(A) an implementation plan for:~~

~~——(i) HCS Program services, except for transportation as a supported home living activity, that is based on the individual's PDP and proposed renewal IPC; and~~

~~——(ii) CFC services, except for CFC support management, that is based on the individual's PDP, and proposed renewal IPC, and if CFC PAS/HAB is included on the PDP, the completed DADS HCS/TxHmL CFC PAS/HAB Assessment form; and~~

~~——(B) a transportation plan, if transportation as a supported home living activity is included on the PDP.~~

~~—(5) Within seven calendar days after development of the proposed renewal IPC as required by paragraph (3) of this subsection, the program provider must comply with the requirements in subsection (e)(1) and (2) of this section.~~

~~—(6) Within seven calendar days after the program provider electronically transmits the proposed renewal IPC to DADS as required by subsection (e)(2) of this section, the service coordinator must comply with the requirements in subsection (e)(3) of this section.~~

~~—(7) The program provider must provide HCS Program services and CFC services in accordance with:~~

~~——(A) an implementation plan that is based on:~~

~~——(i) the individual's PDP;~~

~~——(ii) the renewal IPC; and~~

~~——(iii) if CFC PAS/HAB is included on the PDP, the completed DADS HCS/TxHmL CFC PAS/HAB Assessment form; and~~

~~——(B) a transportation plan, if transportation as a supported home living activity is included on the PDP.~~

~~(b) Revisions to the IPC. Except as provided in subsection (f) of this section, the service coordinator or the program provider may determine whether an individual's IPC needs to be revised to add a new HCS Program service or CFC service or change the amount of an existing service.~~

~~—(1) The service coordinator must notify the program provider if the service coordinator determines that the IPC needs to be revised.~~

~~—(2) The program provider must notify the service coordinator if the program provider determines that the IPC needs to be revised.~~

~~—(3) Within 14 calendar days after the notification required by paragraph (1) or (2) of this subsection:~~

~~——(A) if the IPC needs to be revised to add CFC PAS/HAB or change the amount of CFC PAS/HAB:~~

~~————(i) the service planning team must complete DADS HCS/TxHmL CFC PAS/HAB Assessment form to determine the number of CFC PAS/HAB hours the individual needs; and~~

~~————(ii) the service coordinator must send a copy of the completed form to the program provider for review;~~

~~——(B) the service planning team and the program provider must develop a proposed revised IPC;~~

~~——(C) the service planning team must revise the PDP, if appropriate, and if the PDP is not revised, the service coordinator must document the reasons for the proposed IPC revision;~~

~~——(D) the program provider must revise:~~

~~————(i) the implementation plan for:~~

~~————(I) HCS Program services, except for transportation as a supported home living activity, that is based on the individual's PDP and proposed revised IPC; and~~

~~————(II) CFC services, except for CFC support management, that is based on the individual's PDP, proposed revised IPC, and if CFC PAS/HAB is included on the PDP, the completed DADS HCS/TxHmL CFC PAS/HAB Assessment form; and~~

~~————(ii) the transportation plan, if transportation as a supported home living activity is modified on the PDP or IPC; and~~

~~——(E) the program provider must comply with the requirements in subsection (e)(1) and (2) of this section.~~

~~—(4) Within seven calendar days after the program provider electronically transmits the proposed revised IPC to DADS as required by subsection (e)(2) of this section, the service coordinator must comply with the requirements in subsection (e)(3) of this section.~~

~~—(5) The program provider must provide HCS Program services and CFC services in accordance with:~~

~~——(A) an implementation plan that is based on:~~

~~————(i) the individual's PDP;~~

~~————(ii) the revised IPC; and~~

~~————(iii) if CFC PAS/HAB is included on the PDP, the completed DADS HCS/TxHmL CFC PAS/HAB Assessment form; and~~

~~——(B) the revised transportation plan, if revised in accordance with paragraph (3)(C)(ii) of this subsection.~~

~~(c) Revision of IPC before delivery of services. Except as provided by subsection (d) of this section, if an individual's service planning team and program provider determine that the IPC must be revised to add a new HCS Program service or CFC service or change the amount of an existing service, the program provider must revise the IPC in accordance with subsection (b) of this section before the delivery of a new or increased service.~~

~~(d) Emergency provision of services and revision of the IPC.~~

~~—(1) If an emergency necessitates the provision of an HCS Program service or CFC service to ensure the individual's health and safety and the service is not on the IPC or exceeds the amount on the IPC, the program provider may provide the service before revising the IPC. The program provider must, within one business day after providing the service:~~

~~——(A) document:~~

~~————(i) the circumstances that necessitated providing the new HCS Program service or CFC service or the increase in the amount of the existing HCS Program service or CFC service; and~~

~~————(ii) the type and amount of the service provided;~~

~~——(B) notify the service coordinator of the emergency provision of the service and that the IPC must be revised; and~~

~~——(C) upon request, provide a copy of the documentation required by subparagraph (A) of this paragraph to the service coordinator.~~

~~—(2) Within seven calendar days after providing the service:~~

~~——(A) the service planning team and the program provider must develop a~~

~~proposed revised IPC;~~

~~—— (B) the service planning team must revise the PDP, if appropriate;~~

~~—— (C) the program provider must:~~

~~—— (i) revise the implementation plan that is based on the individual's PDP and proposed revised IPC; and~~

~~—— (ii) develop or revise a transportation plan, if transportation as a supported home living activity is added to or modified on the PDP or IPC; and~~

~~—— (D) the program provider must comply with the requirements in subsection (e)(1) and (2) of this section.~~

~~—— (3) Within seven calendar days after the program provider electronically transmits the proposed revised IPC to DADS as required by subsection (e)(2) of this section, the service coordinator must comply with the requirements in subsection (e)(3) of this section.~~

~~—— (4) The program provider must provide HCS Program services and CFC services in accordance with:~~

~~—— (A) an implementation plan that is based on the individual's PDP and the revised IPC; and~~

~~—— (B) the transportation plan developed or revised in accordance with paragraph (2)(C)(ii) of this subsection.~~

~~(e) Submitting a proposed renewal and revised IPC to DADS. A proposed renewal or revised IPC must be submitted to DADS for authorization in accordance with this subsection.~~

~~—— (1) The program provider must:~~

~~—— (A) sign and date the proposed renewal or revised IPC demonstrating agreement that the services will be provided to the individual; and~~

~~—— (B) ensure that a proposed renewal or revised IPC is signed and dated by the individual or LAR.~~

~~—— (2) The program provider must:~~

~~—— (A) electronically transmit a proposed renewal or revised IPC to DADS;~~

~~—— (B) keep the original proposed renewal or revised IPC in the individual's record and, within three calendar days after electronic transmission, ensure the~~

~~service coordinator receives a copy of the signed proposed renewal or revised IPC;
and~~

~~——(C) ensure the electronically transmitted proposed renewal or revised IPC
contains information identical to that on the original proposed renewal or revised
IPC.~~

~~——(3) The service coordinator must review the electronically transmitted proposed
renewal or revised IPC and:~~

~~——(A) enter the service coordinator's name and date in the DADS data system;~~

~~——(B) enter in the DADS data system whether the service coordinator agrees or
disagrees that the requirements described in §9.159(c) of this subchapter have
been met; and~~

~~——(C) if the service coordinator disagrees that the requirements described in
§9.159(c) of this subchapter have been met, notify the individual or LAR, the
program provider, and DADS of the service coordinator's disagreement in
accordance with DADS instructions.~~

~~(f) Revision of IPC to include CFC support management. If an individual or LAR
requests CFC support management during an IPC year, the service coordinator or
the program provider must revise the IPC as described in the HCS Handbook
available at www.dads.state.tx.us.~~

~~(g) Renewal and revision of IPC when all services are through the CDS option. For
an individual who is receiving all services through the CDS option and, therefore,
does not have a program provider, the service coordinator must perform the
functions of the program provider described in this section.]~~

~~[§9.167. Permanency Planning.~~

~~(a) Permanency planning at enrollment. The provisions contained in this subsection
apply to an applicant under 22 years of age moving from a family setting and
requesting supervised living or residential support.~~

~~——(1) Information. A LIDDA must, before enrollment, inform the applicant and
LAR:~~

~~——(A) of the benefits of living in a family or community setting;~~

~~——(B) that the placement of the applicant is considered temporary; and~~

~~——(C) that an ongoing permanency planning process is required.~~

~~——(2) Permanency planning activities.~~

~~—— (A) A LIDDA must convene a permanency planning meeting with the LAR and, if possible, the applicant, before enrollment.~~

~~—— (B) Before the permanency planning meeting, the LIDDA must review the applicant's records, and, if possible, meet the applicant.~~

~~—— (C) During the permanency planning meeting, the meeting participants must discuss and choose one of the following goals:~~

~~—— (i) for an applicant under 18 years of age:~~

~~—— (I) to live in the applicant's family home where the natural supports and strengths of the applicant's family are supplemented, as needed, by activities and supports provided or facilitated by the LIDDA or program provider; or~~

~~—— (II) to live in a family-based alternative in which a family other than the applicant's family:~~

~~—— (a) has received specialized training in the provision of support and in-home care for an individual under 18 years of age with an intellectual disability or a related condition;~~

~~—— (b) will provide a consistent and nurturing environment in a family home that supports a continued relationship with the applicant's family to the extent possible; and~~

~~—— (c) will provide an enduring, positive relationship with a specific adult who will be an advocate for the applicant; or~~

~~—— (ii) for an applicant 18-21 years of age to live in a setting chosen by the applicant or LAR in which the applicant's natural supports and strengths are supplemented by activities and supports provided or facilitated by the LIDDA or program provider, and to achieve a consistent and nurturing environment in the least restrictive setting, as defined by the applicant and LAR.~~

~~—— (D) To accomplish the goal chosen in accordance with subparagraph (C) of this paragraph, the meeting participants must discuss and identify:~~

~~—— (i) the problems or issues that led the applicant or LAR to request supervised living or residential support;~~

~~—— (ii) the applicant's daily support needs;~~

~~—— (iii) for the applicant under 18 years of age:~~

~~—— (I) barriers to having the applicant reside in the family home;~~

_____ (II) supports that would be necessary for the applicant to remain in the family home; and

_____ (III) actions that must be taken to overcome the barriers and provide the necessary supports;

_____ (iv) for an applicant 18-21 years of age, the barriers to moving to a consistent and nurturing environment as defined by the applicant and LAR;

_____ (v) the importance for the applicant to live in a long-term nurturing relationship with a family;

_____ (vi) alternatives to the applicant living in an institutional setting;

_____ (vii) the applicant's and LAR's need for information and preferences regarding those alternatives;

_____ (viii) how, after the applicant's enrollment, to facilitate regular contact between the applicant and the applicant's family, and, if desired by the applicant and family, between the applicant and advocates and friends in the community to continue supportive and nurturing relationships;

_____ (ix) natural supports and family strengths that will assist in accomplishing the identified permanency planning goal;

_____ (x) activities and supports that can be provided by the family, LIDDA, or program provider to achieve the permanency planning goal;

_____ (xi) assistance needed by the applicant's family:

_____ (I) in maintaining a nurturing relationship with the applicant; and

_____ (II) preparing the family for the applicant's eventual return to the family home or move to a family-based alternative; and

_____ (xii) action steps, both immediate and long term, for achieving the permanency plan goal.

— (E) A LIDDA must make reasonable accommodations to promote the participation of the LAR in a permanency planning meeting, including:

_____ (i) conducting a meeting in person or by telephone, as mutually agreed upon by the LIDDA and LAR;

_____ (ii) conducting a meeting at a time and, if the meeting is in person, at a location that is mutually agreed upon by the LIDDA and LAR;

~~_____ (iii) if the LAR has a disability, providing reasonable accommodations in accordance with the Americans with Disabilities Act, including providing an accessible meeting location or a sign language interpreter, if appropriate; and~~

~~_____ (iv) providing a language interpreter, if appropriate.~~

~~_____ (F) A LIDDA must develop a permanency plan using, as appropriate:~~

~~_____ (i) the Permanency Planning Instrument for Children Under 18 Years of Age, found at www.dads.state.tx.us; or~~

~~_____ (ii) the Permanency Planning Instrument for Individuals 18—21 Years of Age, found at www.dads.state.tx.us.~~

~~_____ (G) A LIDDA must:~~

~~_____ (i) complete the Permanency Planning Review Screen in DADS data system before enrollment;~~

~~_____ (ii) keep a copy of the Permanency Planning Review Approval Status View Screen from DADS data system in the applicant's record; and~~

~~_____ (iii) provide a copy of the permanency plan to the program provider, the applicant, and the LAR.~~

~~_____ (3) Volunteer advocate.~~

~~_____ (A) A LIDDA must inform the applicant and LAR that they may request a volunteer advocate to assist in permanency planning. The applicant or LAR may:~~

~~_____ (i) select a person who is not employed by or under contract with the LIDDA or a program provider; or~~

~~_____ (ii) request the LIDDA to designate a volunteer advocate.~~

~~_____ (B) If an applicant or LAR requests that the LIDDA designate a volunteer advocate or the LIDDA cannot locate the applicant's LAR, the LIDDA must attempt to designate a volunteer advocate to assist in permanency planning who is, in order of preference:~~

~~_____ (i) an adult relative who is actively involved with the applicant;~~

~~_____ (ii) a person who:~~

~~_____ (I) is part of the applicant's natural supports; and~~

~~_____ (II) is not employed by or under contract with the~~

~~LIDDA or a program provider; or~~

~~————— (iii) a person or a child advocacy organization representative who:~~

~~————— (I) is knowledgeable about community services and supports;~~

~~————— (II) is familiar with the permanency planning philosophy and processes; and~~

~~————— (III) is not employed by or under contract with the LIDDA or a program provider.~~

~~— (C) If a LIDDA is unable to locate a volunteer advocate locally, the LIDDA must request assistance from a statewide advocacy organization in identifying an available volunteer advocate who meets the requirements described in subparagraph (B)(iii) of this paragraph. If the statewide advocacy organization is unable to assist the LIDDA in identifying a volunteer advocate, the LIDDA must document all efforts to designate a volunteer advocate in accordance with subparagraph (B) of this paragraph.~~

~~(b) Permanency planning reviews. A LIDDA must, within six months after the initial permanency planning meeting and every six months thereafter until an individual either turns 22 years of age or is no longer receiving supervised living or residential support:~~

~~— (1) provide written notice to the LAR of a meeting to conduct a review of the individual's permanency plan no later than 21 calendar days before the meeting date and include a request for a response from the LAR;~~

~~— (2) convene a meeting to review the individual's current permanency plan in accordance with subsection (a)(2)(C) — (E) of this section, with an emphasis on changes or additional information gathered since the last permanency plan was developed;~~

~~— (3) develop a permanency plan in accordance with subsection (a)(2)(F) of this section;~~

~~— (4) perform actions regarding a volunteer advocate as described in subsection (a)(3) of this section;~~

~~— (5) complete the Permanency Planning Review Screen in DADS data system within 10 calendar days after the meeting;~~

~~— (6) ensure that approval for the individual to continue to reside in an institution is obtained every six months from the DADS commissioner and the HHSC executive commissioner;~~

~~—(7) keep a copy of the Permanency Planning Review Approval Status View Screen from DADS data system in the individual's record;~~

~~—(8) provide a copy of the permanency plan to the program provider, the individual, and the LAR; and~~

~~—(9) if the LIDDA determines it is unable to locate the parent or LAR, notify the service coordinator of such determination.~~

~~(c) Provision of supervised living or residential support after enrollment. If a LIDDA receives information that an individual under 22 years of age who has been enrolled in the HCS Program moved from a family setting and started receiving supervised living or residential support, the LIDDA must, within the timeframes described in the performance contract between DADS and the LIDDA:~~

~~—(1) provide an explanation of services and supports and other information in accordance with §9.158(e)(1) of this subchapter (relating to Process for Enrollment of Applicants); and~~

~~(2) take actions to conduct permanency planning as described in subsection (a) of this section.]~~

~~[§9.168. CDS Option.~~

~~(a) If supported home living, respite, nursing, employment assistance, supported employment, cognitive rehabilitation therapy, or CFC PAS/HAB is included in an applicant's PDP, and the applicant's PDP does not include residential support, supervised living, or host home/companion care, the service coordinator must:~~

~~—(1) inform the applicant or LAR of the applicant's right to participate in the CDS option or discontinue participation in the CDS option at any time, except as provided in §41.405(a) of this title (relating to Suspension of Participation in the CDS Option);~~

~~—(2) inform the applicant or LAR that the applicant or LAR may choose to have supported home living, respite, nursing, employment assistance, supported employment, cognitive rehabilitation therapy, or CFC PAS/HAB provided through the CDS option;~~

~~—(3) provide the applicant or LAR a copy of the Consumer Directed Services Option Overview, Consumer Directed Services Responsibilities, and Employee Qualification Requirements forms, which are found at www.dads.state.tx.us and which contain information about the CDS option, including a description of FMS and support consultation;~~

~~—(4) provide an oral explanation of the information contained in the Consumer Directed Services Option Overview, Consumer Directed Services Responsibilities,~~

~~and Employee Qualification Requirements forms to the applicant or LAR; and~~

~~—(5) provide the applicant or LAR the opportunity to choose to participate in the CDS option and document the applicant's or LAR's choice on the Consumer Participation Choice form, which is found at www.dads.state.tx.us.~~

~~(b) If an applicant or LAR chooses to participate in the CDS option, the service coordinator must:~~

~~—(1) provide names and contact information to the applicant or LAR regarding all FMSAs providing services in the LIDDA's local service area;~~

~~—(2) document the applicant's or LAR's choice of FMSA on the Consumer Participation Choice form;~~

~~—(3) document, in the individual's PDP, a description of the service provided through the CDS option; and~~

~~—(4) document, in the individual's PDP, a description of the individual's service backup plan, if a backup plan is required by Chapter 41 of this title (relating to Consumer Directed Services Option).~~

~~(c) For an individual who is receiving supported home living, respite, nursing, employment assistance, supported employment, cognitive rehabilitation therapy, or CFC PAS/HAB, and is not receiving residential support, supervised living, or host home/companion care, the service coordinator must, at least annually:~~

~~—(1) inform the individual or LAR of the individual's right to participate in the CDS option or discontinue participation in the CDS option at any time, except as provided in §41.405(a) of this title;~~

~~—(2) provide the individual or LAR a copy of the Consumer Directed Services Option Overview, Consumer Directed Services Responsibilities, and Employee Qualification Requirements forms, which are found at www.dads.state.tx.us and which contain information about the CDS option, including FMS and support consultation;~~

~~—(3) provide an oral explanation of the information contained in the Consumer Directed Services Option Overview, Consumer Directed Services Responsibilities and Employee Qualification Requirements forms to the individual or LAR; and~~

~~—(4) provide the individual or LAR the opportunity to choose to participate in the CDS option and document the individual's choice on the Consumer Participation Choice form, which is found at www.dads.state.tx.us.~~

~~(d) If an individual or LAR chooses to participate in the CDS option, the service coordinator must:~~

~~—(1) provide names and contact information to the individual or LAR regarding all FMSAs providing services in the LIDDA's local service area;~~

~~—(2) document the individual's or LAR's choice of FMSA on the Consumer Participation Choice form;~~

~~—(3) document, in the individual's PDP, a description of the service provided through the CDS option;~~

~~—(4) document, in the individual's PDP, a description of the individual's service backup plan, if a backup plan is required by Chapter 41 of this title; and~~

~~—(5) notify the program provider of the individual's or LAR's decision to participate in the CDS option.~~

~~(e) The service coordinator must document in the individual's PDP that the information described in subsections (c) and (d)(1) of this section was provided to the individual or LAR.~~

~~(f) If an individual's PDP includes transportation as a supported home living activity to be delivered through the CDS option, the service planning team must develop a transportation plan.~~

~~(g) For an individual participating in the CDS option, the service coordinator must recommend that DADS terminate the individual's participation in the CDS option (that is, terminate FMS and support consultation) if the service coordinator determines that:~~

~~—(1) the individual's continued participation in the CDS option poses a significant risk to the individual's health or safety; or~~

~~—(2) the individual or LAR has not complied with Chapter 41, Subchapter B of this title (relating to Responsibilities of Employers and Designated Representatives).~~

~~(h) If the service coordinator makes a recommendation in accordance with subsection (g) of this section, the service coordinator must:~~

~~—(1) document:~~

~~——(A) a description of the service recommended for termination;~~

~~——(B) the reasons why termination is recommended;~~

~~——(C) a description of the attempts to resolve the issues before recommending termination;~~

~~—(2) obtain other supporting documentation, as appropriate; and~~

~~—(3) notify the program provider that the IPC needs to be revised.~~

~~(i) Within seven calendar days after notification in accordance with subsection (h)(3) of this section:~~

~~—(1) the service coordinator and the program provider must comply with the requirements described in §9.166(d)(2)(A)—(D) of this subchapter (relating to Renewal and Revision of an IPC); and~~

~~(2) the service coordinator must send the documentation described in subsection (h)(1) of this section to DADS.]~~

~~[§9.169 Fair Hearing~~

~~(a) An applicant whose request for eligibility for the HCS Program is denied or is not acted upon with reasonable promptness, or an individual whose HCS Program services or CFC services have been terminated, suspended, denied, or reduced by DADS receives notice of the right to request a fair hearing in accordance with 1 TAC Chapter 357, Subchapter A (relating to Uniform Fair Hearing Rules).~~

~~(b) Only a service coordinator may recommend that DADS terminate an individual's HCS Program services or CFC services.]~~

~~[§9.170 Reimbursement~~

~~Program provider reimbursement:~~

~~—(1) A program provider is paid for services as described in this paragraph.~~

~~——(A) DADS pays for supported home living, professional therapies, nursing, respite, employment assistance, supported employment, and CFC PAS/HAB in accordance with the reimbursement rate for the specific service.~~

~~——(B) DADS pays for host home/companion care, residential support, supervised living, and day habilitation in accordance with the individual's LON and the reimbursement rate for the specific service.~~

~~——(C) DADS pays for adaptive aids, minor home modifications, and dental treatment based on the actual cost of the item and, if requested, a requisition fee in accordance with the *HCS Program Billing Guidelines*, which are available at www.dads.state.tx.us.~~

~~——(D) DADS pays:~~

~~——(i) for TAS based on a Transition Assistance Services (TAS) Assessment and Authorization form authorized by DADS and the actual cost of the TAS as evidenced by purchase receipts required by the *HCS Program Billing*~~

~~Guidelines; and~~

~~————(ii) if requested, a TAS service fee in accordance with the *HCS Program Billing Guidelines*.~~

~~————(E) DADS pays for pre-enrollment minor home modifications and a pre-enrollment minor home modifications assessment based on a Home and Community-based Services (HCS) Program Pre-enrollment MHM Authorization Request form authorized by DADS and the actual cost of the pre-enrollment minor home modifications and a pre-enrollment minor home modifications assessment as evidenced by documentation required by the *HCS Program Billing Guidelines*.~~

~~————(F) Subject to the requirements in the *HCS Program Billing Guidelines*, DADS pays for TAS, pre-enrollment minor home modifications, and a pre-enrollment minor home modifications assessment regardless of whether the applicant enrolls with the program provider.~~

~~————(G) DADS pays for CFC ERS based on the actual cost of the service, not to exceed the reimbursement rate ceiling for CFC ERS.~~

~~——(2) If an individual's HCS Program services or CFC services are suspended or terminated the program provider must not submit a claim for services provided during the period of the individual's suspension or after the termination, except that the program provider may submit a claim for the first day of the individual's suspension or termination for the following services:~~

~~————(A) day habilitation;~~

~~————(B) supported home living;~~

~~————(C) respite;~~

~~————(D) employment assistance;~~

~~————(E) supported employment;~~

~~————(F) professional therapies;~~

~~————(G) nursing; and~~

~~————(H) CFC PAS/HAB.~~

~~——(3) If the program provider submits a claim for an adaptive aid that costs \$500 or more or for a minor home modification that costs \$1,000 or more, the claim must be supported by a written assessment from a licensed professional specified by DADS in the *HCS Program Billing Guidelines* and other documentation as required by the *HCS Program Billing Guidelines*.~~

~~(4) DADS does not pay the program provider for a service or recoups any payments made to the program provider for a service if:~~

~~———(A) except for an individual receiving TAS, pre-enrollment minor home modifications, or a pre-enrollment minor home modifications assessment, the individual receiving the service is, at the time the service was provided, ineligible for the HCS Program or Medicaid benefits, or was an inpatient of a hospital, nursing facility, or ICF/IID;~~

~~———(B) except for TAS, pre-enrollment minor home modifications, and a pre-enrollment minor home modifications assessment:~~

~~—————(i) the service is provided to an individual during a period of time for which there is not a signed, dated, and authorized IPC for the individual;~~

~~—————(ii) the service is provided during a period of time for which there is not a signed and dated ID/RC Assessment for the individual;~~

~~—————(iii) the service is provided during a period of time for which the individual did not have an LOC determination;~~

~~—————(iv) the service is not provided in accordance with a signed, dated, and authorized IPC meeting the requirements set forth in §9.159(c) of this subchapter (relating to IPC);~~

~~—————(v) the service is not provided in accordance with the individual's PDP or implementation plan;~~

~~—————(vi) the service is provided before the individual's enrollment date into the HCS Program; or~~

~~—————(vii) the service is not included on the signed, dated, and authorized IPC of the individual in effect at the time the service was provided, except as permitted by §9.166(d) of this subchapter (relating to Renewal and Revision of an IPC);~~

~~———(C) the service is not provided in accordance with the *HCS Program Billing Guidelines* or the *CFC Billing Guidelines for HCS and TxHmL Program Providers*;~~

~~———(D) the program provider provides the supervised living or residential support service in a residence in which four individuals or other person receiving similar services live without DADS approval as required in §9.188 of this subchapter (relating to DADS Approval of Residences);~~

~~———(E) the service is not documented in accordance with the *HCS Program Billing Guidelines* or the *CFC Billing Guidelines for HCS and TxHmL Program Providers*;~~

~~—— (F) the claim for the service does not meet the requirements in §49.311 of this title (relating to Claims Payment) or the *HCS Program Billing Guidelines* or the *CFC Billing Guidelines for HCS and TxHmL Program Providers*;~~

~~—— (G) the program provider does not have the documentation described in paragraph (3) of this section;~~

~~—— (H) DADS determines that the service would have been paid for by a source other than the HCS Program if the program provider had submitted to the other source a proper, complete, and timely request for payment for the service;~~

~~—— (I) before including employment assistance on an individual's IPC, the program provider does not ensure and maintain documentation in the individual's record that employment assistance is not available to the individual under a program funded under §110 of the Rehabilitation Act of 1973 or under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.);~~

~~—— (J) before including supported employment on an individual's IPC, the program provider does not ensure and maintain documentation in the individual's record that supported employment is not available to the individual under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.);~~

~~—— (K) the service is provided by a service provider who does not meet the qualifications to provide the service as described in the *HCS Program Billing Guidelines* or the *CFC Billing Guidelines for HCS and TxHmL Program Providers*;~~

~~—— (L) the service of host home/companion care, residential support, or supervised living is provided on the day of the individual's suspension or termination of HCS Program services;~~

~~—— (M) the service was paid at an incorrect LON because the ID/RC Assessment electronically transmitted to DADS does not contain information identical to information on the signed and dated ID/RC Assessment;~~

~~—— (N) for TAS, the service is not provided in accordance with a Transition Assistance Services (TAS) Assessment and Authorization form authorized by DADS;~~

~~—— (O) for pre-enrollment minor home modifications and a pre-enrollment minor home modifications assessment, the service is not provided in accordance with a Home and Community-based Services (HCS) Program Pre-enrollment MHM Authorization Request form authorized by DADS;~~

~~—— (P) for a CFC service, the service is provided to an individual receiving host home/companion care, supervised living, or residential support; or~~

~~—— (Q) for transportation as a supported home living activity, the service is not provided in accordance with a transportation plan.~~

~~—— (5) The program provider must refund to DADS any overpayment made to the program provider within 60 calendar days after the program provider's discovery of the overpayment or receipt of a notice of such discovery from DADS, whichever is earlier.~~

~~—— (6) DADS conducts billing and payment reviews to monitor a program provider's compliance with this subchapter, the *HCS Program Billing Guidelines*, and the *CFC Billing Guidelines for HCS and TxHmL Program Providers*. DADS conducts such reviews in accordance with the Billing and Payment Review Protocol set forth in the *HCS Program Billing Guidelines* and the *CFC Billing Guidelines for HCS and TxHmL Program Providers*. As a result of a billing and payment review, DADS may:~~

~~—— (A) recoup payments from a program provider; and~~

~~—— (B) based on the amount of unverified claims, require a program provider to develop and submit, in accordance with DADS instructions, a corrective action plan that improves the program provider's billing practices.~~

~~—— (7) A corrective action plan required by DADS in accordance with paragraph (6)(B) of this section must:~~

~~—— (A) include:~~

~~—— (i) the reason the corrective action plan is required;~~

~~—— (ii) the corrective action to be taken;~~

~~—— (iii) the person responsible for taking each corrective action; and~~

~~—— (iv) a date by which the corrective action will be completed that is no later than 90 calendar days after the date the program provider is notified the corrective action plan is required;~~

~~—— (B) be submitted to DADS within 30 calendar days after the date the program provider is notified the corrective action plan is required; and~~

~~—— (C) be approved by DADS before implementation.~~

~~—— (8) Within 30 calendar days after the corrective action plan is received by DADS, DADS notifies the program provider if a corrective action plan is approved or if changes to the plan are required.~~

~~—— (9) If DADS requires a program provider to develop and submit a corrective action plan in accordance with paragraph (6)(B) of this section and the program~~

~~provider requests an administrative hearing for the recoupment in accordance with §9.186 of this subchapter (relating to Program Provider's Right to Administrative Hearing), the program provider is not required to develop or submit a corrective action plan while a hearing decision is pending. DADS notifies the program provider if the requirement to submit a corrective action plan or the content of such a plan changes based on the outcome of the hearing.~~

~~—(10) If the program provider does not submit the corrective action plan or complete the required corrective action within the time frames described in paragraph (7) of this section, DADS may impose a vendor hold on payments due to the program provider under the contract until the program provider takes the corrective action.~~

~~—(11) If the program provider does not submit the corrective action plan or complete the required corrective action within 30 calendar days after the date a vendor hold is imposed in accordance with paragraph (10) of this section, DADS may terminate the contract.]~~

~~[§9.186 Program Provider's Right to Administrative Hearing~~

~~(a) A program provider may request an administrative hearing in accordance with 1 TAC §357.484 (relating to Request for a Hearing) if HHSC:~~

~~——(1) proposes or imposes a sanction described in §49.531(a) of this title (relating to Sanction by HHSC); or~~

~~——(2) denies a program provider's claim for payment, including denial of a retroactive LOC and denial of a recommended LON.~~

~~(b) If the basis of an administrative hearing requested in accordance with subsection (a)(2) of this section is a dispute regarding an LON assignment, the program provider may receive an administrative hearing only if reconsideration was requested by the program provider in accordance with §9.165 of this subchapter (relating to Reconsideration of LON Assignment).]~~

~~[§9.189. Referral to DFPS.~~

~~If, within one year after the date DADS receives the notification described in §9.190(e)(35) or (36) of this subchapter (relating to LIDDA Requirements for Providing Service Coordination in the HCS Program), DADS is unable to locate the parent or LAR, DADS refers the case to:~~

~~——(1) the Child Protective Services Division of DFPS if the individual is under 18 years of age; or~~

~~——(2) the Adult Protective Services Division of DFPS if the individual is 18-21 years of age.]~~

~~[§9.190. LIDDA Requirements for Providing Service Coordination in the HCS Program:~~

~~(a) In addition to the requirements described in Chapter 2, Subchapter L of this title (relating to Service Coordination for Individuals with an Intellectual Disability), a LIDDA must ensure:~~

~~—(1) compliance with:~~

~~——(A) this subchapter;~~

~~——(B) Chapter 41 of this title (relating to Consumer Directed Services Option); and~~

~~——(C) Chapter 4, Subchapter L, of this title (relating to Abuse, Neglect, and Exploitation in Local Authorities and Community Centers); and~~

~~—(2) a rights protection officer, as required by §4.113 of this title (relating to Rights Protection Officer at a State MR Facility or MRA), who receives a copy of an HHSC initial intake report or a final investigative report from an FMSA, in accordance with §41.702 of this title (relating to Requirements Related to HHSC Investigations When an Alleged Perpetrator is a Service Provider) or §41.703 of this title (relating to Requirements Related to HHSC Investigations When an Alleged Perpetrator is a Staff Person or a Controlling Person of an FMSA), gives a copy of the report to the individual's service coordinator.~~

~~(b) A LIDDA must employ service coordinators who:~~

~~—(1) meet the minimum qualifications and LIDDA staff training requirements specified in Chapter 2, Subchapter L of this title; and~~

~~—(2) have received training about:~~

~~——(A) the HCS Program and CFC, including the requirements of this subchapter and the HCS Program services and CFC services described in §9.154 of this subchapter (relating to Description of the HCS Program and CFC); and~~

~~——(B) Chapter 41 of this title.~~

~~(c) A LIDDA must have a process for receiving and resolving complaints from a program provider related to the LIDDA's provision of service coordination or the LIDDA's process to enroll an applicant in the HCS Program.~~

~~(d) If, as a result of monitoring, the service coordinator identifies a concern with the implementation of the PDP, the LIDDA must ensure that the concern is communicated to the program provider and attempts are made to resolve the concern. The LIDDA may refer an unresolved concern to HHSC by calling the HHSC~~

~~Complaint and Incident Intake toll-free telephone number at 1-800-458-9858.~~

~~(e) A service coordinator must:~~

~~—(1) assist an individual or LAR in exercising the legal rights of the individual as a citizen and as a person with a disability;~~

~~—(2) provide an individual, LAR, or family member with a written copy of the rights of the individual as described in §9.173(b) of this subchapter (relating to Certification Principles: Rights of Individuals) and the booklet Your Rights In the Home and Community-based Services (HCS) Program, available on the HHSC website, and an oral explanation of such rights;~~

~~——(A) upon the individual's enrollment in the HCS Program;~~

~~——(B) upon revision of the booklet;~~

~~——(C) upon request; and~~

~~——(D) upon change in the individual's legal status (that is when the individual turns 18 years of age, is appointed a guardian, or loses a guardian);~~

~~—(3) document the provision of the rights described in §9.173(b) of this subchapter, and the booklet and oral explanation required by paragraph (2) of this subsection, and ensure that the documentation is signed by:~~

~~——(A) the individual or LAR; and~~

~~——(B) the service coordinator;~~

~~—(4) ensure that, upon enrollment of an individual and annually thereafter, the individual or LAR is informed orally and in writing of the following:~~

~~——(A) the telephone number of the LIDDA to file a complaint;~~

~~——(B) the toll-free telephone number of the HHSC Complaint and Incident Intake, 1-800-458-9858, to file a complaint; and~~

~~——(C) the toll-free telephone number of DFPS, 1-800-647-7418, to report an allegation of abuse, neglect, or exploitation;~~

~~—(5) maintain for an individual for an IPC year:~~

~~——(A) a copy of the IPC;~~

~~——(B) the PDP and, if CFC PAS/HAB is included on the PDP, the completed HHSC HCS/TxHmL CFC PAS/HAB Assessment form;~~

- ~~—— (C) a copy of the ID/RC Assessment;~~
- ~~—— (D) documentation of the activities performed by the service coordinator in providing service coordination; and~~
- ~~—— (E) any other pertinent information related to the individual;~~
- ~~—— (6) initiate, coordinate, and facilitate person-directed planning, including scheduling service planning team meetings;~~
- ~~—— (7) to meet the needs of an individual as those needs are identified, develop for the individual a full range of services and resources using:~~
 - ~~—— (A) providers for services other than HCS Program services and CFC services; and~~
 - ~~—— (B) advocates or other actively involved persons;~~
- ~~—— (8) ensure that the PDP for an applicant or individual:~~
 - ~~—— (A) is developed, reviewed, and updated in accordance with:~~
 - ~~—— (i) §9.158(j)(4)(A) of this subchapter (relating to Process for Enrollment of Applicants);~~
 - ~~—— (ii) §9.166 of this subchapter (relating to Renewal and Revision of an IPC); and~~
 - ~~—— (iii) §2.556 of this title (relating to LIDDA's Responsibilities);~~
 - ~~—— (B) states, for each HCS Program service, other than supervised living and residential support, and for each CFC service, whether the service is critical to the individual's health and safety as determined by the service planning team;~~
- ~~—— (9) participate in the development, renewal, and revision of an individual's IPC in accordance with §9.158 and §9.166 of this subchapter;~~
- ~~—— (10) ensure that the service planning team participates in the renewal and revision of the IPC for an individual in accordance with §9.166 of this subchapter and ensure that the service planning team completes other responsibilities and activities as described in this subchapter;~~
- ~~—— (11) notify the service planning team of the information conveyed to the service coordinator pursuant to §9.178(q)(3)(C) and (4)(B) of this subchapter (relating to Certification Principle: Quality Assurance);~~
- ~~—— (12) if a change to an individual's PDP is needed, other than as required by~~

~~§9.166 of this subchapter:~~

~~——(A) communicate the need for the change to the individual or LAR, the program provider, and other appropriate persons; and~~

~~——(B) revise the PDP as necessary;~~

~~——(13) provide an individual's program provider a copy of the individual's current PDP;~~

~~——(14) monitor the delivery of HCS Program services, CFC services, and non-HCS Program and non-CFC services to an individual;~~

~~——(15) document whether an individual progresses toward desired outcomes identified on the individual's PDP;~~

~~——(16) together with the program provider, ensure the coordination and compatibility of HCS Program services and CFC services with non-HCS Program and non-CFC services, including, in coordination with the program provider, assisting an individual in obtaining a neurobehavioral or neuropsychological assessment and plan of care from a qualified professional as described in §9.174(a)(27)(B) of this subchapter (relating to Certification Principles: Service Delivery);~~

~~——(17) for an individual who has had a guardian appointed, determine, at least annually, if the letters of guardianship are current;~~

~~——(18) for an individual who has not had a guardian appointed, make a referral of guardianship to a court, if appropriate;~~

~~——(19) immediately notify the program provider if the service coordinator becomes aware that an emergency necessitates the provision of an HCS Program service or a CFC service to ensure the individual's health or safety and the service is not on the IPC or exceeds the amount on the IPC;~~

~~——(20) if informed by the program provider that an individual's HCS Program services or CFC services have been suspended:~~

~~——(A) request the program provider enter necessary information in the HHSC data system to inform HHSC of the suspension;~~

~~——(B) review the individual's status and document in the individual's record the reasons for continuing the suspension, at least every 90 calendar days after the effective date of the suspension; and~~

~~——(C) to continue suspension of the services for more than 270 calendar days, submit to HHSC written documentation of each review made in accordance with subparagraph (B) of this paragraph and a request for approval by HHSC to continue~~

~~the suspension;~~

~~—(21) if notified by the program provider that an individual or LAR has refused a nursing assessment and that the program provider has determined it cannot ensure the individual's health, safety, and welfare in the provision of a service as described in §9.174(e) of this of this subchapter;~~

~~——(A) inform the individual or LAR of the consequences and risks of refusing the assessment, including that the refusal will result in the individual not receiving:~~

~~————(i) nursing services; or~~

~~————(ii) host home/companion care, residential support, supervised living, supported home living, respite, employment assistance, supported employment, day habilitation, or CFC PAS/HAB, if the individual needs one of those services and the program provider has determined that it cannot ensure the health and safety of the individual in the provision of the service; and~~

~~——(B) notify the program provider if the individual or LAR continues to refuse the assessment after the discussion with the service coordinator;~~

~~—(22) notify the program provider if the service coordinator becomes aware that an individual has been admitted to a setting described in §9.155(e) of this subchapter (relating to Eligibility Criteria and Suspension of HCS Program Services and of CFC Services);~~

~~—(23) if the service coordinator determines that HCS Program services or CFC services provided to an individual should be terminated, including for a reason described in §9.158(k)(15)(A) or (B) of this subchapter;~~

~~——(A) document a description of:~~

~~————(i) the situation that resulted in the service coordinator's determination that services should be terminated;~~

~~————(ii) the attempts by the service coordinator to resolve the situation;~~
~~and~~

~~——(B) send a written recommendation to terminate the individual's HCS Program services or CFC services to HHSC and include the documentation required by subparagraph (A) of this paragraph;~~

~~——(C) provide a copy of the written recommendation and the documentation required by subparagraph (A) of this paragraph to the program provider;~~

~~—(24) if an individual requests termination of all HCS Program services or all CFC services, the service coordinator must, within ten calendar days after the~~

~~individual's request:~~

~~—— (A) inform the individual or LAR of:~~

~~—— (i) the individual's option to transfer to another program provider;~~

~~—— (ii) the consequences of terminating HCS Program services and CFC services; and~~

~~—— (iii) possible service resources upon termination, including CFC services through a managed care organization; and~~

~~—— (B) submit documentation to HHSC that:~~

~~—— (i) states the reason the individual is making the request; and~~

~~—— (ii) demonstrates that the individual or LAR was provided the information required by subparagraph (A)(ii) and (iii) of this paragraph;~~

~~—— (25) in accordance with HHSC's instructions, manage the process to transfer an individual's HCS Program services and CFC services from one program provider to another or transfer from one FMSA to another, including:~~

~~—— (A) informing the individual or LAR who requests a transfer to another program provider or FMSA that the service coordinator will manage the transfer process;~~

~~—— (B) informing the individual or LAR that the individual or LAR may choose:~~

~~—— (i) to receive HCS Program services and CFC services from any program provider that is in the geographic location preferred by the individual or LAR and whose enrollment has not reached its service capacity in the HHSC data system; or~~

~~—— (ii) to transfer to any FMSA in the geographic location preferred by the individual or LAR; and~~

~~—— (C) if the individual or LAR has not selected another program provider or FMSA, providing the individual or LAR with a list of and contact information for HCS Program providers and FMSAs in the geographic location preferred by the individual or LAR;~~

~~—— (26) be objective in assisting an individual or LAR in selecting a program provider or FMSA;~~

~~—— (27) at the time of assignment and as changes occur, ensure that an individual and LAR and program provider are informed of the name of the individual's service~~

~~coordinator and how to contact the service coordinator;~~

~~—(28) unless contraindications are documented with justification by the service planning team, ensure that a school-age individual receives educational services in a six-hour-per-day program, five days per week, provided by the local school district and that no individual receives educational services at a state-supported living center or at a state center;~~

~~—(29) unless contraindications are documented with justification by the service planning team, ensure that an adult individual under retirement age is participating in a day activity of the individual's choice that promotes achievement of PDP outcomes for at least six hours per day, five days per week;~~

~~—(30) unless contraindications are documented with justification by the service planning team, ensure that a pre-school-age individual receives an early childhood education with appropriate activities and services, including small-group and individual play with peers without disabilities;~~

~~—(31) unless contraindications are documented with justification by the service planning team, ensure that an individual of retirement age has opportunities to participate in day activities appropriate to individuals of the same age and consistent with the individual's or LAR's choice;~~

~~—(32) unless contraindications are documented with justification by the service planning team, ensure that each individual is offered choices and opportunities for accessing and participating in community activities and experiences available to peers without disabilities;~~

~~—(33) assist an individual to meet as many of the individual's needs as possible by using generic community services and resources in the same way and during the same hours as these generic services are used by the community at large;~~

~~—(34) for an individual receiving host home/companion care, residential support, or supervised living, ensure that the individual or LAR is involved in planning the individual's residential relocation, except in a case of an emergency;~~

~~—(35) if the program provider notifies the service coordinator that the program provider is unable to locate the parent or LAR in accordance with §9.174(a)(8)(D) of this subchapter or the LIDDA notifies the service coordinator that the LIDDA is unable to locate the parent or LAR in accordance with §9.167(b)(9) of this subchapter (relating to Permanency Planning):~~

~~——(A) make reasonable attempts to locate the parent or LAR by contacting a person identified by the parent or LAR in the contact information described in paragraph (37)(A) —(B) of this subsection; and~~

~~——(B) notify HHSC, no later than 30 calendar days after the date the service~~

~~coordinator determines the service coordinator is unable to locate the parent or LAR, of the determination and request that HHSC initiate a search for the parent or LAR;~~

~~—(36) if the service coordinator determines that a parent's or LAR's contact information described in paragraph (37)(A) of this subsection is no longer current:~~

~~——(A) make reasonable attempts to locate the parent or LAR by contacting a person identified by the parent or LAR in the contact information described in paragraph (37)(B) of this subsection; and~~

~~——(B) notify HHSC, no later than 30 calendar days after the date the service coordinator determines the service coordinator is unable to locate the parent or LAR, of the determination and request that HHSC initiate a search for the parent or LAR;~~

~~—(37) request from and encourage the parent or LAR of an individual under 22 years of age requesting or receiving supervised living or residential support to provide the service coordinator with the following information:~~

~~——(A) the parent's or LAR's:~~

~~——(i) name;~~

~~——(ii) address;~~

~~——(iii) telephone number;~~

~~——(iv) driver license number and state of issuance or personal identification card number issued by the Department of Public Safety; and~~

~~——(v) place of employment and the employer's address and telephone number;~~

~~——(B) name, address, and telephone number of a relative of the individual or other person whom HHSC or the service coordinator may contact in an emergency situation, a statement indicating the relationship between that person and the individual, and at the parent's or LAR's option:~~

~~——(i) that person's driver license number and state of issuance or personal identification card number issued by the Department of Public Safety; and~~

~~——(ii) the name, address, and telephone number of that person's employer; and~~

~~——(C) a signed acknowledgement of responsibility stating that the parent or LAR agrees to:~~

~~_____ (i) notify the service coordinator of any changes to the contact information submitted; and~~

~~_____ (ii) make reasonable efforts to participate in the individual's life and in planning activities for the individual;~~

~~— (38) within three business days after initiating supervised living or residential support to an individual under 22 years of age:~~

~~_____ (A) provide the information listed in subparagraph (B) of this paragraph to the following:~~

~~_____ (i) the CRCG for the county in which the individual's LAR lives (see the HHSC website for a listing of CRCG chairpersons by county); and~~

~~_____ (ii) the local school district for the area in which the three or four-person residence is located, if the individual is at least three years of age, or the early childhood intervention (ECI) program for the county in which the residence is located, if the individual is less than three years of age (see the HHSC website to search for an ECI program by zip code or by county); and~~

~~_____ (B) as required by subparagraph (A) of this paragraph, provide the following information to the entities described in subparagraph (A) of this paragraph:~~

~~_____ (i) the individual's full name;~~

~~_____ (ii) the individual's gender;~~

~~_____ (iii) the individual's ethnicity;~~

~~_____ (iv) the individual's birth date;~~

~~_____ (v) the individual's social security number;~~

~~_____ (vi) the LAR's name, address, and county of residence;~~

~~_____ (vii) the date of initiation of supervised living or residential support;~~

~~_____ (viii) the address where supervised living or residential support is provided; and~~

~~_____ (ix) the name and phone number of the person providing the information;~~

~~— (39) for an applicant or individual under 22 years of age seeking or receiving supervised living or residential support:~~

~~—— (A) make reasonable accommodations to promote the participation of the LAR in all planning and decision making regarding the individual's care, including participating in:~~

~~—— (i) the initial development and annual review of the individual's PDP;~~

~~—— (ii) decision making regarding the individual's medical care;~~

~~—— (iii) routine service planning team meetings; and~~

~~—— (iv) decision making and other activities involving the individual's health and safety;~~

~~—— (B) ensure that reasonable accommodations include:~~

~~—— (i) conducting a meeting in person or by telephone, as mutually agreed upon by the program provider and the LAR;~~

~~—— (ii) conducting a meeting at a time and location, if the meeting is in person, that is mutually agreed upon by the program provider and the LAR;~~

~~—— (iii) if the LAR has a disability, providing reasonable accommodations in accordance with the Americans with Disabilities Act, including providing an accessible meeting location or a sign language interpreter, if appropriate; and~~

~~—— (iv) providing a language interpreter, if appropriate;~~

~~—— (C) provide written notice to the LAR of a meeting to conduct an annual review of the individual's PDP at least 21 calendar days before the meeting date and request a response from the LAR regarding whether the LAR intends to participate in the annual review;~~

~~—— (D) before an individual who is under 18 years of age, or who is 18-21 years of age and has an LAR, moves to another residence operated by the program provider, attempt to obtain consent for the move from the LAR unless the move is made because of a serious risk to the health or safety of the individual or another person; and~~

~~—— (E) document compliance with subparagraphs (A) — (D) of this paragraph in the individual's record;~~

~~—— (40) conduct:~~

~~—— (A) a pre-move site review for an applicant 21 years of age or older who is enrolling in the HCS Program from a nursing facility; and~~

~~—— (B) post-move monitoring visits for an individual 21 years of age or older~~

~~who enrolled in the HCS Program from a nursing facility or has enrolled in the HCS Program as a diversion from admission to a nursing facility;~~

~~—(41) have a face-to-face contact with an individual to provide service coordination during a month in which it is anticipated that the individual will not receive an HCS Program service unless:~~

~~——(A) the individual's HCS Program services have been suspended; or~~

~~——(B) the service coordinator had a face-to-face contact with the individual that month to comply with §2.556(d) of this title (relating to LIDDA's Responsibilities); and~~

~~—(42) at least annually:~~

~~——(A) using an HHSC form, provide an oral and written explanation to the individual or LAR of:~~

~~——(i) the eligibility requirements for HCS Program services as described in §9.155(a) of this subchapter; and~~

~~——(ii) if the individual's PDP includes CFC services:~~

~~——(I) the eligibility requirements for CFC services as described in §9.155(c) of this subchapter; and~~

~~——(II) the eligibility requirements for CFC services as described in §9.155(d) of this subchapter to individuals who receive MAO Medicaid; and~~

~~——(B) using an HHSC form, provide an oral and written explanation to the individual or LAR of all HCS Program services and CFC services.]~~

~~[§9.191. LIDDA Compliance Review.~~

~~(a) DADS conducts a compliance review of each LIDDA, at least annually, to determine if the LIDDA is in compliance with:~~

~~—(1) Chapter 2, Subchapter L, of this title (relating to Service Coordination for Individuals with an Intellectual Disability);~~

~~—(2) §9.190 of this subchapter (relating to LIDDA Requirements for Providing Service Coordination in the HCS Program); and~~

~~—(3) other requirements for the LIDDA as described in this subchapter.~~

~~(b) If any item of noncompliance remains uncorrected by the LIDDA at the time of the review exit conference, the LIDDA must submit to DADS a plan of correction in~~

~~accordance with the performance contract. DADS may take action as specified in the performance contract if the LIDDA fails to submit or implement an approved plan of correction.]~~

~~[\$9.192. Service Limits.~~

~~(a) The following limits apply to an individual's HCS Program services:~~

~~—(1) for adaptive aids, \$10,000 during an IPC year;~~

~~—(2) for dental treatment, \$2,000 during an IPC year;~~

~~—(3) for minor home modifications and pre-enrollment minor home modifications combined;~~

~~——(A) \$7,500 during the time the individual is enrolled in the HCS Program, which may be paid in one or more IPC years; and~~

~~——(B) after reaching the \$7,500 limit described in subparagraph (A) of this paragraph, a maximum of \$300 for repair and maintenance during the IPC year;~~

~~—(4) for respite, 300 hours during an IPC year; and~~

~~—(5) for TAS:~~

~~——(A) \$2,500 if the applicant's proposed initial IPC does not include residential support, supervised living, or host home/companion care; or~~

~~——(B) \$1,000 if the applicant's proposed initial IPC includes residential support, supervised living, or host home/companion care.~~

~~(b) An individual may receive TAS only once in the individual's lifetime.~~

~~(c) A program provider may request, in accordance with the *HCS Program Billing Guidelines*, authorization of a requisition fee:~~

~~—(1) for dental treatment that is in addition to the \$2,000 service limit described in subsection (a)(2) of this section; or~~

~~——(2) for a minor home modification that is in addition to the \$7,500 service limit described in subsection (a)(3)(A) of this section.]~~

TITLE 26 HEALTH AND HUMAN SERVICES
PART 1 HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 263 HOME AND COMMUNITY-BASED SERVICES (HCS) PROGRAM
 AND COMMUNITY FIRST CHOICE (CFC)

PROPOSED PREAMBLE

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes in the Texas Administrative Code (TAC), Title 26, Part 1, new Chapter 263, Home and Community-based Services (HCS) Program and Community First Choice (CFC), Subchapters A – K, comprised of §§263.1 – 263.9; 263.101 – 263.108; 263.201; 263.301 – 263.304; 263.401; 263.501 - 263.503; 263.601; 263.701 – 263.708; 263.801; 263.802; 263.901 – 263.903; and 263.1000.

BACKGROUND AND PURPOSE

The HCS Program is a Medicaid waiver program approved by the Centers for Medicare & Medicaid Services (CMS) under §1915(c) of the Social Security Act. This waiver program provides community-based services and supports to an eligible individual as an alternative to services provided in an institutional setting. One purpose of the proposal is to move certain HCS Program rules from 40 TAC Chapter 9, Subchapter D to 26 TAC Chapter 263. The repeals of §§9.151, 9.152, 9.154 - 9.170, 9.186, and 9.189 - 9.192 in 40 TAC Chapter 9, Subchapter D, are proposed elsewhere in this issue of the *Texas Register*.

This rule proposal does not include program provider certification principles that are currently in §§9.173 – 9.180, and §§9.181 – 9.183 and reviewed through the survey process. Rules containing the certification standards for the HCS Program will be proposed in 26 TAC Chapter 565 in a future issue of the *Texas Register*.

Another purpose of the proposed new rules is to ensure that the HCS Program complies with the requirements in Title 42, Code of Federal Regulations (CFR), Chapter IV, Subchapter C, Part 441, Subpart G, §441.301(c)(1) - (5). In 2014, CMS amended this regulation to establish new requirements for Home and Community-based Services (HCBS) Medicaid Programs, including requirements for HCBS Program settings and person-centered planning. CMS has given states until March 2023 to be in full compliance with the requirements in 42 CFR §441.301(c)(1) - (5). The proposed new rules will also ensure compliance with the requirements in 42 CFR Chapter IV, Subchapter C, Part 441, Subpart K, §441.530, regarding Home and Community-Based Setting; §441.535, regarding Assessment of functional need; and §441.540, regarding the Person-centered service plan, for Community First Choice (CFC) services because CFC services are available in the HCS Program.

Additional purposes of the proposed new rules are described below.

The proposed new rules implement Texas Government Code §531.02161(b)(4) which requires HHSC to ensure that, if cost effective, clinically effective, and allowed by federal law, a Medicaid recipient has the option to receive certain services, including occupational therapy (OT), physical therapy (PT), and speech-language pathology as a telehealth service.

The proposed new rules require the initial HCS eligibility assessments to be conducted in person and the Community First Choice (CFC) personal assistance services/habilitation (PAS/HAB) assessment to be completed in person unless certain conditions exist in which case the assessment may be completed by telehealth, telephone, or video conferencing. These requirements help ensure the assessments are thorough and accurate.

The proposed new rules include provisions regarding the denial, suspension, reduction, or termination of an individual's HCS Program services to explain HHSC's process in taking one of these actions. The proposed new rules change the existing service coordination monitoring requirement from 90 days to 30 days during an individual's suspension.

The proposed new rules require a program provider and local intellectual and developmental disability authority (LIDDA) to submit a translation of non-English documentation submitted to HHSC. The purpose of the proposed new rule is to help ensure that HHSC's reviews of documentation are efficient.

The proposed new rules require a registered nurse (RN) to complete a comprehensive nursing assessment of an individual in person under specified circumstances. This requirement is included so that the entire comprehensive nursing assessment is completed when necessary to help ensure the health and safety of an individual.

The proposed new rules codify HHSC's current practice of increasing a level of need (LON) 1, 5, or 8 to the next LON because of an individual's high medical needs if the individual meets certain criteria. The proposed new rule also codifies current practice related to individuals transferring to another program provider or choosing a different service delivery option in the HCS Program.

The proposed new rules provide that HHSC may allow program providers and service coordinators to use one or more of the exceptions specified in the rule while an executive order or proclamation declaring a state of disaster under Texas Government Code §418.014 is in effect. This provision is added to help ensure that providers and service coordinators are able to provide services effectively during a disaster.

SECTION-BY-SECTION SUMMARY

New Subchapter A, General Provisions

Proposed new §263.1, Purpose, describes the purpose of the rules.

Proposed new §263.2, Application, describes the persons to whom Chapter 263 applies.

Proposed new §263.3, Definitions, defines the terms used in the new chapter including definitions for the following terms: "audio-only," "comprehensive nursing assessment," "delegated nursing task," "DID--Determination of intellectual disability," "DID report," "EVV--Electronic visit verification," "health maintenance activities," "in person or in-person," "platform," "professional therapies," "store and forward technology," "Supported Decision-Making Agreement," "synchronous audio-visual," "TAC--Texas Administrative Code," "telehealth service," "transfer IPC," and "videoconferencing."

Proposed new §263.4, Description of the HCS Program and CFC, provides descriptions of the HCS Program and CFC including provisions about waiver contract areas and the consumer directed services option.

Proposed new §263.5, Description of HCS Program Services, provides a description of the HCS Program services available through the HCS Program.

Proposed new §263.6, Description of CFC Services, provides a description of the CFC services available through the HCS Program and explains that individuals receiving host home/companion care, supervised living, or residential support may not receive a CFC service.

Proposed new §263.7, Requirement for Translation, requires program providers and LIDDAs to, when they submit documentation to HHSC containing information that is not in English, submit a translation of the information in English at the same time.

Proposed new §263.8, Comprehensive Nursing Assessment, requires an RN to complete the comprehensive nursing assessment for an applicant or individual who has nursing on their individual plan of care (IPC), using the HHSC Comprehensive Nursing Assessment form. The proposed new rule also specifies when a comprehensive nursing assessment must be completed in person, and when the comprehensive nursing assessment does not have to be completed in person.

Proposed new §263.9, Providing Physical Therapy, Occupational Therapy, and Speech and Language Pathology as a Telehealth Service, allows a service provider of PT, OT, or speech and language pathology to provide PT, OT, or speech and language pathology to an individual as a telehealth service except for certain activities that must be performed in person in accordance with the Texas Medicaid Provider Procedures Manual. The proposed new rule also describes the requirements for providing PT, OT, or speech and language pathology as a telehealth service, including obtaining the individual's or legally authorized representative's (LAR) consent before the provision of the telehealth service.

New Subchapter B, Eligibility, Enrollment, and Review

Proposed new §263.101, Eligibility Criteria for HCS Program Services and CFC Services, describes the eligibility criteria for HCS Program Services and CFC Services. The proposed rule is different from the current rule regarding eligibility criteria because the proposed rule specifically lists a hospital, an inpatient chemical dependency treatment facility, and a mental health facility as settings in which an individual cannot reside instead of using the phrase, "a facility licensed or subject to being licensed by the Department of State Health Services." In addition, the proposed rule is different from the current rule because the proposed rule does not include as a prohibited residential setting, a setting in which two or more dwellings create a distinguishable residential area. This restriction is included in proposed new §263.501, Requirements for Service Settings.

Proposed new §263.102, Calculation of Co-payment, describes the method for determining an individual's or couple's co-payment for sharing in the cost of HCS Program services because their income exceeds the maximum personal needs allowance.

Proposed new §263.103, HCS Interest List, describes how HHSC maintains the interest list for individuals interested in receiving services in the HCS Program. The proposed rule is different from the current rule in how HHSC assigns an interest list date to an applicant after the applicant's name is removed from the interest list in accordance with subsection (g)(1) - (4) and the applicant requests to be placed back on the list. In the current rule, if such an applicant makes the request within 90 days after their name was removed from the list, HHSC adds the applicant's name to the HCS interest list using the interest list date that was in effect at the time the applicant's name was removed from the list. In the proposed rule, HHSC adds the applicant's name to the HCS interest list in this situation using the interest list date that was in effect at the time the applicant's name was removed, only if the request to be placed back on the list is the applicant's first request. Further, if the applicant's request to be placed back on the list is made more than 90 days after their name was removed from the list and the request is the applicant's first request, the proposed rule provides that HHSC adds the applicant's name to the interest list using the interest list date that was in effect at the time the applicant's name was removed from the list, if HHSC determines that extenuating circumstances exist. If a request to be placed back on an interest by an applicant in these situations is not the applicant's first request, the proposed rule provides that the applicant's name is added back using the date of the request as the interest list date. The reason for these changes is to remove an incentive for an applicant to repeatedly decline a written offer of HCS Program services.

Proposed new §263.104, Process for Enrollment of Applicants, describes the process for offering an applicant enrollment and enrolling an applicant into the HCS Program.

Proposed new §263.105, LOC Determination, describes the process for a LIDDA to request a level of care (LOC) from HHSC for an applicant and for a program provider to request an LOC from HHSC for an individual.

Proposed new §263.106, LON Assignment, describes the process for requesting a level of need (LON) from HHSC for an applicant and an individual and the LONs that may be assigned. The proposed rule also describes the criteria that must exist and the process for an individual's LON to be increased because of the individual's dangerous behavior or high medical needs.

Proposed new §263.107, HHSC Review of LON, describes the process by which HHSC reviews an LON.

Proposed new §263.108, Reconsideration of LON Assignment, describes the process by which a program provider may request a reconsideration by HHSC of an LON assignment, if the program provider disagrees with an LON assignment.

New Subchapter C, Person-Centered Planning

Proposed new §263.201, Person-Centered Planning Process, requires a service coordinator and program provider to ensure the person-centered planning process is led by an individual to the maximum extent possible and that the person-centered planning process be used to develop a person directed plan (PDP), implementation plan, initial IPC, renewal IPC, revised IPC, service backup plan, and transportation plan. The proposed new rule also describes the activities involved in the person-centered planning process.

New Subchapter D, Development and Review of an IPC

Proposed new §263.301, IPC Requirements, describes the requirements of an IPC.

Proposed new §263.302, Renewal and Revision of an IPC, describes the process for developing a renewal IPC and a revision IPC. The proposed rule includes several requirements that are not part of the current rule regarding renewal IPCs and revision IPCs. Specifically, the proposed rule requires the service planning team to complete the HHSC HCS/TxHmL CFC PAS/HAB Assessment form when revising the IPC to add CFC PAS/HAB or update the HHSC HCS/TxHmL CFC PAS/HAB Assessment form when revising the IPC to change the amount of CFC PAS/HAB. This requirement helps ensure a consistent method for determining the number of CFC PAS/HAB hours during an IPC revision. The proposed rule requires that the service planning team convene a meeting to update the PDP and develop a revised IPC if the addition, removal or change of a service results in the addition, removal, or change to an outcome in the PDP. If the change made to an existing service does not require the addition, removal, or a change to an outcome in the PDP, the proposed rule requires the service coordinator to document the reasons for the IPC revision. The proposed rule also requires the program provider to convene a meeting with the individual or LAR to revise the implementation plans for HCS Program services, and CFC services and transportation plan. The proposed rule

requires the service coordinator to send a copy of the updated PDP and HHSC HCS/TxHmL CFC PAS/HAB Assessment form to the program provider, the individual or LAR and, if applicable, the financial management services agency (FMSA). The proposed rule provides that, for an individual who is receiving all service through the consumer directed services (CDS) option, the service coordinator is not required to comply with the requirement to review and agree or disagree with the IPC information entered in the HHSC data system.

Proposed new §263.303, HHSC Review of an IPC, describes HHSC's process for reviewing an IPC. The proposed rule provides that HHSC may review an IPC to determine if it meets the IPC requirements described in proposed §263.301(c), relating to IPC Requirements. In addition, the proposed rule codifies current practice that HHSC may deny or reduce an HCS or CFC service if an IPC does not meet requirements in §263.301(c).

Proposed new §263.304, Service Limits, lists the service limits for certain HCS Program services provided to an individual. The proposed rule includes several provisions that are not part of the current rule regarding service limits. Specifically, the proposed rule allows an individual to use \$300 per IPC year for maintenance of a minor home modification (MHM) before reaching the lifetime limit for MHM. Under the current rule, the lifetime limit of \$7,500 must be exhausted prior to the use of the \$300 maintenance fee. This change gives the individual flexibility to use the MHM funds for maintenance. The proposed rule provides that the service limit is for respite and in-home respite combined. The proposed rule provides that the limit for day habilitation and in-home day habilitation is combined to clarify existing policy. The proposed rule also provides that a program provider may request authorization of a requisition fee for an adaptive aid that is in addition to the \$10,000 service limit to codify current practice.

New Subchapter E, CDS Option

Proposed new §263.401, CDS Option, provides that if certain services are on an applicant's PDP, a service coordinator must perform specified activities including informing the applicant about the CDS option. The proposed rule also provides that if an applicant or individual chooses to receive a service through the CDS option, a service coordinator must perform specific activities including documenting the choice of FMSA. The proposed rule requires the service coordinator to provide information about the CDS option to individuals annually. The proposed rule describes the requirements regarding a recommendation by the service coordinator that HHSC terminate an individual's participation in the CDS option.

New Subchapter F, Requirements for Service Settings and Program Provider Owned or Controlled Residential Settings

Proposed new §263.501, Requirements for Service Settings, requires a program provider to ensure that a setting in which individual receives HCS Program and CFC services meet certain criteria including that it's based on the individual's preferences, and needs; it supports the individual's access to the greater

community to the same degree as a person not enrolled in a Medicaid waiver program; it ensures the individual's rights of privacy, dignity and respect, and it optimizes an individual's independence in making life choices. In addition, the proposed rule requires that a setting in which an individual receives an HCS Program service or CFC service is not a setting presumed to have the qualities of an institution except that an HCS Program service or a CFC service may be provided in a setting that is presumed to have the qualities of an institution if CMS determines through a heightened scrutiny review that the setting does not have the qualities of an institution and does have the qualities of home and community-based settings.

Proposed new 263.502, Requirements for Program Provider Owned or Controlled Residential Settings, requires the program provider to ensure certain criteria in each residence in which residential support, supervised living, or host home/companion care is provided, including that an individual has privacy in the individual's bedroom, has an operable lock on an individual's bedroom door at no cost to the individual, and has the freedom and support to control the individual's schedule and activities that are not part of the implementation plan. The proposed rule also requires the program provider to notify the service coordinator if the program provider becomes aware that a modification to the criteria is needed and requires a service coordinator given such notification to convene a service planning team meeting to update the PDP.

Proposed new §263.503, Residential Agreements, requires a program provider to have a residential agreement with an individual or LAR if the individual is living in a three-person residence or four-person residence, and to ensure that the individual or LAR has a residential agreement with the service provider of host home/companion care if the individual is living in a residence in which host home/companion care is provided. In addition, the proposed rule describes the required contents of the residential agreement and requires the program provider to give the individual or LAR at least three calendar days to review, request changes, and sign the residential agreement; and to provide a copy of the residential agreement to the individual or LAR. The proposed rule also describes the requirements for a program provider and service coordinator if an individual or LAR is delinquent in payment of room or board and the program provider wants to evict the individual. Further, the proposed rule describes the criteria that must exist before a program provider proceeds to evict an individual. The proposed rule describes the requirements for a program provider and service coordinator after an individual is evicted. Also, the proposed rule describes the required actions for a program provider or service coordinator if the program provider determines that the provision in the residential agreement regarding decoration of the individual's bedroom needs to be modified.

New Subchapter G, Reimbursement by HHSC

Proposed new §263.601, Program Provider Reimbursement, describes how a program provider is reimbursed for services provided in the HCS Program. The proposed rule describes the basis for payment of service by HHSC to a program provider and requires a program provider to submit a service claim that meets certain requirements including 40 TAC §49.311, relating to Claims Payment, and

the HCS Program Billing Requirements or the CFC Billing Requirements for HCS and TxHmL Program Providers. The proposed rule explains when a program provider may submit a claim for a service provided during the period of the individual's suspension or after termination of the service. The proposed rule requires a claim submitted for an adaptive aid that costs \$500 or more or for a minor home modification that costs \$1,000 or more to be supported by a written assessment from a licensed professional. The proposed rule describes reasons that HHSC does not pay for or recoups payments for a service, including a program provider not complying with 40 TAC §49.305, relating to Records; providing CFC PAS/HAB or in-home day habilitation to an individual with a residential type of "own/family home" or providing in-home respite and the service claim does not match the electronic visit verification (EVV) visit transaction. The proposed rule provides that HHSC conducts fiscal compliance reviews and describes the actions HHSC may take as a result of a review.

New Subchapter H, Transfer, Denials, Suspension, Reduction, and Termination

Proposed new §263.701, Process for Individual to Transfer to a Different Program Provider or FMSA, describes the process for an individual to transfer to a different program provider or FMSA.

Proposed new §263.702, Process for Individual to Receive a Service Through the CDS Option that the Individual is Receiving from a Program Provider, describes the process for an individual to transfer services received through the CDS option to a program provider.

Proposed new §263.703, Denial of a Request for Enrollment into the HCS Program, describes the basis and process for HHSC to deny an individual's request for enrollment into the HCS Program.

Proposed new §263.704, Denial of HCS Program Services or CFC Services, describes the basis and process for HHSC to deny an HCS Program Service or CFC Service.

Proposed new §263.705, Suspension of HCS Program Services and CFC Services, describes the basis and process for HHSC to suspend an individual's HCS Program services and CFC services.

Proposed new §263.706, Reduction of HCS Program Services or CFC Services, describes the basis and process for HHSC to reduce an individual's HCS Program service or CFC service.

Proposed new §263.707, Termination of HCS Program Services and CFC Services with Advance Notice, describes the basis and process for HHSC to terminate an individual's HCS Program Services and CFC Services when advance notice of the termination is required.

Proposed new §263.708, Termination of HCS Program Services and CFC Services Without Advance Notice, describes the basis and process for HHSC to terminate an individual's HCS Program Services and CFC Services when advance notice of the termination is not required.

New Subchapter I, Hearings

Proposed new §263.801, Fair Hearing, describes the requirement for applicants and individuals to receive a notice of the right to request a fair hearing in accordance with 1 TAC Chapter 357, Subchapter A, relating to Uniform Fair Hearing Rules.

Proposed new §263.802, Program Provider's Right to Administrative Hearing, describes when a program provider may request an administrative hearing and that the program provider may receive an administrative hearing for a dispute involving a LON assignment only if reconsideration was requested by the program provider in accordance with proposed new §263.108.

New Subchapter J, LIDDA Requirements

Proposed new §263.901, LIDDA Requirements for Providing Service Coordination in the HCS Program, describes requirements for the LIDDA in the provision of service coordination to applicants and individuals. The proposed rule includes several provisions that are not part of the current rule regarding LIDDA requirements. Specifically, the proposed rule changes the timeframe requirement for a service coordinator to complete a comprehensive non-introductory person-centered service planning training from two years to within six months after the service coordinator's date of hire unless an extension of the six-month timeframe is granted by HHSC. The proposed rule describes when the service coordinator is required to provide an individual, LAR, or family member with the Your Rights In the Home and Community-based Services (HCS) Program booklet, and the HHSC HCS Rights Addendum form, and an oral explanation of the rights in the booklet and the form. The proposed rule requires the service coordinator to ensure that the updated finalized PDP is signed by the individual or LAR. In addition, the proposed rule requires the service coordinator to ensure the service planning team determines whether an individual who does not have a guardian would benefit from having a guardian or a less restrictive alternative to a guardian. Further, the proposed rule requires the service coordinator to update an individual's PDP with specific information described in the rule, if a service coordinator is notified by the program provider that a modification to a program provider owned or controlled residential setting requirement is needed based on a specific assessed need of an individual. The proposed rule also describes the requirements for a service coordinator to inform applicants and individuals about responsibilities related to EVV.

Proposed new §263.902, Permanency Planning, describes the required activities a LIDDA must perform regarding permanency planning for an applicant under 22 years of age moving from a family setting and requesting supervised living or residential support.

Proposed new §263.903, Referral from HHSC to DFPS, provides that if HHSC is unable to locate a parent or LAR of an individual, HHSC refers the case to the Department of Family and Protective Services (DFPS).

New Subchapter K, Declaration of Disaster

Proposed new §263.1000, Exceptions to Certain Requirements During Declaration of Disaster, provides that HHSC may allow program providers and service coordinators to use one or more of the exceptions described in the rule while an executive order or proclamation declaring a state of disaster under Texas Government Code §418.014 is in effect. The rule provides that HHSC notifies program providers and LIDDAs if it allows an exception to be used and the date an allowed exception must no longer be used. The proposed rule also defines "disaster area."

FISCAL NOTE

Trey Wood, HHSC Chief Financial Officer, has determined that for each year of the first five years that the rules will be in effect, there will be an estimated additional cost to state government as a result of enforcing and administering the proposed rule that allows an individual to use \$300 per IPC year for maintenance of a MHM before reaching the lifetime limit for MHMs.

The effect on state government for each year of the first five years the proposed rule is in effect is an estimated cost of \$5,186 in fiscal year (FY) 2022, \$5,186 in FY 2023, \$5,186 in FY 2024, \$5,186 in FY 2025, and \$5,186 in FY 2026.

In addition, Trey Wood has determined that for each year of the first five years that the rules will be in effect, there may be additional costs to state government if an individual in a disaster area needs to exceed the service limits for adaptive aids and MHMs if an adaptive aid or MHM is damaged or destroyed as a result of the disaster. There may also be additional costs to state government if HHSC denies a residential service until an individual or LAR pays the amount of delinquent room or board, from preparing and sending written notices of the denial, and to pay the cost for conducting a fair hearing, if requested by the individual or LAR. However, HHSC lacks sufficient information to provide an estimate of these costs.

Trey Wood has also determined that for each year of the first five years that the rules will be in effect, there will be an additional cost to local government as a result of enforcing and administering the rules that require a LIDDA to conduct an inventory for client and agency planning, and certain standardized measures for completing a determination of intellectual disability in person. There will also be an additional cost to local government for administering the rules that require a LIDDA service coordinator to perform activities relating to an individual who becomes delinquent or does not pay room and board under a residential agreement as proposed. However, there are multiple complexities and uncertainties related to the fiscal impact of this requirements for HHSC to provide an estimate of these costs.

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years that the rules will be in effect:

- (1) the proposed rules will not create or eliminate a government program;
- (2) implementation of the proposed rules will not affect the number of HHSC employee positions;
- (3) implementation of the proposed rules will result in no assumed change in future legislative appropriations;
- (4) the proposed rules will not affect fees paid to HHSC;
- (5) the proposed rules will create a new rule;
- (6) the proposed rules will repeal existing rules;
- (7) the proposed rules will not change the number of individuals subject to the rules; and
- (8) the proposed rules will not affect the state's economy.

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT ANALYSIS

Trey Wood has also determined that the rules could have an adverse economic effect on small businesses and micro-businesses due to the cost to comply.

HHSC does not have the data to estimate the number of small businesses or micro-businesses subject to the rule, however as of January 24, 2022, there are 583 HCS program providers. As of January 24, 2022, there are 610 HCS and TxHmL legal entities. Legal entities include program providers that may be contracted to be both HCS program providers and TxHmL program providers and program providers that are only contracted to be HCS program providers or TxHmL program providers.

HHSC did not consider any alternative methods that would achieve the purpose of the proposed new rules while minimizing the adverse impact on small businesses or micro-businesses because the rules requiring a program provider to have a residential agreement with each individual living in an HCS residential setting, and to install a lock on an individual's bedroom door if there is not one, are necessary for the HCS Program to comply with federal law and for HHSC to receive federal funds.

HHSC did not consider any alternative methods for the proposed new rule requiring a program provider or LIDDA to submit a translation of information in English if the program provider or LIDDA submits documentation to HHSC containing information that is not in English, because there is no alternative method that would achieve

the purpose of ensuring that HHSC's reviews of the documentation submitted are efficient.

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because the rules are necessary to receive a source of federal funds or comply with federal law.

PUBLIC BENEFIT AND COSTS

Stephanie Stephens, State Medicaid Director, has determined that for each year of the first five years the rules are in effect, individuals will benefit from the implementation of federal regulations that help ensure an individual receives services that are person-centered and promote the autonomy of the individual and that are provided in a setting that is integrated in the greater community.

Trey Wood has also determined that for the first five years the rules are in effect, persons who are required to comply with the proposed rules may incur economic costs because program providers will develop and implement a residential agreement with each individual who receives host home/companion care, residential support, or supervised living. Further, Program providers may incur court costs to evict an individual who fails to pay room or board and for attorney's fees arising out of any dispute relating to the residential agreement. In addition, HCS program providers may also incur a cost to purchase and install a lock on a bedroom door for an individual receiving host home/companion care, residential support, or supervised living, if the door does not currently have a lock; and to submit a translation of information in English if the program provider submits documentation to HHSC containing information that is not in English. However, HHSC lacks sufficient information to provide an estimate of these costs.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Texas Government Code §2007.043.

PUBLIC HEARING

A public hearing to receive comments on this proposal will be held via GoToWebinar on September 26, 2022 at 1:00 p.m. (central time). The link to register for the GoToWebinar meeting is <https://attendee.gotowebinar.com/register/5797564706801514763>.

Persons requiring further information, special assistance, or accommodations should contact Olu Oguntade at (512)438-4478.

PUBLIC COMMENT

Written comments on the proposal may be submitted to Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin, Texas 78711-3247, or street address 701 W. 51st Street, Austin, Texas 78751; or emailed to HHSRulesCoordinationOffice@hhs.texas.gov.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register*. Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 21R058" in the subject line.

STATUTORY AUTHORITY

The new sections are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Human Resources Code §32.021, which authorizes the Executive Commissioner of HHSC to adopt rules necessary for the proper and efficient operation of the Medicaid program.

The new sections affect Texas Government Code §531.0055 and Texas Human Resources Code §32.021.

This agency hereby certifies that this proposal has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

ADDITIONAL INFORMATION

For further information, please call: (512) 438-4478.

Legend:

Single Underline = Proposed new language

~~[Strikethrough and brackets]~~ = Current language proposed for deletion

Regular print = Current language (No change.) = No changes are being considered for the designated subdivision

TITLE 26	HEALTH AND HUMAN SERVICES
PART 1	HEALTH AND HUMAN SERVICES COMMISSION
<u>CHAPTER 263</u>	<u>HOME AND COMMUNITY-BASED SERVICES (HCS)</u>
	<u>PROGRAM AND COMMUNITY FIRST CHOICE (CFC)</u>
<u>SUBCHAPTER A</u>	<u>GENERAL PROVISIONS</u>

§263.1. Purpose.

The purpose of this chapter is to describe certain policies, procedures, and requirements of the HCS Program.

§263.2. Application.

This chapter applies to:

- (1) a program provider;
- (2) a LIDDA;
- (3) an applicant and the applicant's LAR; and
- (4) an individual and the individual's LAR.

§263.3. Definitions.

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

(1) Abuse--

- (A) physical abuse;
- (B) sexual abuse; or
- (C) verbal or emotional abuse.

(2) Actively involved--Significant, ongoing, and supportive involvement with an applicant or individual by a person, as determined by the applicant's or individual's service planning team or program provider, based on the person's:

- (A) interactions with the applicant or individual;

(B) availability to the applicant or individual for assistance or support when needed; and

(C) knowledge of, sensitivity to, and advocacy for the applicant's or individual's needs, preferences, values, and beliefs.

(3) ADLs--Activities of daily living. Basic personal everyday activities, including tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

(4) Agency foster home--This term has the meaning set forth in Texas Human Resources Code §42.002.

(5) ALF--Assisted living facility. A facility licensed in accordance with Texas Health and Safety Code Chapter 247, Assisted Living Facilities.

(6) Applicant--A Texas resident seeking services in the Home and Community-Based Services Program.

(7) Audio-only--An interactive, two-way audio communication platform that only uses sound.

(8) Auxiliary aid--A service or device that enables an individual with impaired sensory, manual, or speaking skills to participate in the person-centered planning process. An auxiliary aid includes interpreter services, transcription services, and a text telephone.

(9) Business day--Any day except a Saturday, Sunday, or national or state holiday listed in Texas Government Code §662.003(a) or (b).

(10) Calendar day--Any day, including weekends and holidays.

(11) CDS option--Consumer directed services option. A service delivery option as defined in 40 TAC §41.103 (relating to Definitions).

(12) CFC--Community First Choice.

(13) CFC ERS--CFC emergency response services.

(14) CFC FMS--The term used for financial management services on the individual plan of care (IPC) of an applicant or individual if the applicant will receive or the individual receives only CFC personal assistance services (PAS)/habilitation (HAB) through the CDS option.

(15) CFC support consultation--The term used for support consultation on the IPC of an applicant or individual if the applicant will receive or the individual receives only CFC PAS/HAB through the CDS option.

(16) CMS--Centers for Medicare & Medicaid Services. The federal agency within the United States Department of Health and Human Services that administers the Medicare and Medicaid programs.

(17) Competitive employment--Employment that pays an individual at least minimum wage if the individual is not self-employed.

(18) Comprehensive nursing assessment--A comprehensive physical and behavioral assessment of an individual, including the individual's health history, current health status, and current health needs, that is completed by a registered nurse (RN).

(19) Contract--A provisional contract or a standard contract.

(20) CRCG--Community resource coordination group. A local interagency group, composed of public and private agencies, that develops service plans for individuals whose needs can be met only through interagency coordination and cooperation. The group's role and responsibilities are described in the Memorandum of Understanding on Coordinated Services to Persons Needing Services from More Than One Agency, available on the Texas Health and Human Services Commission (HHSC) website.

(21) Delegated nursing task--A nursing task delegated by an RN to an unlicensed person in accordance with:

(A) 22 TAC Chapter 224 (relating to Delegation of Nursing Tasks by Registered Professional Nurses to Unlicensed Personnel for Clients with Acute Conditions or in Acute Care Environments); and

(B) 22 TAC Chapter 225 (relating to RN Delegation to Unlicensed Personnel and Tasks Not Requiring Delegation in Independent Living Environments for Clients with Stable and Predictable Conditions).

(22) Designated Representative--This term has the meaning set forth in 40 TAC §41.103.

(23) DFPS--The Department of Family and Protective Services.

(24) DID--Determination of intellectual disability. This term has the meaning set forth in §304.102 of this title (relating to Definitions).

(25) DID report--Determination of intellectual disability report. This term has the meaning set forth in §304.102 of this title.

(26) Emergency--An unexpected situation in which the absence of an immediate response could reasonably be expected to result in a risk to the health and safety of an individual or another person.

(27) Emergency situation--An unexpected situation involving an individual's health, safety, or welfare, of which a person of ordinary prudence would determine that the legally authorized representative (LAR) should be informed, such as an individual:

(A) needing emergency medical care;

(B) being removed from the individual's residence by law enforcement;

(C) leaving the individual's residence without notifying a staff member or service provider and not being located; and

(D) being moved from the individual's residence to protect the individual (for example, because of a hurricane, fire, or flood).

(28) EVV--Electronic visit verification. This term has the meaning set forth in 1 TAC §354.4003 (relating to Definitions).

(29) Exploitation--The illegal or improper act or process of using, or attempting to use, an individual or the resources of an individual for monetary or personal benefit, profit, or gain.

(30) Family-based alternative--A family setting in which the family provider or providers are specially trained to provide support and in-home care for children with disabilities or children who are medically fragile.

(31) FMS--Financial management services.

(32) FMSA--Financial management services agency. As defined in 40 TAC §41.103, an entity that provides financial management services to an individual participating in the CDS option.

(33) Former military member--A person who served in the United States Army, Navy, Air Force, Marine Corps, Coast Guard, or Space Force:

(A) who declared and maintained Texas as the person's state of legal residence in the manner provided by the applicable military branch while on active duty; and

(B) who was killed in action or died while in service, or whose active duty otherwise ended.

(34) Four-person residence--A residence:

(A) that a program provider leases or owns;

(B) in which at least one person but no more than four persons receive:

(i) residential support;

(ii) supervised living;

(iii) a non-HCS Program service similar to residential support or supervised living (for example, services funded by DFPS or by a person's own resources); or

(iv) respite;

(C) that, if it is the residence of four persons, at least one of those persons receives residential support;

(D) that is not the residence of any persons other than a service provider, the service provider's spouse or person with whom the service provider has a spousal relationship, or a person described in subparagraph (B) of this paragraph; and

(E) that is not a setting described in §263.501(b) of this chapter (relating to Requirements for Service Settings).

(35) GRO--General residential operation. This term has the meaning set forth in Texas Human Resources Code §42.002.

(36) HCS--Home and Community-based Services. Services provided through the HCS Program operated by HHSC as authorized by CMS in accordance with §1915(c) of the Social Security Act.

(37) Health maintenance activities--This term has the meaning set forth in 22 TAC §225.4 (relating to Definitions).

(38) Health-related tasks--Specific tasks related to the needs of an individual, which can be delegated or assigned by a licensed health care professional under state law to be performed by a service provider of CFC PAS/HAB. This includes tasks delegated by an RN; health maintenance activities, that may not require delegation; and activities assigned to a service provider of CFC PAS/HAB by a licensed physical therapist, occupational therapist, or speech-language pathologist.

(39) HHSC--The Texas Health and Human Services Commission.

(40) Hospital--A public or private institution licensed or exempt from licensure in accordance with Texas Health and Safety Code (THSC) Chapters 13, 241, 261, or 552.

(41) IADLs--Instrumental activities of daily living. Activities related to living independently in the community, including meal planning and preparation; managing finances; shopping for food, clothing, and other essential items;

performing essential household chores; communicating by phone or other media; and traveling around and participating in the community.

(42) ICAP--Inventory for Client and Agency Planning. An instrument designed to assess a person's needs, skills, and abilities.

(43) ICF/IID--Intermediate care facility for individuals with an intellectual disability or related conditions. An ICF/IID is a facility in which ICF/IID Program services are provided and that is:

(A) licensed in accordance with THSC Chapter 252; or

(B) certified by HHSC, including a state supported living center.

(44) ICF/IID Program--The Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions Program, which provides Medicaid-funded residential services to individuals with an intellectual disability or related conditions.

(45) ID/RC Assessment--Intellectual Disability/Related Conditions Assessment. A form used by HHSC for level of care determination and level of need assignment.

(46) Implementation plan--A written document developed by a program provider for an individual that, for each HCS Program service and CFC service on the individual's IPC to be provided by the program provider, except for supported home living and CFC support management, includes:

(A) a list of outcomes identified in the person-directed plan that will be addressed using HCS Program services and CFC services;

(B) specific objectives to address the outcomes required by subparagraph (A) of this paragraph that are:

(i) observable, measurable, and outcome-oriented; and

(ii) derived from assessments of the individual's strengths, personal goals, and needs;

(C) a target date for completion of each objective;

(D) the number of units of HCS Program services and CFC services needed to complete each objective;

(E) the frequency and duration of HCS Program services and CFC services needed to complete each objective; and

(F) the signature and date of the individual, LAR, and the program provider.

(47) Individual--A person enrolled in the HCS Program.

(48) Initial IPC--The first IPC for an individual developed before the individual's enrollment into the HCS Program.

(49) Inpatient chemical dependency treatment facility--A facility licensed in accordance with THSC Chapter 464, Facilities Treating Persons with a Chemical Dependency.

(50) In person or in-person--Within the physical presence of another person who is awake. In person or in-person does not include using videoconferencing or a telephone.

(51) Intellectual disability--This term has the meaning set forth in §304.102 of this title.

(52) IPC--Individual plan of care. A written plan that:

(A) states:

(i) the type and amount of each HCS Program service and each CFC service, except for CFC support management, to be provided to the individual during an IPC year;

(ii) the services and supports to be provided to the individual through resources other than HCS Program services or CFC services, including natural supports, medical services, and educational services; and

(iii) if an individual will receive CFC support management; and

(B) is authorized by HHSC.

(53) IPC cost--Estimated annual cost of HCS Program services included on an IPC.

(54) IPC year--The effective period of an initial IPC and renewal IPC as described in this paragraph.

(A) Except as provided in subparagraph (B) of this paragraph, the IPC year for an initial and renewal IPC is a 365-calendar day period starting on the begin date of the initial or renewal IPC.

(B) If the begin date of an initial or renewal IPC is March 1 or later in a year before a leap year or January 1 - February 28 of a leap year, the IPC year for the initial or renewal IPC is a 366-calendar day period starting on the begin date of the initial or renewal IPC.

(C) A revised IPC does not change the begin or end date of an IPC year.

(55) LAR--Legally authorized representative. A person authorized by law to act on behalf of another person with regard to a matter described in this chapter, including a parent, guardian, or managing conservator of a minor; a guardian of an adult; an agent appointed under a power of attorney; or a representative payee appointed by the Social Security Administration. An LAR, such as an agent appointed under a power of attorney or representative payee appointed by the Social Security Administration, may have limited authority to act on behalf of a person.

(56) LIDDA--Local intellectual and developmental disability authority. An entity designated by the executive commissioner of HHSC, in accordance with THSC §533A.035.

(57) LOC--Level of care. A determination given to an applicant or individual as part of the eligibility determination process based on data submitted on the ID/RC Assessment.

(58) LON--Level of need. An assignment given by HHSC to an individual upon which reimbursement for host home/companion care, supervised living, residential support, in-home day habilitation, and day habilitation is based.

(59) Managed care organization--This term has the meaning set forth in Texas Government Code §536.001.

(60) MAO Medicaid--Medical Assistance Only Medicaid. A type of Medicaid by which an applicant or individual qualifies financially for Medicaid assistance but does not receive Supplemental Security Income (SSI) benefits.

(61) Medicaid HCBS--Medicaid home and community-based services. Medicaid services provided to an individual in an individual's home and community, rather than in a facility.

(62) Mental health facility--A facility licensed in accordance with THSC Chapter 577, Private Mental Hospitals and Other Mental Health Facilities.

(63) Military family member--A person who is the spouse or child (regardless of age) of:

(A) a military member; or

(B) a former military member.

(64) Military member--A member of the United States military serving in the Army, Navy, Air Force, Marine Corps, Coast Guard, or Space Force on active duty

who has declared and maintains Texas as the member's state of legal residence in the manner provided by the applicable military branch.

(65) Natural supports--Unpaid persons, including family members, volunteers, neighbors, and friends, who voluntarily assist an individual to achieve the individual's identified goals.

(66) Neglect--A negligent act or omission that caused physical or emotional injury or death to an individual or placed an individual at risk of physical or emotional injury or death.

(67) Nursing facility--A facility licensed in accordance with THSC Chapter 242.

(68) PDP--Person-directed plan. A plan developed with an applicant or individual and LAR using an HHSC form that describes the supports and services necessary to achieve the desired outcomes identified by the applicant or individual and LAR and to ensure the applicant's or individual's health and safety.

(69) Performance contract--A written agreement between HHSC and a LIDDA for the performance of delegated functions, including those described in THSC §533A.035.

(70) Permanency planning--A philosophy and planning process that focuses on the outcome of family support for an applicant or individual under 22 years of age by facilitating a permanent living arrangement in which the primary feature is an enduring and nurturing parental relationship.

(71) Physical abuse--Any of the following:

(A) an act or failure to act performed knowingly, recklessly, or intentionally, including incitement to act, that caused physical injury or death to an individual or placed an individual at risk of physical injury or death;

(B) an act of inappropriate or excessive force or corporal punishment, regardless of whether the act results in a physical injury to an individual;

(C) the use of a restraint on an individual not in compliance with federal and state laws, rules, and regulations; or

(D) seclusion.

(72) Platform--This term has the meaning set forth in Texas Government Code §531.001(4-d).

(73) Post-move monitoring visit--A visit conducted by the service coordinator in accordance with the Intellectual and Developmental Disability Preadmission Screening and Resident Review (IDD-PASRR) Handbook.

(74) Pre-enrollment minor home modifications assessment--An assessment performed by a licensed professional as required by the HCS Program Billing Requirements to determine the need for pre-enrollment minor home modifications.

(75) Pre-move site review--A review conducted by the service coordinator in accordance with HHSC's IDD PASRR Handbook.

(76) Professional therapies--Services that consist of the following:

(A) audiology;

(B) occupational therapy;

(C) physical therapy;

(D) speech and language pathology;

(E) behavioral support;

(F) cognitive rehabilitation therapy;

(G) dietary services; and

(H) social work.

(77) Program provider--A person, as defined in 40 TAC §49.102 (relating to Definitions), that has a contract with HHSC to provide HCS Program services, excluding an FMSA.

(78) Provisional contract--A contract that HHSC enters into with a program provider in accordance with 40 TAC §49.208 (relating to Provisional Contract Application Approval) that has a term of no more than three years, not including any extension agreed to in accordance with 40 TAC §49.208(e).

(79) Related condition--A severe and chronic disability that:

(A) is attributed to:

(i) cerebral palsy or epilepsy; or

(ii) any other condition, other than mental illness, found to be closely related to an intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability, and requires treatment or services similar to those required for individuals with an intellectual disability;

(B) is manifested before the individual reaches age 22;

(C) is likely to continue indefinitely; and

(D) results in substantial functional limitation in at least three of the following areas of major life activity:

(i) self-care;

(ii) understanding and use of language;

(iii) learning;

(iv) mobility;

(v) self-direction; and

(vi) capacity for independent living.

(80) Relative--A person related to another person within the fourth degree of consanguinity or within the second degree of affinity. A more detailed explanation of this term is included in the HCS Program Billing Requirements.

(81) Renewal IPC--An IPC developed for an individual in accordance with §263.302(a) of this chapter (relating to Renewal and Revision of an IPC).

(82) Residential child care facility--This term has the meaning set forth in Texas Human Resources Code §42.002.

(83) Revised IPC--An initial IPC or a renewal IPC that is revised during an IPC year in accordance with §263.302(b) or (d) of this chapter to add a new HCS Program service or CFC service or change the amount of an existing service.

(84) RN--Registered nurse. A person licensed to practice professional nursing in accordance with Texas Occupations Code Chapter 301.

(85) Service backup plan--A plan that ensures continuity of critical program services if service delivery is interrupted.

(86) Service coordination--A service as defined in 40 TAC Chapter 2, Subchapter L (relating to Service Coordination for Individuals with an Intellectual Disability).

(87) Service coordinator--An employee of a LIDDA who provides service coordination to an individual.

(88) Service planning team--One of the following:

(A) for an applicant or individual other than one described in subparagraphs (B) or (C) of this paragraph, a planning team consisting of:

(i) an applicant or individual and LAR;

(ii) service coordinator; and

(iii) other persons chosen by the applicant or individual or LAR, for example, a staff member of the program provider, a family member, a friend, or a teacher;

(B) for an applicant 21 years of age or older who is residing in a nursing facility and enrolling in the HCS Program, a planning team consisting of:

(i) the applicant and LAR;

(ii) the service coordinator;

(iii) a staff member of the program provider;

(iv) providers of specialized services;

(v) a nursing facility staff person who is familiar with the applicant's needs;

(vi) other persons chosen by the applicant or LAR, for example, a family member, a friend, or a teacher; and

(vii) at the discretion of the LIDDA and with the approval of the individual or LAR, other persons who are directly involved in the delivery of services to persons with an intellectual or developmental disability; or

(C) for an individual 21 years of age or older who has enrolled in the HCS Program from a nursing facility or has enrolled in the HCS Program as a diversion from admission to a nursing facility, for 365 calendar days after enrollment, a planning team consisting of:

(i) the individual and LAR;

(ii) the service coordinator;

(iii) a staff member of the program provider;

(iv) other persons chosen by the individual or LAR, for example, a family member, a friend, or a teacher; and

(v) at the discretion of the LIDDA and with the approval of the individual or LAR, other persons who are directly involved in the delivery of services to persons with an intellectual or developmental disability.

(89) Service provider--A person, who may be a staff member, who directly provides an HCS Program service or CFC service to an individual.

(90) Sexual abuse--Any of the following:

(A) sexual exploitation of an individual;

(B) non-consensual or unwelcomed sexual activity with an individual; or

(C) consensual sexual activity between an individual and a service provider, staff member, volunteer, or controlling person, unless a consensual sexual relationship with an adult individual existed before the service provider, staff member, volunteer, or controlling person became a service provider, staff member, volunteer, or controlling person.

(91) Sexual activity--An activity that is sexual in nature, including kissing, hugging, stroking, or fondling with sexual intent.

(92) Sexual exploitation--A pattern, practice, or scheme of conduct against an individual that can reasonably be construed as being for the purposes of sexual arousal or gratification of any person:

(A) which may include sexual contact; and

(B) does not include obtaining information about an individual's sexual history within standard accepted clinical practice.

(93) Specialized services--This term has the meaning set forth in §303.102 of this title (relating to Definitions).

(94) Staff member--An employee or contractor of an HCS program provider.

(95) Standard contract--A contract that HHSC enters into with a program provider in accordance with 40 TAC §49.209 (relating to Standard Contract) that has a term of no more than five years, not including any extension agreed to in accordance with 40 TAC §49.209(d).

(96) State supported living center--A state-supported and structured residential facility operated by HHSC to provide to persons with an intellectual disability a variety of services, including medical treatment, specialized therapy, and training in the acquisition of personal, social, and vocational skills, but does not include a community-based facility owned by HHSC.

(97) Store and forward technology--This term has the meaning set forth in Texas Occupations Code §111.001(2).

(98) Supported Decision-Making Agreement--This term has the meaning set forth in Texas Estates Code §1357.002(4).

(99) Synchronous audio-visual--An interactive, two-way audio and video communication platform that:

(1) allows a service to be provided to an individual in real time; and

(2) conforms to the privacy requirements under the Health Insurance Portability and Accountability Act.

(100) TAC--Texas Administrative Code. A compilation of state agency rules published by the Texas Secretary of State in accordance with Texas Government Code Chapter 2002, Subchapter C.

(101) TANF--Temporary Assistance for Needy Families.

(102) TAS--Transition assistance services.

(103) Telehealth service--This term has the meaning set forth in Texas Occupations Code §111.001.

(104) Temporary admission--A stay in a facility listed in §263.705(a) of this chapter (relating to Suspension of HCS Program Services and CFC Services) for 270 calendar days or less or, if an extension is granted in accordance with §263.705(h) of this chapter, a stay in such a facility for more than 270 calendar days.

(105) Three-person residence--A residence:

(A) that a program provider leases or owns;

(B) in which at least one person but no more than three persons receive:

(i) residential support;

(ii) supervised living;

(iii) a non-HCS Program service similar to residential support or supervised living (for example, services funded by DFPS or by a person's own resources); or

(iv) respite;

(C) that is not the residence of any person other than a service provider, the service provider's spouse or person with whom the service provider has a spousal relationship, or a person described in subparagraph (B) of this paragraph; and

(D) that is not a setting described in §263.501(b) of this chapter.

(106) THSC--Texas Health and Safety Code. Texas statutes relating to health and safety.

(107) Transfer IPC--An IPC that is developed in accordance with §263.701 of this chapter (relating to Process for Individual to Transfer to a Different Program Provider or FMSA) and §263.702 of this chapter (relating to Process for Individual to Receive a Service Through the CDS Option that the Individual is Receiving from a Program Provider) when an individual transfers to another program provider or chooses a different service delivery option.

(108) Transition plan--A written plan developed in accordance with §303.701 of this title (relating to Transition Planning for a Designated Resident) for an applicant residing in a nursing facility who is enrolling in the HCS Program.

(109) Transportation plan--A written plan based on person-directed planning and developed with an applicant or individual using the HHSC Individual Transportation Plan form available on the HHSC website. A transportation plan is used to document how supported home living will be delivered to support an individual's desired outcomes and purposes for transportation as identified in the PDP.

(110) Vendor hold--A temporary suspension of payments that are due to a program provider under a contract.

(111) Verbal or emotional abuse--Any act or use of verbal or other communication, including gestures:

(A) to:

(i) harass, intimidate, humiliate, or degrade an individual; or

(ii) threaten an individual with physical or emotional harm; and

(B) that:

(i) results in observable distress or harm to the individual; or

(ii) is of such a serious nature that a reasonable person would consider it harmful or a cause of distress.

(112) Videoconferencing--An interactive, two-way audio and video communication:

(1) used to conduct a meeting between two or more persons who are in different locations; and

(2) that conforms to the privacy requirements under the Health Insurance Portability and Accountability Act.

(113) Volunteer--A person who works for a program provider without compensation, other than reimbursement for actual expenses.

§263.4. Description of the HCS Program and CFC.

(a) The HCS Program is a Medicaid waiver program approved by CMS pursuant to §1915(c) of the Social Security Act. It provides community-based services and supports to eligible individuals as an alternative to the ICF/IID Program. The HCS Program is operated by HHSC.

(b) Enrollment in the HCS Program is limited to the number of individuals in specified target groups and to the geographic areas approved by CMS.

(c) HCS Program services described in §263.5 of this subchapter (relating to Description of HCS Program Services) and CFC services described in §263.6 of this subchapter (relating to Description of CFC Services) are selected for inclusion in an individual's IPC to ensure the individual's health, safety, welfare, and integration in the community. HCS Program services and CFC Services supplement rather than replace the individual's natural supports and other community services for which the individual may be eligible and prevent the individual's admission to an institutional setting.

(d) CFC is a state plan option governed by 42 CFR Chapter 441, Subpart K, regarding Home and Community-Based Attendant Services and Supports State Plan Option (Community First Choice).

(e) HHSC has grouped Texas counties into geographical areas, referred to as "local service areas," each of which is served by a LIDDA. HHSC has further grouped the local service areas into "waiver contract areas." A list of the counties included in each local service area and waiver contract area is available on the HHSC website.

(1) A program provider may provide HCS Program services and CFC services only to persons residing in the counties specified for the program provider in the HHSC automated enrollment and billing system.

(2) A program provider must have a separate contract for each waiver contract area served by the program provider.

(3) A program provider may have a contract to serve one or more local service areas within a waiver contract area, but the program provider must serve all of the counties within each local service area covered by the contract.

(4) A program provider may not have more than one contract per waiver contract area.

(f) A program provider must comply with all applicable state and federal laws, rules, and regulations.

(g) The CDS option is a service delivery option, described in 40 TAC Chapter 41 (relating to Consumer Directed Services Option), in which an individual or LAR employs and retains service providers and directs the delivery of a service through the CDS option, as described in 40 TAC §41.108 (relating to Services Available Through the CDS Option).

§263.5. Description of HCS Program Services.

(a) HCS Program services are described in this section and in Appendix C of the HCS Program waiver application approved by CMS and available on the HHSC website.

(1) Adaptive aids are devices, controls, or items that are necessary to address specific needs identified in an individual's service plan. Adaptive aids enable an individual to maintain or increase the ability to perform ADLs or the ability to perceive, control, or communicate with the environment in which the individual lives.

(2) Audiology is the provision of audiology as defined in the Texas Occupations Code Chapter 401.

(3) Speech and language pathology is the provision of speech-language pathology, as defined in the Texas Occupations Code Chapter 401.

(4) Occupational therapy is the practice of occupational therapy as described in the Texas Occupations Code Chapter 454.

(5) Physical therapy is the provision of physical therapy as defined in the Texas Occupations Code Chapter 453.

(6) Dietary services are the provision of nutrition services as defined in the Texas Occupations Code Chapter 701.

(7) Behavioral support is the provision of specialized interventions that:

(A) assist an individual to increase adaptive behaviors to replace or modify maladaptive or socially unacceptable behaviors that prevent or interfere with the individual's inclusion in home and family life or community life; and

(B) improve an individual's quality of life.

(8) Social work is the provision of social work as defined in Texas Occupations Code Chapter 505.

(9) Cognitive rehabilitation therapy is assistance to an individual in learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry in order to enable the individual to compensate for the lost cognitive functions, including reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems.

(10) Day habilitation is assistance with acquiring, retaining, or improving self-help, socialization, and adaptive skills provided in a location other than the residence of an individual. Day habilitation does not include in-home day habilitation.

(11) In-home day habilitation is assistance with acquiring, retaining, or improving self-help, socialization, and adaptive skills provided in an individual's residence.

(12) Dental treatment is:

(A) emergency dental treatment;

(B) preventive dental treatment;

(C) therapeutic dental treatment; and

(D) orthodontic dental treatment, excluding cosmetic orthodontia.

(13) Minor home modifications are physical adaptations to an individual's home to address specific needs identified by an individual's service planning team and include pre-enrollment minor home modifications which are modifications completed before an applicant is discharged from a nursing facility, an ICF/IID, or a GRO and before the effective date of the applicant's enrollment in the HCS Program.

(14) Licensed vocational nursing is the provision of licensed vocational nursing, as defined in the Texas Occupations Code Chapter 301.

(15) Registered nursing is the provision of professional nursing, as defined in the Texas Occupations Code Chapter 301.

(16) Specialized registered nursing is the provision of registered nursing to an individual who has a tracheostomy or is dependent on a ventilator.

(17) Specialized licensed vocational nursing is the provision of licensed vocational nursing to an individual who has a tracheostomy or is dependent on a ventilator.

(18) Supported home living is transportation of an individual with a residential type of "own/family home."

(19) Host home/companion care is residential assistance from a service provider who lives in the same residence as the individual and in a residence that the program provider does not lease or own.

(20) Supervised living is residential assistance provided in a three-person residence or four-person residence in which service providers are present in the residence and are able to respond to the needs of individuals during normal sleeping hours.

(21) Residential support is residential assistance provided in a three-person residence or four-person residence in which service providers are present and awake in the residence whenever an individual is present in the residence.

(22) Respite is temporary relief for an unpaid caregiver in a location other than the individual's home for an individual who has a residential type of "own/family home."

(23) In-home respite is temporary relief for an unpaid caregiver in the individual's home for an individual who has a residential type of "own/family home."

(24) Employment assistance is assistance to help an individual locate paid employment in the community.

(25) Supported employment is assistance, in order to sustain competitive employment, to an individual who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which individuals without disabilities are employed.

(26) TAS is assistance to an applicant in setting up a household in the community before being discharged from a nursing facility, an ICF/IID, or a GRO and before enrolling in the HCS Program and consists of:

(A) for an applicant whose initial IPC does not include residential support, supervised living, or host home/companion care:

(i) paying security deposits required to lease a home, including an apartment, or to establish utility services for a home;

(ii) purchasing essential furnishings for a home, including a table, a bed, chairs, window blinds, eating utensils, and food preparation items;

(iii) paying for expenses required to move personal items, including furniture and clothing, into a home;

(iv) paying for services to ensure the health and safety of the applicant in a home, including pest eradication, allergen control, or a one-time cleaning before occupancy; and

(v) purchasing essential supplies for a home, including toilet paper, towels, and bed linens; and

(B) for an applicant whose initial IPC includes residential support, supervised living, or host home/companion care:

(i) purchasing bedroom furniture;

(ii) purchasing personal linens for the bedroom and bathroom; and

(iii) paying for allergen control.

(b) The services described in this subsection are for an individual who is receiving at least one HCS Program service through the CDS option.

(1) FMS is a service defined in 40 TAC §41.103 (relating to Definitions).

(2) Support consultation is a service defined in 40 TAC §41.103.

§263.6. Description of CFC Services.

(a) CFC services are described in this subsection and in the Medicaid State Plan approved by CMS and available on the HHSC website.

(1) CFC PAS/HAB:

(A) consists of:

(i) personal assistance services that provide assistance to an individual in performing ADLs and IADLs based on the individual's person-centered service plan, including:

(I) non-skilled assistance with the performance of the ADLs and IADLs;

(II) household chores necessary to maintain the home in a clean, sanitary, and safe environment;

(III) escort services, which consist of accompanying and assisting an individual to access services or activities in the community, but do not include transporting an individual; and

(IV) assistance with health-related tasks; and

(ii) habilitation that provides assistance to an individual in acquiring, retaining, and improving self-help, socialization, and daily living skills and training the individual on ADLs, IADLs, and health-related tasks, such as:

(I) self-care;

(II) personal hygiene;

(III) household tasks;

(IV) mobility;

(V) money management;

(VI) community integration, including how to get around in the community;

(VII) use of adaptive equipment;

(VIII) personal decision making;

(IX) reduction of challenging behaviors to allow individuals to accomplish ADLs, IADLs, and health-related tasks; and

(X) self-administration of medication; and

(B) does not include transporting the individual, which means driving the individual from one location to another.

(2) CFC support management provides training to an individual or LAR on how to select, manage, and dismiss an unlicensed service provider of CFC PAS/HAB, as described in the HCS Handbook, if:

(A) the individual is receiving CFC PAS/HAB; and

(B) the individual or LAR requests to receive CFC support management.

(3) CFC ERS consists of backup systems and supports used to ensure continuity of services and supports, including electronic devices and an array of available technology, personal emergency response systems, and other mobile communication devices and is provided only to an individual who:

(A) lives alone, who is alone for significant parts of the day, or has no regular caregiver for extended periods of time; and

(B) would otherwise require extensive routine supervision.

(b) CFC PAS/HAB and CFC ERS are not available to an individual who is receiving:

(1) host home/companion care;

(2) supervised living; or

(3) residential support.

§263.7. Requirement for Translation.

If a program provider or LIDDA submits documentation to HHSC containing information that is not in English, the program provider or LIDDA must, at the same time, submit a translation of the information in English.

§263.8. Comprehensive Nursing Assessment.

(a) An RN must complete a comprehensive nursing assessment:

(1) of an applicant in person, if the applicant's initial IPC includes a sufficient number of RN nursing units for the program provider's RN to perform a comprehensive nursing assessment as described in §263.104(k)(9) of this chapter (relating to Process for Enrollment of Applicants); and

(2) of an individual in person:

(A) when the health status of the individual changes;

(B) at least annually if a nursing service is on the individual's renewal IPC;

(C) before an unlicensed service provider performs a delegated nursing task;
and

(D) if the RN who completed the most recent comprehensive nursing assessment of the individual is no longer providing a nursing service to the individual, except as provided in subsection (b) of this section.

(b) The comprehensive nursing assessment required to be completed in accordance with subsection (a)(2)(D) of this section does not have to be completed in person if an unlicensed service provider is not performing a delegated nursing task or a health maintenance activity for the individual.

(c) An RN must document a comprehensive nursing assessment required by subsection (a) of this section using the HHSC Comprehensive Nursing Assessment form.

§263.9. Providing Physical Therapy, Occupational Therapy, and Speech and Language Pathology as a Telehealth Service.

(a) Except as described in subsection (c) of this section, a service provider of physical therapy, occupational therapy, or speech and language pathology may provide physical therapy, occupational therapy, or speech and language pathology to an individual as a telehealth service.

(b) If a service provider of physical therapy, occupational therapy, or speech and language pathology provides physical therapy, occupational therapy, or speech and language pathology to an individual as a telehealth service, a program provider must ensure that the service provider:

(1) uses a synchronous audio-visual platform to interact with the individual, supplemented with or without asynchronous store and forward technology;

(2) does not use an audio-only platform to provide the service; and

(3) before providing the telehealth service:

(A) obtains the written informed consent of the individual or LAR to provide the service; or

(B) obtains the individual or LAR's oral consent to receive the telehealth service and documents the oral consent in the individual's record.

(c) A program provider must ensure that a service provider of physical therapy, occupational therapy, or speech and language pathology performs services in person, as required by the Texas Medicaid Provider Procedures Manual. Such services include:

(1) a service that requires a physical agent modality or hands-on therapy, such as a paraffin bath, aquatic therapy, manual therapy, massage, and ultrasound;

(2) orthotic management and training, initial encounter and subsequent encounters;

(3) prosthetic management or training for an upper or lower extremity, initial encounter and subsequent encounters;

(4) a wheelchair assessment and training; and

(5) a complex rehabilitation technology assessment.

TITLE 26	HEALTH AND HUMAN SERVICES
PART 1	HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 263	<u>HOME AND COMMUNITY-BASED SERVICES (HCS)</u> <u>PROGRAM AND COMMUNITY FIRST CHOICE (CFC)</u>
SUBCHAPTER B	<u>ELIGIBILITY, ENROLLMENT, AND REVIEW</u>

§263.101. Eligibility Criteria for HCS Program Services and CFC Services.

(a) An applicant or individual is eligible for HCS Program services if the applicant or individual:

(1) meets the financial eligibility criteria as described in Appendix B of the HCS Program waiver application approved by CMS and available on the HHSC website;

(2) meets one of the following criteria:

(A) based on a DID and as determined by HHSC in accordance with §263.105 of this subchapter (relating to LOC Determination), qualifies for an ICF/IID LOC I, as defined in §261.238 of this title (relating to ICF/MR Level of Care I Criteria);

(B) as determined by HHSC in accordance with §263.105 of this subchapter, qualifies for an ICF/IID LOC I as defined in §261.238 of this title or ICF/IID LOC VIII, as defined in §261.239 of this title (relating to ICF/MR Level of Care VIII Criteria), and has been determined by HHSC:

(i) to have an intellectual disability or a related condition;

(ii) to need specialized services; and

(iii) to be inappropriately placed in a Medicaid certified nursing facility based on an annual resident review conducted in accordance with the requirements of Chapter 303 of this title (relating to Preadmission Screening and Resident Review (PASRR)); or

(C) meets the following criteria:

(i) based on a DID and as determined by HHSC in accordance with §261.237 of this title (relating to Level of Care) qualifies for one of the following levels of care:

(I) an ICF/IID LOC I as defined in §261.238 of this title; or

(II) an ICF/IID LOC VIII as defined in §261.239 of this title;

(ii) meets one of the following:

(I) resides in a nursing facility immediately before enrolling in the HCS Program; or

(II) is at imminent risk of entering a nursing facility as determined by HHSC; and

(iii) is offered HCS Program services designated for a member of the reserved capacity group "Individuals with a level of care I or VIII residing in a nursing facility" included in Appendix B of the HCS Program waiver application approved by CMS and available on the HHSC website;

(3) has an IPC cost that does not exceed:

(A) \$167,468 for an applicant or individual with an LON 1, LON 5, or LON 8;

(B) \$168,615 for an applicant or individual with an LON 6; or

(C) \$305,877 for an applicant or individual with an LON 9;

(4) is not enrolled in another waiver program and is not receiving a service that may not be received if the individual is enrolled in the HCS Program as identified in the Mutually Exclusive Services table in Appendix II of the HCS Handbook available on the HHSC website;

(5) does not reside in:

(A) a hospital;

(B) an ICF/IID;

(C) a nursing facility;

(D) an ALF;

(E) a residential child care facility licensed by HHSC unless it is an agency foster home;

(F) an inpatient chemical dependency treatment facility;

(G) a mental health facility;

(H) a residential facility operated by the Texas Workforce Commission; or

(I) a residential facility operated by the Texas Juvenile Justice Department, a jail, or a prison; and

(6) requires the provision of:

(A) at least one HCS Program service per month or a monthly monitoring visit by a service coordinator as described in §263.901(e)(40) of this chapter (relating to LIDDA Requirements for Providing Service Coordination in the HCS Program); and

(B) at least one HCS Program service per IPC year.

(b) For applicants or individuals with spouses who live in the community, the income and resource eligibility requirements are determined according to the spousal impoverishment provisions in §1924 of the Social Security Act and as specified in the Medicaid State Plan.

(c) Except as provided in subsection (d) of this section, an applicant or individual is eligible for a CFC service under this chapter if the applicant or individual:

(1) meets the criteria described in subsection (a) of this section;

(2) requires the provision of the CFC service; and

(3) is not receiving host home/companion care, supervised living, or residential support.

(d) To be eligible for a CFC service under this chapter, an applicant or individual receiving MAO Medicaid must, in addition to meeting the eligibility criteria described in subsection (c) of this section, receive an HCS Program service at least monthly, as required by 42 CFR §441.510(d), which may not be met by a monthly monitoring visit by a service coordinator as described in §263.901(e)(40) of this chapter.

§263.102. Calculation of Co-payment.

(a) Individuals and eligible couples determined to be financially eligible based on the special institutional income limit may be required to share in the cost of HCS Program services. The method for determining the individual's or couple's co-payment is described in subsections (b) and (c) of this section and documented on the HHSC Waiver Program Co-Pay Worksheet.

(b) The co-payment amount as determined by HHSC is the individual's or couple's remaining income after all allowable expenses have been deducted. The co-payment amount is applied only to the cost of HCS Program services specified on each individual's IPC. The co-payment must not exceed the cost of services actually delivered. The co-payment must be paid by the individual or couple, authorized representative, or trustee directly to the program provider in accordance with the HHSC determination. When calculating the co-payment amount for an individual or a couple whose income exceeds the maximum personal needs allowance, the following are deducted:

(1) the cost of the individual's or couple's maintenance needs, which must be equivalent to the special institutional income limit for eligibility under the Texas Medicaid program;

(2) the cost of the maintenance needs of the individual's or couple's dependent children, which is an amount equivalent to the TANF basic monthly grant for children or a spouse with children, using the recognizable needs amounts in the TANF Budgetary Allowances Chart; and

(3) the costs incurred for medical or remedial care that are necessary but are not subject to payment by Medicare, Medicaid, or any other third party, which include the costs of health insurance premiums, deductibles, and co-insurance.

(c) When calculating the co-payment amount for individuals with community spouses, HHSC determines the amount of the recipient's income applicable to payment in accordance with §1924 of the Social Security Act and 42 CFR §435.726.

§263.103. HCS Interest List.

(a) A LIDDA must maintain an up-to-date interest list of applicants interested in receiving HCS Program services for whom the LIDDA is the applicant's designated LIDDA in the HHSC data system.

(b) A person may request that an applicant's name be added to the HCS interest list by contacting the LIDDA serving the Texas county in which the applicant or person resides.

(c) If a request is made in accordance with subsection (b) of this section for an applicant who resides in Texas, a LIDDA must add the applicant's name to the HCS interest list using the date the LIDDA receives the request as the HCS interest list date.

(d) For an applicant under 22 years of age who is residing in an ICF/IID or nursing facility located in Texas, HHSC adds the applicant's name to the HCS interest list using the date of admission to the ICF/IID or nursing facility as the HCS interest list date.

(e) For an applicant determined diagnostically or functionally ineligible during the enrollment process for the Community Living Assistance and Support Services (CLASS) Program, Deaf-Blind with Multiple Disabilities (DBMD) Program, or Medically Dependent Children Program (MDCP):

(1) if the applicant's name is not on the HCS interest list, at the request of the applicant or LAR, HHSC adds the applicant's name to the HCS interest list using the applicant's interest list date for the program for which the applicant was determined ineligible as the HCS interest list date;

(2) if the applicant's name is on the HCS interest list and the applicant's interest list date for the program for which the applicant was determined ineligible is earlier than the applicant's HCS interest list date, at the request of the applicant or LAR, HHSC changes the applicant's HCS interest list date to the applicant's interest list date for the program for which the applicant was determined ineligible; or

(3) if the applicant's name is on the HCS interest list and the applicant's HCS interest list date is earlier than the applicant's interest list date for the program for which the applicant was determined ineligible, HHSC does not change the applicant's HCS interest list date.

(f) This subsection applies to an applicant who was enrolled in MDCP and, because the applicant did not meet the LOC criteria for medical necessity for nursing facility care or did not meet the age requirement of being under 21 years of age, was determined ineligible for MDCP after November 30, 2019.

(1) At the request of the applicant or LAR, HHSC adds the applicant's name to the HCS interest list:

(A) using the MDCP interest list date as the HCS interest list date, if the applicant's name is not on the HCS interest list but it was previously on the HCS interest list; or

(B) using the date HHSC receives the request as the HCS interest list date, if the applicant's name is not on the HCS interest list and it never has been on the HCS interest list.

(2) At the request of the applicant or LAR, HHSC changes the HCS interest list date to the MDCP interest list date if the applicant's MDCP interest list date is earlier than the applicant's HCS interest list date.

(g) HHSC or the LIDDA removes an applicant's name from the HCS interest list if:

(1) the applicant or LAR requests in writing that the applicant's name be removed from the HCS interest list, unless the applicant is under 22 years of age and residing in an ICF/IID or nursing facility;

(2) the applicant moves out of Texas, unless the applicant is a military family member living outside of Texas:

(A) while the military member is on active duty; or

(B) for less than one year after the former military member's active duty ends;

(3) the applicant declines an offer of HCS Program services or, as described in §263.104(f) of this subchapter (relating to Process for Enrollment of Applicants), an offer of HCS Program services is withdrawn, unless:

(A) the applicant is a military family member living outside of Texas:

(i) while the military member is on active duty, or

(ii) for less than one year after the former military member's active duty ends; or

(B) the applicant is under 22 years of age and residing in an ICF/IID or nursing facility;

(4) the applicant is a military family member living outside of Texas for more than one year after the former military member's active duty ends;

(5) the applicant is deceased; or

(6) HHSC has denied the applicant enrollment in the HCS Program and the applicant or LAR has had an opportunity to exercise the applicant's right to appeal the decision in accordance with §263.801 of this chapter (relating to Fair Hearing) and did not appeal the decision or appealed and did not prevail.

(h) If HHSC or the LIDDA removes an applicant's name from the HCS interest list in accordance with subsection (g)(1)-(4) of this section, the LIDDA receives an oral or written request from a person to add the applicant's name to the HCS interest list within 90 calendar days after the name was removed, and the request is the applicant's first request:

(1) the LIDDA must notify HHSC of the request; and

(2) HHSC:

(A) adds the applicant's name to the HCS interest list using the HCS interest list date that was in effect at the time the applicant's name was removed from the HCS interest list; and

(B) notifies the applicant or LAR in writing that the applicant's name has been added to the HCS interest list in accordance with subparagraph (A) of this paragraph.

(i) If HHSC or the LIDDA removes an applicant's name from the HCS interest list in accordance with subsection (g)(1)-(4) of this section, the LIDDA receives an oral or written request from a person to add the applicant's name to the HCS interest list more than 90 calendar days after the name was removed, and the request is the applicant's first request:

(1) one of the following occurs:

(A) the LIDDA adds the applicant's name to the HCS interest list using the date the LIDDA receives the oral or written request as the HCS interest list date; or

(B) if HHSC determines that extenuating circumstances exist, HHSC adds the applicant's name to the HCS interest list using the HCS interest list date that was in effect at the time the applicant's name was removed from the HCS interest list as the HCS interest list date; and

(2) HHSC notifies the applicant or LAR in writing that the applicant's name has been added to the HCS interest list in accordance with paragraph (1) of this subsection.

(j) If HHSC or the LIDDA removes an applicant's name from the HCS interest list in accordance with subsection (g)(1)-(4) of this section, the LIDDA receives an oral or written request from a person to add the applicant's name to the HCS interest list, and the request is not the applicant's first request:

(1) the LIDDA adds the applicant's name to the HCS interest list using the date the LIDDA receives the oral or written request as the HCS interest list date; and

(2) HHSC notifies the applicant or LAR in writing that the applicant's name has been added to the HCS interest list in accordance with paragraph (1) of this subsection.

(k) If HHSC or the LIDDA removes an applicant's name from the HCS interest list in accordance with subsection (g)(6) of this section and the LIDDA subsequently receives an oral or written request from a person to add the applicant's name to the HCS interest list:

(1) the LIDDA must add the applicant's name to the HCS interest list using the date the LIDDA receives the oral or written request as the HCS interest list date; and

(2) HHSC notifies the applicant or LAR in writing that the applicant's name has been added to the HCS interest list in accordance with paragraph (1) of this subsection.

§263.104. Process for Enrollment of Applicants.

(a) HHSC notifies a LIDDA, in writing, when the opportunity for enrollment in the HCS Program becomes available in the LIDDA's local service area and directs the LIDDA to offer enrollment to an applicant:

(1) whose interest list date, assigned in accordance with §263.103 of this subchapter (relating to HCS Interest List), is earliest on the statewide interest list for the HCS Program maintained by HHSC; or

(2) who is a member of a target group identified in the HCS Program waiver application approved by CMS.

(b) Except as provided in subsection (c) of this section, a LIDDA must offer enrollment in the HCS Program in writing and deliver it to the applicant or LAR by United States mail or by hand delivery.

(c) A LIDDA must offer enrollment in the HCS Program to an applicant described in subsection (a)(2) of this section in accordance with HHSC's procedures.

(d) A LIDDA must include in a written offer that is made in accordance with subsection (a)(1) of this section:

(1) a statement that:

(A) if the applicant or LAR does not respond to the offer of enrollment in the HCS Program within 30 calendar days after the LIDDA's written offer, the LIDDA withdraws the offer; and

(B) if the applicant is currently receiving services from the LIDDA that are funded by general revenue and the applicant or LAR declines the offer of enrollment in the HCS Program, the LIDDA terminates those services funded by general revenue that are similar to services provided in the HCS Program; and

(2) the HHSC Deadline Notification form, which is available on the HHSC website.

(e) If an applicant or LAR responds to an offer of enrollment in the HCS Program, a LIDDA must:

(1) provide the applicant, LAR, and, if the LAR is not a family member, at least one family member if possible, both an oral and written explanation of the services and supports for which the applicant may be eligible, including the ICF/IID Program, both state supported living centers and community-based facilities, waiver programs authorized under §1915(c) of the Social Security Act, and other community-based services and supports, using the HHSC Explanation of Services and Supports document, which is available on the HHSC website;

(2) provide the applicant and LAR both an oral and a written explanation of all HCS Program services and CFC services using the HHSC Understanding Program Eligibility and Services form, which is available on the HHSC website; and

(3) give the applicant or LAR the HHSC Waiver Program Verification of Freedom of Choice form, which is available on the HHSC website, to document the applicant's choice between the HCS Program or the ICF/IID Program.

(f) A LIDDA must withdraw an offer of enrollment in the HCS Program made to an applicant or LAR if:

(1) within 30 calendar days after the LIDDA's offer made to the applicant or LAR in accordance with subsection (a)(1) of this section, the applicant or LAR does not respond to the offer of enrollment in the HCS Program;

(2) within seven calendar days after the applicant or LAR receives the HHSC Waiver Program Verification of Freedom of Choice form from the LIDDA in accordance with subsection (e)(3) of this section, the applicant or LAR does not use the form to document the applicant's choice, the HCS Program or the ICF/IID Program;

(3) within 30 calendar days after the applicant or LAR receives the contact information for all program providers in the LIDDA's local service area in accordance with subsection (j)(3) of this section, the applicant or LAR does not document the choice of a program provider using the HHSC Documentation of Provider Choice form, which is available on the HHSC website;

(4) the applicant or LAR does not complete the necessary activities to finalize the enrollment process and HHSC has approved the withdrawal of the offer; or

(5) the applicant has moved out of the State of Texas.

(g) If a LIDDA withdraws an offer of enrollment in the HCS Program made to an applicant, the LIDDA must notify the applicant or LAR of such action, in writing, by certified United States mail.

(h) If an applicant is currently receiving services from a LIDDA that are funded by general revenue and the applicant or LAR declines the offer of enrollment in the HCS Program, the LIDDA must terminate those services funded by general revenue that are similar to services provided in the HCS Program.

(i) If a LIDDA terminates an applicant's services in accordance with subsection (h) of this section, the LIDDA must notify the applicant or LAR of the termination, in writing, by certified United States mail and provide an opportunity for a review in accordance with 40 TAC §2.46 (relating to Notification and Appeals Process).

(j) If an applicant or LAR accepts the offer of enrollment in the HCS Program, the LIDDA must compile and maintain information necessary to process the applicant's request for enrollment.

(1) If the applicant's financial eligibility for the HCS Program must be established, the LIDDA must initiate, monitor, and support the processes necessary to obtain a financial eligibility determination.

(2) The LIDDA must complete an ID/RC Assessment in accordance with §263.105 of this subchapter (relating to LOC Determination) and §263.106 of this subchapter (relating to LON Assignment).

(A) The LIDDA must:

(i) do one of the following:

(I) conduct a DID in accordance with §304.401 of this title (relating to Conducting a Determination of Intellectual Disability) except that the following activities must be conducted in person:

(-a-) a standardized measure of the individual's intellectual functioning using an appropriate test based on the characteristics of the individual; and

(-b-) a standardized measure of the individual's adaptive abilities and deficits reported as the individual's adaptive behavior level; or

(II) review and endorse a DID report in accordance with §304.403 of this title (relating to Review and Endorsement of a Determination of Intellectual Disability Report); and

(ii) determine whether the applicant has been diagnosed by a licensed physician as having a related condition.

(B) The LIDDA must:

(i) conduct an ICAP assessment in person; and

(ii) recommend an LON assignment to HHSC in accordance with §263.106 of this subchapter.

(C) The LIDDA must enter the information from the completed ID/RC Assessment and electronically submit the information to HHSC for approval in accordance with §263.105(a) of this subchapter and §263.106(a) of this subchapter and, if applicable, submit supporting documentation as required by §263.107(c) of this subchapter (relating to HHSC Review of LON).

(3) The LIDDA must provide names and contact information to the applicant or LAR for all program providers in the LIDDA's local service area.

(4) The LIDDA must assign a service coordinator who, together with other members of the applicant's service planning team, must:

(A) develop a PDP;

(B) if CFC PAS/HAB is included on the PDP, complete the HHSC HCS/TxHmL CFC PAS/HAB Assessment form, which is available on the HHSC website, to determine the number of CFC PAS/HAB hours the applicant needs; and

(C) develop an initial IPC in accordance with §263.301(c) of this chapter (relating to IPC Requirements).

(5) The CFC PAS/HAB Assessment form required by paragraph (4)(B) of this subsection must be completed in person with the individual unless the following conditions are met in which case the form may be completed by videoconferencing or telephone:

(A) the service coordinator gives the individual the opportunity for completing the form in person in lieu of completing it by videoconferencing or telephone and the individual agrees to the form being completed by videoconferencing or telephone; and

(B) the individual receives appropriate in-person support during the completion of the form by videoconferencing or telephone.

(6) A service coordinator must discuss the CDS option with the applicant or LAR in accordance with §263.401(a) and (b) of this chapter (relating to CDS Option).

(k) A service coordinator must:

(1) arrange for meetings and visits with potential program providers as requested by an applicant or LAR;

(2) review the initial IPC with potential program providers as requested by the applicant or LAR;

(3) ensure that the applicant's or LAR's choice of a program provider is documented on the HHSC Documentation of Provider Choice form and that the form is signed by the applicant or LAR;

(4) negotiate and finalize the initial IPC and the date services will begin with the selected program provider, consulting with HHSC if necessary to reach agreement with the selected program provider on the content of the initial IPC and the date services will begin;

(5) determine whether the applicant meets the following criteria:

(A) is being discharged from a nursing facility, an ICF/IID, or a GRO; and

(B) anticipates needing TAS;

(6) if the service coordinator determines that the applicant meets the criteria described in paragraph (5) of this subsection:

(A) complete, with the applicant or LAR and the selected program provider, the HHSC Transition Assistance Services (TAS) Assessment and Authorization form, which is available on the HHSC website, in accordance with the form's instructions, which includes:

(i) identifying the TAS the applicant needs; and

(ii) estimating the monetary amount for each transition assistance service identified, which must be within the service limit described in §263.304(a)(6) of this chapter (relating to Service Limits);

(B) submit the completed form to HHSC to determine if TAS is authorized;

(C) send the form authorized by HHSC to the selected program provider; and

(D) include the TAS and the monetary amount authorized by HHSC on the applicant's initial IPC;

(7) determine whether an applicant meets the following criteria:

(A) is being discharged from a nursing facility, an ICF/IID, or a GRO;

(B) has not met the maximum service limit for minor home modifications as described in §263.304 (a)(3)(A) of this chapter; and

(C) anticipates needing pre-enrollment minor home modifications and a pre-enrollment minor home modifications assessment;

(8) if the service coordinator determines that an applicant meets the criteria described in paragraph (7) of this subsection:

(A) complete, with the applicant or LAR and selected program provider, the HHSC Home and Community-based Services (HCS) Program Pre-enrollment MHM Authorization Request form, which is available on the HHSC website, in accordance with the form's instructions, which includes:

(i) identifying the pre-enrollment minor home modifications the applicant needs;

(ii) identifying the pre-enrollment minor home modifications assessments conducted by the program provider; and

(iii) based on documentation provided by the program provider as required by the *HCS Program Billing Requirements*, stating the cost of:

(I) the pre-enrollment minor home modifications identified on the form, which must be within the service limit described in §263.304(a)(3)(A) of this chapter; and

(II) the pre-enrollment minor home modifications assessments conducted;

(B) submit the completed form to HHSC to determine if pre-enrollment minor home modification and pre-enrollment minor home modifications assessments are authorized;

(C) send the form authorized by HHSC to the selected program provider; and

(D) include the pre-enrollment minor home modifications, pre-enrollment minor home modifications assessments, and the monetary amount for these services authorized by HHSC on the applicant's initial IPC;

(9) if an applicant or LAR chooses a program provider to deliver supported home living, nursing, host home/companion care, residential support, supervised living, respite, employment assistance, supported employment, in-home day habilitation, day habilitation, or CFC PAS/HAB, ensure that the initial IPC includes a sufficient number of RN nursing units for the program provider's RN to perform a comprehensive nursing assessment unless:

(A) nursing services are not on the IPC and the applicant or LAR and selected program provider have determined that no nursing tasks will be performed by an unlicensed service provider as documented on the HHSC Nursing Task Screening Tool form; or

(B) an unlicensed service provider will perform a nursing task and a physician has delegated the task as a medical act under Texas Occupations Code Chapter 157, as documented by the physician;

(10) if an applicant or LAR refuses to include on the initial IPC a sufficient number of RN nursing units for the program provider's RN to perform a comprehensive nursing assessment as required by paragraph (9) of this subsection:

(A) inform the applicant or LAR that the refusal:

(i) will result in the applicant not receiving nursing services from the program provider; and

(ii) if the applicant needs host home/companion care, residential support, supervised living, supported home living, respite, employment assistance, supported employment, in-home day habilitation, day habilitation, or CFC PAS/HAB from the program provider, will result in the individual not receiving that service unless:

(I) the program provider's unlicensed service provider does not perform nursing tasks in the provision of the service; and

(II) the program provider determines that it can ensure the applicant's health, safety, and welfare in the provision of the service; and

(B) document the refusal of the RN nursing units on the initial IPC for a comprehensive nursing assessment by the program provider's RN in the applicant's record;

(11) ensure that the applicant or LAR signs and dates the initial IPC in person, electronically, by fax, or by United States mail;

(12) ensure that the selected program provider signs and dates the initial IPC, demonstrating agreement that the services will be provided to the applicant;

(13) sign and date the initial IPC, which indicates that the service coordinator agrees that the requirements described in §263.301(c) of this chapter have been met;

(14) using the HHSC Understanding Program Eligibility and Services form, which is available on the HHSC website, provide an oral and written explanation to the applicant or LAR:

(A) of the eligibility requirements for HCS Program services as described in §263.101(a) of this subchapter (relating to Eligibility Criteria for HCS Program Services and CFC Services);

(B) if the applicant's PDP includes CFC services:

(i) of the eligibility requirements for CFC services as described in §263.101(c) of this subchapter to applicants who do not receive MAO Medicaid; and

(ii) of the eligibility requirements for CFC services as described in §263.101(d) of this subchapter to applicants who receive MAO Medicaid;

(C) that HCS Program services may be terminated if:

(i) the individual no longer meets the eligibility criteria described in §263.101(a) of this subchapter; or

(ii) the individual or LAR requests termination of HCS Program services;
and

(D) if the applicant's PDP includes CFC services, that CFC services may be terminated if:

(i) the individual no longer meets the eligibility criteria described in §263.101(c) or (d) of this subchapter; or

(ii) the individual or LAR requests termination of CFC services.

(l) A LIDDA must conduct permanency planning in accordance with §263.902(a) of this chapter (relating to Permanency Planning).

(m) After an initial IPC is finalized and signed in accordance with subsection (k) of this section, the LIDDA must:

(1) enter the information from the initial IPC in the HHSC data system and electronically submit it to HHSC;

(2) keep the original initial IPC in the individual's record;

(3) ensure the information from the initial IPC entered in the HHSC data system and electronically submitted to HHSC contains information identical to the information on the initial IPC; and

(4) submit other required enrollment information to HHSC.

(n) HHSC notifies the applicant or LAR, the selected program provider, the FMSA, if applicable, and the LIDDA of its approval or denial of the applicant's enrollment. When the enrollment is approved, HHSC authorizes the applicant's enrollment in the HCS Program through the HHSC data system and issues an enrollment letter to the applicant that includes the effective date of the applicant's enrollment in the HCS Program.

(o) Before the applicant's service begin date, the LIDDA must provide to the selected program provider and FMSA, if applicable:

(1) copies of all enrollment documentation and associated supporting documentation, including relevant assessment results and recommendations;

(2) the completed ID/RC Assessment;

(3) the initial IPC;

(4) the applicant's PDP; and

(5) if CFC PAS/HAB is included on the PDP, the completed HHSC HCS/TxHmL CFC PAS/HAB Assessment form.

(p) Except for the provision of TAS, pre-enrollment minor home modifications, and a pre-enrollment minor home modifications assessment, the selected program provider must not initiate services until notified of HHSC's approval of the applicant's enrollment.

(q) The selected program provider and the individual or LAR must develop:

(1) an implementation plan for:

(A) HCS Program services, except for supported home living, that is based on the individual's PDP and IPC; and

(B) CFC services, except for CFC support management, that is based on the individual's PDP, IPC, and if CFC PAS/HAB is included on the PDP, the completed HHSC HCS/TxHmL CFC PAS/HAB Assessment form; and

(2) a transportation plan, if supported home living is included on the PDP.

(r) A LIDDA must retain in an applicant's record:

(1) the HHSC Waiver Program Verification of Freedom of Choice form;

(2) the HHSC Documentation of Provider Choice form, if applicable;

(3) the HHSC Deadline Notification form; and

(4) any other correspondence related to the offer of enrollment in the HCS Program.

§263.105. LOC Determination.

(a) A LIDDA must request an LOC from HHSC for an applicant in accordance with this subsection.

(1) The LIDDA must complete an ID/RC Assessment for an applicant that:

(A) includes the LOC recommended by a person qualified to perform an initial evaluation of LOC in accordance with Appendix B of the HCS Program waiver application approved by CMS; and

(B) is signed and dated in accordance with the instructions for completing the ID/RC Assessment.

(2) The LIDDA must enter information from the completed ID/RC Assessment in the HHSC data system and electronically submit the information to HHSC.

(3) The LIDDA must ensure that the information entered in the HHSC data system and electronically submitted to HHSC is identical to the information on the completed ID/RC Assessment.

(4) The LIDDA must send a copy of the completed ID/RC Assessment and supporting documentation to HHSC, as requested by HHSC.

(b) A program provider must request an LOC for an individual from HHSC in accordance with this subsection.

(1) No more than 60 calendar days before the expiration date of an individual's ID/RC Assessment, a program provider must:

(A) complete an ID/RC Assessment that:

(i) includes the LOC recommended by a person qualified to perform a reevaluation of LOC in accordance with Appendix B of the HCS Program waiver application approved by CMS; and

(ii) is signed and dated by the program provider in accordance with the instructions for completing the ID/RC Assessment; and

(B) enter information from the completed ID/RC Assessment in the HHSC data system and electronically submit the information.

(2) A program provider must:

(A) ensure that the information entered and electronically submitted in the HHSC data system is identical to the information on the completed ID/RC Assessment;

(B) within three calendar days after entering and electronically submitting the information in the HHSC data system, provide the service coordinator with a copy of the completed ID/RC Assessment; and

(C) send a copy of the completed ID/RC Assessment and supporting documentation to HHSC, as requested by HHSC.

(3) If the program provider enters information from a completed ID/RC Assessment in the HHSC data system and electronically submits the information on a date that is more than 180 calendar days after the expiration date of the previous ID/RC Assessment, the program provider must:

(A) send to HHSC a copy of the completed ID/RC Assessment by a method, as instructed by HHSC, that:

(i) includes the recommended LOC; and

(ii) is signed and dated by the program provider in accordance with the instructions for completing the ID/RC Assessment;

(B) within three calendar days after sending the completed ID/RC Assessment to HHSC, provide the service coordinator with a copy of the completed ID/RC Assessment; and

(C) submit documentation supporting the ID/RC Assessment to HHSC, as requested by HHSC.

(c) For an LOC requested in accordance with subsection (b) of this section, within seven calendar days after a program provider enters information from a completed ID/RC Assessment in the HHSC data system and electronically submits the information, the service coordinator or a LIDDA representative other than the service coordinator must:

(1) review the information entered in the HHSC data system and electronically submitted, to determine if the information in the HHSC data system is identical to the information on the completed ID/RC Assessment the service coordinator received from the program provider;

(2) enter in the HHSC data system:

(A) the service coordinator's name and date of review; and

(B) one of the following:

(i) that the service coordinator agrees with the ID/RC Assessment, if the information in the HHSC data system is identical to the completed ID/RC Assessment; or

(ii) that the service coordinator disagrees with the ID/RC Assessment, if the information in the HHSC data system is not identical to the completed ID/RC Assessment; and

(3) if the service coordinator or a LIDDA representative other than the service coordinator enters in the HHSC data system that the service coordinator disagrees with the ID/RC Assessment, notify HHSC and the program provider of the service coordinator's disagreement in accordance with HHSC's instructions.

(d) For an LOC requested in accordance with subsection (b) of this section, HHSC considers a service coordinator's agreement or disagreement with an ID/RC Assessment in making an LOC determination.

(e) Information on an ID/RC Assessment must be supported by current data obtained from standardized evaluations and formal assessments that measure physical, emotional, social, and cognitive factors. A signed and dated ID/RC Assessment and documentation supporting the recommended LOC must be maintained in an individual's record.

(f) When HHSC receives a request for an LOC in accordance with subsection (a) or (b) of this section, HHSC determines if an applicant or individual qualifies for an LOC required by §263.101(a)(2) of this subchapter (relating to Eligibility Criteria for HCS Program Services and CFC Services).

(g) HHSC approves an LOC or sends a written notification:

(1) to the applicant, individual, or LAR that the applicant or individual is not eligible for HCS Program services or CFC services and provides the applicant, individual, or LAR with an opportunity to request a fair hearing in accordance with §263.801 of this chapter (relating to Fair Hearing);

(2) to the LIDDA that the LOC has been denied; and

(3) to the program provider using the HHSC data system that the LOC has been denied, if the applicant has selected a program provider or an individual is receiving services from a program provider.

(h) An LOC determination is valid for a period of time as described in this subsection.

(1) Except as provided in paragraph (2) of this subsection, an LOC determination is valid for a 365-calendar day period starting on the begin date of the ID/RC Assessment.

(2) If the begin date of the ID/RC Assessment is March 1 or later in a year before a leap year or January 1-February 28 of a leap year, the LOC determination is valid for a 366-calendar day period starting on the begin date of the ID/RC Assessment.

(i) An ID/RC Assessment submitted in accordance with subsection (b) of this section is effective on the date after the individual's previous ID/RC Assessment expires.

(j) If the LON of an individual receiving HCS Program services changes from a LON 5, LON 8, LON 6, or LON 9 to a LON 1, HHSC notifies the LIDDA of the change using the HHSC HCS Level of Care Redetermination Cover Sheet form.

(1) The LIDDA must, within 30 business days after receiving the notification:

(A) conduct a DID in accordance with §304.401 of this title (relating to Conducting a Determination of Intellectual Disability);

(B) complete the LIDDA section of the HHSC HCS Level of Care Redetermination Cover Sheet form, and return the form to HHSC; and

(C) submit a copy of the results of the new DID and any other pertinent information regarding the reassessment of the individual to HHSC.

(2) If the LIDDA is unable to complete the requirements described in paragraph (1) of this subsection within the 30-business day timeframe, the LIDDA must notify HHSC of the reasons for the delay.

(3) HHSC reviews the information submitted by the LIDDA regarding the redetermination and notifies the LIDDA and the HCS program provider of the review decision using the HHSC HCS Level of Care Redetermination Cover Sheet form.

(k) For an individual who is receiving all services through the CDS option and, therefore, does not have a program provider, the service coordinator:

(1) must perform the functions of the program provider described in subsection (b) of this section; and

(2) is not required to comply with subsection (c) of this section.

§263.106. LON Assignment.

(a) A LIDDA must request an LON for an applicant from HHSC at the time an applicant is enrolled into the HCS Program. The LON is requested by entering the information from a completed ID/RC Assessment, that includes the recommended LON and is signed and dated by the service coordinator, in the HHSC data system and electronically submitting the information to HHSC. The electronically submitted ID/RC Assessment must contain information identical to the information on the signed and dated ID/RC Assessment.

(b) A program provider must request an LON for an individual from HHSC in accordance with this subsection.

(1) Before the expiration of an ID/RC Assessment, the program provider must enter the information from the completed ID/RC Assessment in the HHSC data system and electronically submit the information to HHSC that includes the recommended LON and is signed and dated by the program provider.

(2) The program provider must ensure the information from the completed ID/RC Assessment entered in the HHSC data system and electronically submitted

contains information that is identical to the information on the signed and dated ID/RC Assessment.

(3) The program provider must, within three calendar days after submission, provide the service coordinator with a copy of the signed and dated ID/RC Assessment.

(4) If applicable, the program provider must submit supporting documentation to HHSC as required by §263.107(c) of this chapter (relating to HHSC Review of LON).

(c) For an LON requested in accordance with subsection (b) of this section, within seven calendar days after the program provider enters the information from the completed ID/RC Assessment in the HHSC data system and electronically submits the information:

(1) the service coordinator or a LIDDA representative other than the service coordinator must review the ID/RC Assessment in HHSC data system and enter in the HHSC data system:

(A) the service coordinator's name and date; and

(B) whether the service coordinator agrees or disagrees with how the ID/RC Assessment was entered in the HHSC data system; and

(2) if the service coordinator disagrees with how the ID/RC Assessment was entered in the HHSC data system, the service coordinator and program provider must resolve the disagreement.

(d) If the service coordinator disagrees with the ID/RC Assessment for a reason other than how the ID/RC Assessment was entered in the HHSC data system, the service coordinator must notify the individual, LAR, HHSC, and the program provider of the service coordinator's disagreement in accordance with HHSC instructions.

(e) The service coordinator's agreement or disagreement is considered in HHSC review of an ID/RC Assessment submitted in accordance with subsection (b) of this section.

(f) The program provider must maintain documentation supporting the recommended LON in the individual's record.

(g) HHSC assigns an LON to an individual based on the individual's ICAP service level score, information reported on the individual's ID/RC Assessment, and required supporting documentation. Documentation supporting a recommended LON must be submitted to HHSC in accordance with HHSC guidelines.

(h) HHSC assigns one of five LONs as follows:

(1) an intermittent LON (LON 1) is assigned if the individual's ICAP service level score equals 7, 8, or 9;

(2) a limited LON (LON 5) is assigned if the individual's ICAP service level score equals 4, 5, or 6;

(3) an extensive LON (LON 8) is assigned if the individual's ICAP service level score equals 2 or 3;

(4) a pervasive LON (LON 6) is assigned if the individual's ICAP service level score equals 1; and

(5) regardless of an individual's ICAP service level score, a pervasive plus LON (LON 9) is assigned if the individual meets the criteria set forth in subsection (j) of this section.

(i) An LON 1, 5, or 8, determined in accordance with subsection (g) of this section, is increased to the next LON by HHSC, due to an individual's dangerous behavior, if supporting documentation submitted to HHSC proves that:

(1) the individual exhibits dangerous behavior that could cause serious physical injury to the individual or others;

(2) a written behavior support plan has been implemented that meets HHSC guidelines and is based on ongoing written data, targets the dangerous behavior with individualized objectives, and specifies intervention procedures to be followed when the behavior occurs;

(3) more service providers are needed and available than would be needed if the individual did not exhibit dangerous behavior;

(4) service providers are constantly prepared to physically prevent the dangerous behavior or intervene when the behavior occurs; and

(5) the individual's ID/RC Assessment is correctly scored with a "1" in the "Behavior" section.

(j) HHSC assigns an LON 9 if supporting documentation submitted to HHSC proves that:

(1) the individual exhibits extremely dangerous behavior that could be life threatening to the individual or to others;

(2) a written behavior support plan has been implemented that meets HHSC guidelines and is based on ongoing written data, targets the extremely dangerous

behavior with individualized objectives, and specifies intervention procedures to be followed when the behavior occurs;

(3) management of the individual's behavior requires a service provider to exclusively and constantly supervise the individual during the individual's waking hours, which must be at least 16 hours per day;

(4) the service provider assigned to supervise the individual has no other duties during such assignment; and

(5) the individual's ID/RC Assessment is correctly scored with a "2" in the "Behavior" section.

(k) An LON 1, 5, or 8, determined in accordance with subsection (g) of this section, is increased to the next LON by HHSC, due to an individual's high medical needs, if:

(1) the individual has an ID/RC Assessment reflecting a frequency code of "6" in the "Nursing" section;

(2) a completed HHSC Level of Need (LON) Review/Increase Cover Sheet form is submitted to HHSC; and

(3) supporting documentation described in subsection (l) of this section submitted to HHSC with the cover sheet form proves that the individual requires 181 minutes or more per week of:

(A) a nursing service listed in §263.5(a)(14) – (17) of this chapter (relating to Description of HCS Program Services) provided in person;

(B) in-person nursing services provided by another source; or

(C) a combination of the nursing services described in subparagraphs (A) and (B) of this paragraph.

(l) The following supporting documentation must be submitted to HHSC as described in subsection (k)(3) of this section:

(1) a completed HHSC Medical Increase Worksheet - HCS Program Only form, identifying:

(A) a description of the ongoing medical condition requiring the individual to receive 181 minutes or more of in-person nursing services per week;

(B) a description of the in-person treatments that need to be provided to the individual and the in-person nursing tasks that need to be performed for the individual;

(C) the frequency of a nursing task that needs to be performed and the amount of time required to complete the nursing task; and

(D) if applicable, extenuating circumstances that may contribute to the individual's need to receive 181 minutes or more of in-person nursing services per week;

(2) the individual's most current:

(A) implementation plan for the nursing services listed in §263.5(a)(14) – (17) of this chapter that are provided in person;

(B) ICAP assessment booklet and computer scoring sheet;

(C) PDP; and

(D) comprehensive nursing assessment;

(3) nursing notes of all in-person nursing services provided to the individual within the immediate 30 days before the date the ID/RC Assessment is electronically submitted to HHSC;

(4) service planning notes relating to the individual's ongoing medical issues completed within the immediate 365 days before the ID/RC Assessment is electronically submitted to HHSC;

(5) any professional assessments that discuss the changes in the individual's medical condition or changes in needed medical interventions completed within the immediate 365 days before the date the ID/RC Assessment is electronically submitted; and

(6) other documents evidencing that the individual requires 181 minutes or more of in-person nursing services per week, such as:

(A) focused or quarterly nursing assessments;

(B) physician's orders;

(C) medication administration records; and

(D) treatment sheets, if used.

(m) A program provider must conduct an ICAP assessment in accordance with this subsection.

(1) A program provider must conduct an ICAP assessment of an individual:

(A) within three years after the individual's enrollment and every third year thereafter;

(B) if changes in the individual's functional skills or behavior occur that are not expected to be of short duration or cyclical in nature; or

(C) if the individual's skills and behavior are inconsistent with the individual's assigned LON.

(2) If the results of an ICAP assessment demonstrate that the individual's LON assignment may not be accurate, the program provider must submit a completed ID/RC Assessment to HHSC recommending a revision of the individual's LON assignment.

§263.107. HHSC Review of LON.

(a) HHSC may review a recommended or assigned LON at any time to determine if it is appropriate. If HHSC reviews an LON, documentation supporting the LON must be submitted to HHSC in accordance with HHSC's request. HHSC may modify an LON and recoup or deny payment based on its review.

(b) Before assigning an LON, HHSC reviews documentation supporting the recommended LON if:

(1) an LON is requested that is an increase from the individual's current LON;

(2) an LON 9 is requested in accordance with §263.106(j) of this subchapter (relating to LON Assignment);

(3) an LON is requested in accordance with §263.106(i) of this subchapter; or

(4) an LON is requested in accordance with §263.106(k) and (l) of this subchapter.

(c) Documentation supporting a recommended LON described in subsection (b) of this section must be submitted to HHSC and received by HHSC within seven calendar days after electronically submitting the recommended LON.

(1) Within 21 calendar days after receiving the supporting documentation, HHSC:

(A) requests additional documentation;

(B) electronically approves the recommended LON; or

(C) provides written notification that the recommended LON has been denied.

(2) HHSC reviews any additional documentation submitted in accordance with HHSC's request and:

(A) electronically approves the recommended LON; or

(B) provides written notification that the recommended LON has been denied to the program provider and the service coordinator.

§263.108. Reconsideration of LON Assignment.

(a) If a program provider disagrees with an LON assignment, the program provider may request that HHSC reconsider the assignment.

(b) The program provider may receive reconsideration only if the program provider submitted documentation supporting the recommended LON as required by §263.107(c) of this subchapter (relating to HHSC Review of LON).

(c) To request reconsideration of an LON assignment, the program provider must submit a written request for reconsideration to HHSC within 10 calendar days after receipt of the notification from HHSC that the recommended LON was denied. A program provider may send HHSC documentation, in addition to that required by §263.107(c) of this subchapter, to support the request for reconsideration of an LON assignment.

(d) Within 21 calendar days after receipt of a request for reconsideration, HHSC electronically approves the recommended LON or sends written notification that the recommended LON has been denied to the program provider and the service coordinator. A written notification that the recommended LON has been denied gives the program provider the right to request an administrative hearing in accordance §263.802 of this chapter (relating to Program Provider's Right to Administrative Hearing).

TITLE 26	HEALTH AND HUMAN SERVICES
PART 1	HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 263	<u>HOME AND COMMUNITY-BASED SERVICES (HCS)</u>
	<u>PROGRAM AND COMMUNITY FIRST CHOICE (CFC)</u>
SUBCHAPTER C	<u>PERSON-CENTERED PLANNING</u>

§263.201. Person-Centered Planning Process.

(a) Person-centered planning is a process that empowers an applicant or individual to plan the applicant's or individual's services and supports to achieve desired outcomes.

(b) The service coordinator and program provider must ensure the person-centered planning process is led by an individual to the maximum extent possible. An individual's LAR has a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the LAR.

(c) The person-centered planning process must be used to develop a PDP, implementation plan, initial IPC, renewal IPC, revised IPC, service backup plan, and transportation plan.

(d) The person-centered planning process must:

(1) include people chosen by an applicant, individual, or LAR;

(2) provide the information and support the applicant or individual needs to lead the planning process and make informed choices and decisions;

(3) occur at a time and location convenient to the applicant or individual and LAR;

(4) consider the applicant's or individual's cultural preferences;

(5) provide information in plain language to the applicant or individual in a manner that is accessible to:

(A) the applicant or individual through the provision of an auxiliary aid at no cost to the applicant or individual in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act; and

(B) the applicant or individual with limited English proficiency through the provision of language services at no cost to the applicant or individual, including oral interpretation and written translations;

(6) use strategies for solving conflict or disagreement within the person-centered planning process;

(7) provide information to the individual or LAR to allow the individual or LAR to make informed decisions including:

(A) a written and oral description of the services available in the HCS Program; and

(B) the name and qualifications of the individual's service providers, in writing; and

(8) inform the individual or LAR that the individual or LAR may request revisions to the PDP, implementation plan, initial IPC, renewal IPC, revised IPC, service backup plan, and transportation plan at any time by communicating the request to the service coordinator or the program provider.

(e) A program provider must participate in a service planning team meeting if requested by the individual or LAR.

TITLE 26	HEALTH AND HUMAN SERVICES
PART 1	HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 263	<u>HOME AND COMMUNITY-BASED SERVICES (HCS)</u>
	<u>PROGRAM AND COMMUNITY FIRST CHOICE (CFC)</u>
SUBCHAPTER D	<u>DEVELOPMENT AND REVIEW OF AN IPC</u>

§263.301. IPC Requirements.

(a) An IPC must be based on the PDP and specify:

(1) the type and amount of each HCS Program service and CFC service to be provided to an individual during an IPC year;

(2) the services and supports to be provided to the individual through resources other than HCS Program services or CFC services during an IPC year, including natural supports, medical services, day activity, and educational services;

(3) if an individual will receive CFC support management; and

(4) if there are any HCS Program services or CFC services identified on the PDP as critical, requiring a service backup plan.

(b) If an applicant's or individual's IPC includes only CFC PAS/HAB to be delivered through the CDS option, a service coordinator must include in the IPC:

(1) CFC FMS instead of FMS; and

(2) if the applicant or individual will receive support consultation, CFC support consultation instead of support consultation.

(c) The type and amount of each HCS Program service and CFC service in an IPC:

(1) must be necessary to protect the individual's health and welfare in the community;

(2) must not be available to the individual through any other source, including the Medicaid State Plan, other governmental programs, private insurance, or the individual's natural supports;

(3) must be the most appropriate type and amount to meet the individual's needs;

(4) must be cost effective;

(5) must be necessary to enable community integration and maximize independence;

(6) if an adaptive aid or minor home modification, must:

(A) be included on HHSC's approved list in the *HCS Program Billing Requirements*; and

(B) be within the service limit described in §263.304 of this subchapter (relating to Service Limits);

(7) if an adaptive aid costing \$500 or more, must be supported by a written assessment from a licensed professional specified by HHSC in the *HCS Program Billing Requirements*;

(8) if a minor home modification costing \$1,000 or more, must be supported by a written assessment from a licensed professional specified by HHSC in the *HCS Program Billing Requirements*;

(9) if dental treatment, must be within the service limit described in §263.304 of this subchapter;

(10) if respite, must be within the service limit described in §263.304 of this subchapter;

(11) if TAS, must be:

(A) supported by a Transition Assistance Services (TAS) Assessment and Authorization form authorized by HHSC; and

(B) within the service limit described in §263.304(a)(6)(A) or (B) of this subchapter;

(12) if pre-enrollment minor home modifications, must be:

(A) supported by a written assessment from a licensed professional if required by the *HCS Program Billing Requirements*;

(B) supported by a Home and Community-based Services (HCS) Program Pre-enrollment MHM Authorization Request form authorized by HHSC;

(C) within the service limit described in §263.304(a)(3)(A) of this subchapter;

(13) if a pre-enrollment minor home modifications assessment, must be supported by a Home and Community-based Services (HCS) Program Pre-enrollment MHM Authorization Request form authorized by HHSC; and

(14) if CFC PAS/HAB, must be supported by the HHSC HCS/TxHmL CFC PAS/HAB Assessment form.

§263.302. Renewal and Revision of an IPC.

(a) Renewal of an IPC. At least annually and before the expiration of an individual's IPC, an individual's IPC must be renewed in accordance with this subsection and HHSC's instructions.

(1) At least 60 but no more than 90 calendar days before the expiration of an individual's IPC, the service coordinator must:

(A) notify the service planning team that the individual's PDP must be reviewed and updated;

(B) convene a meeting of the service planning team to:

(i) review and update the individual's PDP; and

(ii) if CFC PAS/HAB is included on the PDP, complete the HHSC HCS/TxHmL CFC PAS/HAB Assessment form to determine the number of CFC PAS/HAB hours the individual needs; and

(C) use the HHSC Understanding Program Eligibility and Services form to provide the individual or LAR both an oral and written explanation of:

(i) the eligibility requirements for the HCS Program as described in §263.101(a) of this chapter (relating to Eligibility Criteria for HCS Program Services and CFC Services);

(ii) if the individual's PDP includes CFC services:

(I) the eligibility requirements for CFC services as described in §263.101(c) of this chapter to individuals who do not receive MAO Medicaid; and

(II) the eligibility requirements for CFC services as described in §263.101(d) of this chapter to individuals who receive MAO Medicaid;

(iii) all HCS Program services and CFC services as described in §263.4 of this chapter (relating to Description of the HCS Program and CFC);

(iv) the reason HCS Program services and CFC services may be suspended as described in §263.705(a) of this chapter (relating to Suspension of HCS Program Services and CFC Services); and

(v) the reason HCS Program services and CFC services may be terminated as described in §263.707 of this chapter (relating to Termination of HCS Program Services and CFC Services with Advance Notice) and §263.708 of this chapter (relating to Termination of HCS Program Services and CFC Services Without Advance Notice).

(2) The HHSC HCS/TxHmL CFC PAS/HAB Assessment form required by paragraph (1)(B)(ii) of this subsection must be completed in person with the individual unless the following conditions are met, in which case the form may be completed by videoconferencing or telephone:

(A) the service coordinator gives the individual the opportunity for completing the form in person in lieu of completing it by videoconferencing or telephone and the individual agrees to the form being completed by videoconferencing or telephone; and

(B) the individual receives appropriate in-person support during the completion of the form by videoconferencing or telephone.

(3) The service coordinator, within 10 calendar days after the PDP is updated, must send a copy of the following to the program provider, the individual or LAR and, if applicable, the FMSA:

(A) the updated PDP; and

(B) if CFC PAS/HAB is included on the PDP, a copy of the completed HHSC HCS/TxHmL CFC PAS/HAB Assessment form.

(4) The program provider must ensure that a meeting between the service planning team and the program provider occurs at least 30 but no more than 60 calendar days before the expiration of the individual's IPC to:

(A) review the PDP and, if CFC PAS/HAB is included on the PDP, the completed HHSC HCS/TxHmL CFC PAS/HAB Assessment form; and

(B) develop the renewal IPC that meets the requirements described in §263.301(c) of this subchapter (relating to IPC Requirements), including completion of the CDS option portion of the renewal IPC, if applicable, and the non-HCS Program services and non-CFC services.

(5) The program provider must convene a meeting with the individual or LAR to develop, before the effective date of the renewal IPC:

(A) an implementation plan for:

(i) HCS Program services, except for supported home living, that is based on the individual's PDP and renewal IPC; and

(ii) CFC services, except for CFC support management, that is based on the individual's PDP, and renewal IPC, and if CFC PAS/HAB is included on the PDP, the completed HHSC HCS/TxHmL CFC PAS/HAB Assessment form; and

(B) a transportation plan, if supported home living is included on the PDP.

(6) Within seven calendar days after development of the renewal IPC as required by paragraph (4) of this subsection, the program provider must comply with the requirements in subsection (e)(1) of this section.

(7) Within seven calendar days after the program provider enters the information from the renewal IPC in the HHSC data system and electronically submits the information to HHSC as required by subsection (e)(1)(C) of this section, the service coordinator must comply with the requirements in subsection (e)(2) of this section.

(8) The program provider must provide HCS Program services and CFC services in accordance with:

(A) an implementation plan that is based on:

(i) the individual's PDP;

(ii) the renewal IPC; and

(iii) if CFC PAS/HAB is included on the PDP, the completed HHSC HCS/TxHmL CFC PAS/HAB Assessment form; and

(B) a transportation plan, if supported home living is included on the PDP.

(b) Revisions to an IPC. Except as provided in subsection (f) of this section, a service coordinator or a program provider may determine whether an individual's IPC needs to be revised to add a new HCS Program service or CFC service or change the amount of an existing service.

(1) The service coordinator must notify the program provider if the service coordinator determines that the IPC needs to be revised.

(2) The program provider must notify the service coordinator if the program provider determines that the IPC needs to be revised.

(3) Within 14 calendar days after the notification required by paragraph (1) or (2) of this subsection:

(A) if the IPC needs to be revised to add CFC PAS/HAB, the service planning team must complete the HHSC HCS/TxHmL CFC PAS/HAB Assessment form in order to determine the number of CFC PAS/HAB hours the individual needs;

(B) if the IPC needs to be revised to change the amount of CFC PAS/HAB, the service planning team must update the HHSC HCS/TxHmL CFC PAS/HAB Assessment form to reflect the amount of CFC PAS/HAB needed to meet the individual needs;

(C) the service coordinator must send a copy of the completed or updated HHSC HCS/TxHmL CFC PAS/HAB Assessment form to the program provider for review;

(D) if a new service is being added or a current service is being removed from the IPC or the amount of a service is being increased or decreased and requires the addition of, removal of, or a change to an outcome in the PDP:

(i) the service coordinator must convene a meeting with the service planning team to update the PDP; and

(ii) the service planning team and the program provider must convene a meeting to develop a revised IPC;

(E) if the amount of an existing service is being increased or decreased or a requisition fee is added or removed and does not require the addition of, removal of, or a change to an outcome in the PDP:

(i) the program provider must develop a revised IPC; and

(ii) the service coordinator must document the reasons for the IPC revision;

(F) the program provider must convene a meeting with the individual or LAR to revise:

(i) the implementation plan for:

(I) HCS Program services, except for supported home living, that is based on the individual's PDP and revised IPC; and

(II) CFC services, except for CFC support management, that is based on the individual's PDP, revised IPC, and if CFC PAS/HAB is included on the PDP, the completed HHSC HCS/TxHmL CFC PAS/HAB Assessment form; and

(ii) the transportation plan, if supported home living is modified on the PDP or IPC; and

(G) the program provider must comply with the requirements in subsection (e)(1) of this section.

(4) The CFC PAS/HAB Assessment form required by paragraph (3)(A) of this subsection must be completed in person with the individual unless the following conditions are met, in which case the form may be completed by videoconferencing or telephone:

(A) the service coordinator gives the individual the opportunity for completing the form in person in lieu of completing it by videoconferencing or telephone and the individual agrees to the form being completed by videoconferencing or telephone; and

(B) the individual receives appropriate in-person support during the completion of the form by videoconferencing or telephone.

(5) The service coordinator, within 10 calendar days after the PDP is updated, must send a copy of the following to the program provider, the individual or LAR and, if applicable, the FMSA:

(A) the updated PDP; and

(B) if CFC PAS/HAB was updated on the PDP, a copy of the updated HHSC HCS/TxHmL CFC PAS/HAB Assessment form.

(6) Within seven calendar days after the program provider enters the information from the revised IPC in the HHSC data system and electronically submits the information to HHSC as required by subsection (e)(1)(C) of this section, the service coordinator must comply with the requirements in subsection (e)(2) of this section.

(7) The program provider must provide HCS Program services and CFC services in accordance with:

(A) an implementation plan that is based on:

(i) the individual's PDP;

(ii) the revised IPC; and

(iii) if CFC PAS/HAB is included on the PDP, the completed HHSC HCS/TxHmL CFC PAS/HAB Assessment form; and

(B) the revised transportation plan, if revised in accordance with paragraph (3)(F)(ii) of this subsection.

(c) Revision of an IPC before delivery of services. Except as provided by subsection (d) of this section, if an individual's service planning team and program provider determine that the IPC must be revised to add a new HCS Program service or CFC service or change the amount of an existing service, the program provider must revise the IPC in accordance with subsection (b) of this section before the delivery of a new or increased service.

(d) Emergency provision of services and revision of an IPC.

(1) If an emergency necessitates the provision of an HCS Program service or CFC service to ensure the individual's health and safety and the service is not on the IPC or exceeds the amount on the IPC, the program provider may provide the service before revising the IPC. The program provider must, within one business day after providing the service:

(A) document:

(i) the circumstances that necessitated providing the new HCS Program service or CFC service or the increase in the amount of the existing HCS Program service or CFC service; and

(ii) the type and amount of the service provided;

(B) notify the service coordinator of the emergency provision of the service and that the IPC must be revised; and

(C) upon request, provide a copy of the documentation required by subparagraph (A) of this paragraph to the service coordinator.

(2) Within seven calendar days after providing the service:

(A) the service planning team and the program provider must develop a revised IPC;

(B) the service planning team must update the PDP and, if appropriate, complete the HHSC HCS/TxHmL CFC PAS/HAB Assessment form if adding CFC PAS/HAB to the IPC, or update the HHSC HCS/TxHmL CFC PAS/HAB Assessment form if changing the amount of CFC PAS/HAB on the IPC;

(C) the program provider must:

(i) revise the implementation plan that is based on the individual's PDP and revised IPC; and

(ii) develop or revise a transportation plan, if supported home living is added to or modified on the PDP or IPC; and

(D) the program provider must comply with the requirements in subsection (e)(1) of this section.

(3) Within seven calendar days after the program provider enters the information from the revised IPC in the HHSC data system and electronically submits the information to HHSC as required by subsection (e)(1)(C) of this section, the service coordinator must comply with the requirements in subsection (e)(2) of this section.

(4) The program provider must provide HCS Program services and CFC services in accordance with:

(A) an implementation plan that is based on the individual's PDP and the revised IPC; and

(B) the transportation plan developed or revised in accordance with paragraph (2)(C)(ii) of this subsection.

(e) Submitting a renewal and revised IPC to HHSC. A renewal or revised IPC must be submitted to HHSC in accordance with this subsection.

(1) A program provider must:

(A) sign and date the renewal or revised IPC;

(B) ensure that the individual or LAR signs and dates the renewal or revised IPC in person, electronically, by fax, or by United States mail;

(C) after the renewal or revised IPC is signed and dated, enter information from the renewal or revised IPC in the HHSC data system and electronically submit the information to HHSC;

(D) ensure that the information entered in the HHSC data system and electronically submitted is identical to the information on the original signed and dated renewal or revised IPC;

(E) within three calendar days after entering the information in the HHSC data system and electronically submitting the information, ensure the service coordinator receives a copy of the original signed and dated renewal or revised IPC; and

(F) keep the original signed and dated renewal or revised IPC in the individual's record.

(2) The service coordinator must review the information entered and submitted in the HHSC data system from the original signed and dated renewal or revised IPC and:

(A) enter the service coordinator's name and date in the HHSC data system; and

(B) enter in the HHSC data system whether the service coordinator agrees or disagrees that the requirements described in §263.301(c) of this subchapter have been met.

(3) If the service coordinator disagrees with how the IPC was entered in the HHSC data system, the service coordinator and program provider must resolve the disagreement.

(4) If the service coordinator disagrees with the IPC for a reason other than how the IPC was entered in the HHSC data system, the service coordinator must notify the individual, LAR, HHSC and the program provider of the service coordinator's disagreement in accordance with HHSC instructions.

(f) Revision of an IPC to include CFC support management. If an individual or LAR requests CFC support management during an IPC year, the service coordinator or the program provider must revise the IPC as described in the HCS Handbook.

(g) Renewal and revision of an IPC when all services are through the CDS option. For an individual who is receiving all services through the CDS option and, therefore, does not have a program provider, the service coordinator must:

(1) perform the functions of the program provider described in this section; and

(2) is not required to comply with subsection (e)(2) of this section.

§263.303. HHSC Review of an IPC.

(a) HHSC may review an IPC to determine if the type and amount of HCS Program services and CFC services specified in the IPC meet the requirements described in §263.301(c) of this subchapter (relating to IPC Requirements).

(1) If an IPC submitted to HHSC exceeds 100 percent of the estimated annualized average per capita cost for ICF/IID Program services, a LIDDA or program provider must immediately submit documentation supporting the IPC to HHSC, including a copy of the signed and dated IPC, the PDP, the implementation plans for the services on the IPC, and assessments. A LIDDA or program provider must submit additional documentation as requested by HHSC.

(2) If requested by HHSC for an IPC other than one described in paragraph (1) of this subsection:

(A) a LIDDA must submit documentation supporting an initial IPC to HHSC; and

(B) a LIDDA or program provider must submit documentation supporting a renewal or revised IPC to HHSC.

(b) HHSC considers a service coordinator's agreement or disagreement that a renewal or revised IPC meets the requirements described in §263.301(c) of this subchapter, as required by §263.302(e)(3) of this subchapter (relating to Renewal and Revision of an IPC), in its review of an IPC.

(c) Based on a review of an IPC, HHSC may deny or reduce an HCS Program service or a CFC service in accordance with §263.704 of this chapter (relating to Denial of HCS Program Services or CFC Services) and §263.706 of this chapter (relating to Reduction of HCS Program Services or CFC Services).

§263.304. Service Limits.

(a) The following limits apply to an individual's HCS Program services:

(1) for adaptive aids, \$10,000 during an IPC year;

(2) for dental treatment, \$2,000 during an IPC year;

(3) for minor home modifications and pre-enrollment minor home modifications combined:

(A) \$7,500 during the time the individual is enrolled in the HCS Program, which may be paid in one or more IPC years; and

(B) a maximum of \$300 for repair and maintenance during an IPC year;

(4) for respite and in-home respite combined, 300 hours during an IPC year;

(5) for day habilitation and in-home day habilitation combined, 260 units during an IPC year; and

(6) for TAS:

(A) \$2,500 if the applicant's initial IPC does not include residential support, supervised living, or host home/companion care; or

(B) \$1,000 if the applicant's initial IPC includes residential support, supervised living, or host home/companion care.

(b) An individual may receive TAS only once in the individual's lifetime.

(c) A program provider may request, in accordance with the *HCS Program Billing Requirements*, authorization of a requisition fee:

(1) for dental treatment that is in addition to the \$2,000 service limit described in subsection (a)(2) of this section;

(2) for a minor home modification that is in addition to the \$7,500 service limit described in subsection (a)(3)(A) of this section; or

(3) for an adaptive aid that is in addition to the \$10,000 service limit described in subsection (a)(1) of this section.

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SUBCHAPTER E	<u>CDS Option</u>

§263.401. CDS Option.

(a) If supported home living, respite, nursing, employment assistance, supported employment, cognitive rehabilitation therapy, or CFC PAS/HAB is included in an applicant's PDP, and the applicant's PDP does not include residential support, supervised living, or host home/companion care, the service coordinator must:

(1) inform the applicant or LAR of the applicant's right to participate in the CDS option or discontinue participation in the CDS option at any time, except as provided in 40 TAC §41.405(a) (relating to Suspension of Participation in the CDS Option);

(2) inform the applicant or LAR that the applicant or LAR may choose to have supported home living, respite, nursing, employment assistance, supported employment, cognitive rehabilitation therapy, or CFC PAS/HAB provided through the CDS option;

(3) provide the applicant or LAR a copy of the HHSC Consumer Directed Services Option Overview form, the HHSC Consumer Directed Services Responsibilities form, and the HHSC Employee Qualification Requirements form, which are found at the HHSC website and which contain information about the CDS option, including a description of FMS and support consultation;

(4) provide an oral explanation of the information contained in the HHSC Consumer Directed Services Option Overview form, the HHSC Consumer Directed Services Responsibilities form, and the HHSC Employee Qualification Requirements form to the applicant or LAR; and

(5) provide the applicant or LAR the opportunity to choose to participate in the CDS option and document the applicant's or LAR's choice on the HHSC Consumer Participation Choice form, which is available on the HHSC website.

(b) If an applicant or LAR chooses to participate in the CDS option, the service coordinator must:

(1) provide names and contact information to the applicant or LAR regarding all FMSAs providing services in the LIDDA's local service area;

(2) document the applicant's or LAR's choice of FMSA on the Consumer Participation Choice form;

(3) document, in the individual's PDP, a description of the service provided through the CDS option; and

(4) document, in the individual's PDP, whether the service is critical to meeting the individual's health and safety as determined by the service planning team.

(c) For an individual who is receiving supported home living, respite, nursing, employment assistance, supported employment, cognitive rehabilitation therapy, or CFC PAS/HAB, and is not receiving residential support, supervised living, or host home/companion care, the service coordinator must, at least annually:

(1) inform the individual or LAR of the individual's right to participate in the CDS option or discontinue participation in the CDS option at any time;

(2) provide the individual or LAR a copy of the Consumer Directed Services Option Overview, Consumer Directed Services Responsibilities, and Employee Qualification Requirements forms, which are available on the HHSC website and which contain information about the CDS option, including FMS and support consultation;

(3) provide an oral explanation of the information contained in the Consumer Directed Services Option Overview, Consumer Directed Services Responsibilities and Employee Qualification Requirements forms to the individual or LAR; and

(4) provide the individual or LAR the opportunity to choose to participate in the CDS option and document the individual's choice on the Consumer Participation Choice form, which is available on the HHSC website.

(d) If an individual or LAR chooses to participate in the CDS option, the service coordinator must:

(1) provide names and contact information to the individual or LAR regarding all FMSAs providing services in the LIDDA's local service area;

(2) document the individual's or LAR's choice of FMSA on the Consumer Participation Choice form;

(3) document, in the individual's PDP, a description of the service provided through the CDS option;

(4) document, in the individual's PDP, whether the service is critical to meeting the individual's health and safety as determined by the service planning team; and

(5) notify the program provider of the individual's or LAR's decision to participate in the CDS option.

(e) The service coordinator must document in the individual's PDP that the information described in subsections (c) and (d)(1) of this section was provided to the individual or LAR.

(f) If an individual's PDP includes supported home living to be delivered through the CDS option, the service coordinator must develop, with the individual or LAR and other members of the service planning team, a transportation plan.

(g) For an individual participating in the CDS option, the service coordinator must recommend that HHSC terminate the individual's participation in the CDS option (that is, terminate FMS and support consultation) if the service coordinator determines that:

(1) the individual's continued participation in the CDS option poses a significant risk to the individual's health or safety; or

(2) the individual or LAR has not complied with 40 TAC Chapter 41, Subchapter B (relating to Responsibilities of Employers and Designated Representatives).

(h) If the service coordinator makes a recommendation in accordance with subsection (g) of this section, the service coordinator must:

(1) document:

(A) a description of the service recommended for termination;

(B) the reasons why termination is recommended; and

(C) a description of the attempts to resolve the issues before recommending termination;

(2) obtain other supporting documentation, as appropriate; and

(3) if the individual receives a service from the program provider, notify the program provider that the IPC needs to be revised.

(i) Within seven calendar days after notification in accordance with subsection (h)(3) of this section:

(1) the service planning team and the program provider must comply with the requirements described in §263.302(d)(2)(A) - (D) of this chapter (relating to Renewal and Revision of an IPC); and

(2) the service coordinator must send the documentation described in subsection (h)(1) and (2) of this section to HHSC.

PART 1	HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 263	HOME AND COMMUNITY-BASED SERVICES (HCS)
	PROGRAM AND COMMUNITY FIRST CHOICE (CFC)
SUBCHAPTER F	REQUIREMENTS FOR SERVICE SETTINGS AND PROGRAM
	PROVIDER OWNED OR CONTROLLED RESIDENTIAL SETTINGS

§263.501. Requirements for Service Settings.

(a) A program provider must ensure that a setting in which an individual receives a HCS Program service or a CFC service:

(1) is based on the needs and preferences of the individual as documented in the individual's PDP;

(2) is integrated in and supports the individual's access to the greater community to the same degree as a person not enrolled in a Medicaid waiver program, including opportunities for the individual:

(A) to seek employment and work in a competitive integrated setting;

(B) engage in community life; and

(C) control personal resources;

(3) ensures the individual's rights of privacy, dignity and respect, and freedom from coercion and restraint; and

(4) optimizes, not regiments, individual initiative, autonomy, and independence in making life choices, including choices regarding daily activities, physical environment, and with whom to interact.

(b) Except as provided in subsection (c) of this section, a program provider must ensure that HCS Program services and CFC services are not provided in a setting that is presumed to have the qualities of an institution. A setting is presumed to have the qualities of an institution if the setting:

(1) is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;

(2) is located in a building on the grounds of, or immediately adjacent to, a public institution; or

(3) has the effect of isolating individuals from the broader community of persons not receiving Medicaid HCBS.

(c) A program provider may provide an HCS Program service or a CFC service to an individual in a setting that is presumed to have the qualities of an institution as

described in subsection (b) of this section, if CMS determines through a heightened scrutiny review that the setting:

- (1) does not have the qualities of an institution; and
- (2) does have the qualities of home and community-based settings.

§263.502. Requirements for Program Provider Owned or Controlled Residential Settings.

(a) In each residence in which a program provider provides residential support, supervised living, or host home/companion care, the program provider must ensure that, except as provided in subsection (b) of this section:

- (1) an individual has privacy in the individual's bedroom;
- (2) an individual has the option not to share a bedroom with a roommate;
- (3) an individual sharing a bedroom has a choice of roommates;
- (4) a lock is installed on the individual's bedroom door at no cost to the individual and that:
 - (A) the lock is operable by the individual; and
 - (B) only the individual, a roommate of the individual, and staff designated by the program provider have keys to the individual's bedroom door;
- (5) an individual can furnish and decorate the individual's bedroom; and
- (6) while in the residence, an individual has the freedom and support:
 - (A) to control the individual's schedule and activities that are not part of the implementation plan; and
 - (B) to have access to food at any time.

(b) If a program provider becomes aware that a modification to a requirement described in subsection (a)(1)-(6) of this section is needed based on a specific assessed need of an individual, the program provider must:

- (1) notify the service coordinator of the needed modification; and
- (2) provide the service coordinator the information described in §263.901(e)(21) of this chapter relating to (LIDDA Requirements for Providing Service Coordination in the HCS Program) as requested by the service coordinator.

(c) If a service coordinator receives a notification as described in subsection (b) of this section, the service coordinator must convene a service planning team meeting to update the PDP as described §263.901(e)(21) of this chapter.

(d) After the service planning team updates the PDP as required by subsection (c) of this section, the program provider may implement the modifications.

§263.503. Residential Agreements.

(a) During a service planning team meeting to develop or update an individual's PDP, a service coordinator must inform an individual or LAR of the following if the individual is interested in receiving residential assistance:

(1) that the residential setting options available in the HCS Program consist of:

(A) a residence in which the individual receives host home/companion care;

(B) a three-person residence in which the individual receives residential support or supervised living; or

(C) a four-person residence in which the individual receives residential support or supervised living;

(2) that if the individual or LAR selects a residence described in paragraph (1) of this subsection, the individual or LAR will be responsible for paying room and board in accordance with a residential agreement described in subsections (b) and (c) of this section;

(3) that if the individual or LAR does not pay room or board as required by a residential agreement, the individual's program provider or service provider of host home/companion care may evict the individual in accordance with the residential agreement and state law; and

(4) that if an individual is evicted by a program provider or service provider of host home/companion care and the individual or LAR has not paid the delinquent room or board, HHSC will deny the individual residential support, supervised living, or host home/companion care until the individual or LAR pays the delinquent room or board.

(b) An individual's program provider must ensure that:

(1) an individual living in a three-person residence or four-person residence or LAR has a written residential agreement with the program provider; and

(2) an individual living in a residence in which host home/companion care is provided or LAR has a written residential agreement with the service provider of

host home/companion care if the individual does not own the residence or lease the residence from another person.

(c) The residential agreement required by subsection (b) of this section must include:

(1) the physical address of the residence;

(2) the name of the individual;

(3) if a three-person residence or four-person residence, the name of the program provider;

(4) if a residence in which host home/companion care is provided, the name of the service provider of host home/companion care;

(5) the beginning date of the residential agreement;

(6) the date the residential agreement expires;

(7) a provision that:

(A) the program provider or service provider of host home/companion care and the individual or LAR agree that the residential agreement is a "lease" under Texas Property Code Chapter 92 and that they are subject to state law governing residential tenancies, including Texas Property Code Chapters 24, 91, and 92 and Texas Rules of Civil Procedure Rule 510; and

(B) to the extent allowed by law, in the event of a conflict or inconsistency between any provision of the residential agreement and any provision of state statutory law, including Texas Property Code Chapters 91 and 92, the provision in the residential agreement governs;

(8) a provision that the individual or LAR is not waiving any right or remedy provided to tenants under state law and is not agreeing to any notice period that is shorter than the notice period to which tenants are entitled under state law;

(9) the amount the individual or LAR is paying for room or a description of other consideration for room, if the individual is paying in kind in lieu of a monetary amount;

(10) the amount the individual or LAR is paying for board or a description of other consideration for board, if the individual is paying in kind in lieu of a monetary amount;

(11) the day of the month that the amount for room and board is due, which will not be before the day of the month that an individual receives a primary source of

income, such as supplemental security income and social security disability insurance;

(12) the amount of a late fee, which may be charged only once per month and will not exceed 10 percent of the amount for room and board, that the program provider or host home/companion care service provider may charge the individual or LAR if room and board is not paid by the day it is due;

(13) a provision that allows the individual or LAR to terminate the residential agreement before its expiration date without any obligation under the residential agreement except an obligation that accrued before the date of termination, if the individual permanently moves from the residence for any reason, including transferring to a different program provider;

(14) a provision that the program provider or service provider of host home/companion care agrees to refund to the individual or LAR an amount for board paid to the program provider or service provider for the days that the individual was temporarily away from the residence for at least one 24-hour period using the following formula to determine the daily amount for board (the monthly amount for board ÷ the number of days in the month);

(15) a provision that the program provider or service provider of host home/companion care agrees to refund to the individual or LAR an amount for room and board paid to the program provider or services provider for the days that the individual was away from the residence because the individual permanently moved from the residence using the following formula to determine the daily amount for room and board (the monthly amount for room and board ÷ the number of days in the month);

(16) a provision that the individual may furnish and decorate the individual's bedroom;

(17) a provision that the program provider or service provider of host home/companion care agrees to be responsible for all repairs to the residence resulting from normal wear and tear, as defined in Texas Property Code §92.001;

(18) a provision that allows eviction of the individual only if:

(A) the individual or LAR fails to pay room or board, which does not include any late fee; or

(B) the individual's HCS Program services and CFC services are terminated;

(19) a provision that the program provider or service provider of host home/companion care will, before giving the individual or LAR a notice to vacate, give the individual or LAR a notice of proposed eviction that allows the individual or LAR at least 60 calendar days to pay the delinquent room or board;

(20) a provision that if the individual or LAR pays the delinquent room or board within the period required by paragraph (19) of this subsection, the program provider or service provider of host home/companion care will not give the individual or LAR a notice to vacate or otherwise proceed to evict the individual;

(21) a provision that the program provider or service provider of host home/companion care will not demand the entire balance of the unpaid room or board owed under the residential agreement if the individual or LAR violates the residential agreement;

(22) a provision that the program provider or service provider of host home/companion care and the individual or LAR are not entitled to reimbursement for attorney's fees arising out of any dispute relating to the residential agreement; and

(23) the signature of the individual or the LAR.

(d) The program provider must:

(1) give the individual or LAR at least three calendar days to review, request changes, and sign the residential agreement;

(2) ensure the residential agreement is fully executed before the individual begins living in a three-person residence, four-person residence, or a residence in which host home/companion care is provided, except that an individual may begin living in one of these residences before a residential agreement is fully executed in the event of an emergency;

(3) if an individual begins living in a three-person residence, four-person residence, or a residence in which host home/companion care is provided before a residential agreement is fully executed because of an emergency, as allowed by paragraph (2) of this subsection:

(A) document the details of the emergency; and

(B) ensure the residential agreement is fully executed within seven calendar days after the individual begins living in the residence; and

(4) provide one copy of the residential agreement to the individual or LAR within three calendar days after the date the residential agreement is fully executed.

(e) If a program provider becomes aware that a modification to subsection (c)(16) of this section is needed based on a specific assessed need of an individual, the program provider must:

(1) notify the service coordinator of the needed modification; and

(2) provide the service coordinator the information described in §263.901(e)(21) of this chapter relating to (LIDDA Requirements for Providing Service Coordination in the HCS Program) as requested by the service coordinator.

(f) If a service coordinator receives a notification as described in subsection (e) of this section, the service coordinator must convene a meeting of the service planning team to update the PDP in accordance with §263.901(e)(21) of this chapter.

(g) After the service planning team updates the PDP as required by §263.901(e)(21) of this chapter, the program provider may implement the modification.

(h) If an individual or LAR is delinquent in payment of room or board and the program provider or service provider wants to evict the individual, the program provider must:

(1) notify the service coordinator that the individual or LAR is delinquent in the payment of room or board under the residential agreement and that the program provider or service provider wants to evict the individual;

(2) after providing the notification required by paragraph (1) of this subsection, meet with the individual or LAR, including the representative payee if one has been appointed by the Social Security Administration, and the service coordinator to discuss the alleged non-payment of room or board and possible eviction; and

(3) if the program provider or service provider intends to proceed to evict the individual at the meeting required by paragraph (2) of this subsection:

(A) give the individual or LAR a written notice of proposed eviction that allows the individual or LAR at least 60 calendar days to pay the delinquent room or board; and

(B) provide the service coordinator with a copy of the written notice of proposed eviction.

(i) If the individual or LAR pays the delinquent room or board within the period required by subsection (h)(3) of this section, the program provider or service provider of host home/companion care must not give the individual or LAR a notice to vacate or otherwise proceed to evict the individual.

(j) If the individual or LAR does not pay the delinquent room or board within the period required by subsection (h)(3) of this section, the program provider:

(1) must report the failure to pay to one of the following as appropriate:

(A) the Social Security Administration;

(B) the probate court that appointed the individual's guardian; or

(C) DFPS as an allegation of the LAR's exploitation of the individual;

(2) must meet with the individual or LAR and the service coordinator to discuss alternative living settings for the individual; and

(3) if the program provider or service provider wants to proceed to evict the individual, the program provider must:

(A) give the individual or LAR a written notice to vacate the residence in accordance with the residential agreement and state law; and

(B) send a copy of the written notice described in subparagraph (A) of this paragraph to the individual's service coordinator within one business day after the individual or LAR is given the notice.

(k) If an individual is evicted by a program provider or service provider of host home/companion care and the individual or LAR has not paid the delinquent room or board, the service coordinator must convene a meeting or meetings to update the PDP and revise the IPC as described in §263.302(b)(3)(D) of this chapter (relating to Renewal and Revision of an IPC). If the individual or LAR wants to keep residential support, supervised living, or host home/companion care on the individual's IPC, the service coordinator must inform the individual or LAR at the meeting or meetings that HHSC will deny residential support, supervised living, or host home/companion care, if included on the individual's IPC, until the individual pays the delinquent room or board.

(l) If a program provider evicts an individual who has an LAR and the LAR fails to arrange an alternative living setting for the individual, the program provider must report the LAR's failure to DFPS as neglect of the individual and notify the service coordinator that such report was made.

(m) If an individual pays the delinquent room or board, a program provider must, within one business day after the payment, notify the individual's service coordinator that the individual is no longer delinquent.

TITLE 26 HEALTH AND HUMAN SERVICES
PART 1 HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 263 HOME AND COMMUNITY-BASED SERVICES (HCS)
PROGRAM AND COMMUNITY FIRST CHOICE (CFC)
SUBCHAPTER G REIMBURSEMENT BY HHSC

§263.601. Program Provider Reimbursement.

(1) HHSC pays a program provider as described in this paragraph.

(A) HHSC pays for supported home living, professional therapies, nursing, respite, in-home respite, employment assistance, supported employment, and CFC PAS/HAB in accordance with the reimbursement rate for the specific service.

(B) HHSC pays for host home/companion care, residential support, supervised living, in-home day habilitation and day habilitation in accordance with the individual's LON and the reimbursement rate for the specific service.

(C) HHSC pays for adaptive aids, minor home modifications, and dental treatment based on the actual cost of the item and, if requested, a requisition fee in accordance with the HCS Program Billing Requirements available on the HHSC website.

(D) HHSC pays:

(i) for TAS based on a Transition Assistance Services (TAS) Assessment and Authorization form authorized by HHSC and the actual cost of the TAS as evidenced by purchase receipts required by the HCS Program Billing Requirements; and

(ii) if requested, a TAS service fee in accordance with the HCS Program Billing Requirements.

(E) HHSC pays for pre-enrollment minor home modifications and a pre-enrollment minor home modifications assessment based on a Home and Community-based Services (HCS) Program Pre-enrollment MHM Authorization Request form authorized by HHSC and the actual cost of the pre-enrollment minor home modifications and a pre-enrollment minor home modifications assessment, as evidenced by documentation required by the HCS Program Billing Requirements.

(F) Subject to the requirements in the HCS Program Billing Requirements, HHSC pays for TAS, pre-enrollment minor home modifications, and a pre-enrollment minor home modifications assessment regardless of whether the applicant enrolls with the program provider.

(G) HHSC pays for CFC ERS based on the actual cost of the service, not to exceed the reimbursement rate ceiling for CFC ERS.

(2) To be paid for the provision of a service, a program provider must submit a service claim that meets the requirements in 40 TAC §49.311 (relating to Claims Payment) and the HCS Program Billing Requirements or the CFC Billing Requirements for HCS and TxHmL Program Providers.

(3) If an individual's HCS Program services or CFC services are suspended or terminated a program provider must not submit a claim for services provided during the period of the individual's suspension or after the termination, except that the program provider may submit a claim for the first day of the individual's suspension or termination for the following services:

(A) in-home day habilitation;

(B) day habilitation;

(C) supported home living;

(D) in-home respite

(E) respite;

(F) employment assistance;

(G) supported employment;

(H) professional therapies;

(I) nursing; and

(J) CFC PAS/HAB.

(4) If a program provider submits a claim for an adaptive aid that costs \$500 or more or for a minor home modification that costs \$1,000 or more, the claim must be supported by a written assessment from a licensed professional specified by HHSC in the HCS Program Billing Requirements and other documentation as required by the HCS Program Billing Requirements.

(5) HHSC does not pay a program provider for:

(A) a service or recoups any payments made to the program provider for a service if:

(i) except for an individual receiving TAS, pre-enrollment minor home modifications, or a pre-enrollment minor home modifications assessment, the individual receiving the service is, at the time the service was provided, ineligible for the HCS Program or Medicaid benefits, or was an inpatient of a hospital, nursing facility, or ICF/IID;

(ii) except for TAS, pre-enrollment minor home modifications, and a pre-enrollment minor home modifications assessment:

(I) the service is provided to an individual during a period of time for which there is not a signed, dated, and authorized IPC for the individual;

(II) the service is provided during a period of time for which there is not a signed and dated ID/RC Assessment for the individual;

(III) the service is provided during a period of time for which the individual did not have an LOC determination;

(IV) the service is not provided in accordance with a signed, dated, and authorized IPC meeting the requirements set forth in §263.301(c) of this chapter (relating to IPC Requirements);

(V) the service is not provided in accordance with the individual's PDP or implementation plan;

(VI) the service is provided before the individual's enrollment date into the HCS Program; or

(VII) the service is not included on the signed, dated, and authorized IPC of the individual in effect at the time the service was provided, except as permitted by §263.302(d) of this chapter (relating to Renewal and Revision of an IPC);

(iii) the service is not provided in accordance with the HCS Program Billing Requirements or the CFC Billing Requirements for HCS and TxHmL Program Providers;

(iv) the service is not documented in accordance with the HCS Program Billing Requirements or the CFC Billing Requirements for HCS and TxHmL Program Providers;

(v) the program provider does not comply with 40 TAC §49.305 (relating to Records);

(vi) the claim for the service was not prepared and submitted in accordance with the HCS Program Billing Requirements or the CFC Billing Requirements for HCS and TxHmL Program Providers;

(vii) the claim for the service does not meet the requirements in 40 TAC §49.311 (relating to Claims Payment) or the HCS Program Billing Requirements or the CFC Billing Requirements for HCS and TxHmL Program Providers;

(viii) the program provider does not have the documentation described in paragraph (3) of this section;

(ix) HHSC determines that the service would have been paid for by a source other than the HCS Program if the program provider had submitted to the other source a proper, complete, and timely request for payment for the service;

(x) the service is provided by a service provider who does not meet the qualifications to provide the service as described in the HCS Program Billing Requirements or the CFC Billing Requirements for HCS and TxHmL Program Providers;

(xi) the service was paid at an incorrect LON because the information entered in the HHSC data system from a completed ID/RC Assessment is not identical to the information on the completed ID/RC Assessment; or

(xii) the service was not provided;

(B) supervised living or residential support, if the program provider provides the supervised living or residential support service in a residence in which four individuals or other persons receiving similar services live without HHSC's approval as described in rules governing the HCS Program;

(C) employment assistance, if before including the employment assistance on an individual's IPC, the program provider does not ensure and maintain documentation in the individual's record that employment assistance is not available to the individual under a program funded under §110 of the Rehabilitation Act of 1973 or under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.);

(D) supported employment, if before including the supported employment on an individual's IPC, the program provider does not ensure and maintain documentation in the individual's record that supported employment is not available to the individual under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.);

(E) host home/companion care, residential support, or supervised living, if the host home/companion care, residential support, or supervised living is provided on the day of the individual's suspension or termination of HCS Program services;

(F) TAS, if the TAS, is not provided in accordance with a Transition Assistance Services (TAS) Assessment and Authorization form authorized by HHSC;

(G) pre-enrollment minor home modifications and a pre-enrollment minor home modifications assessment, if the pre-enrollment minor home modifications and a pre-enrollment minor home modifications assessment, is not provided in

accordance with a Home and Community-based Services (HCS) Program Pre-enrollment MHM Authorization Request form authorized by HHSC;

(H) a CFC service, if the CFC service, is provided to an individual receiving host home/companion care, supervised living, or residential support;

(I) supported home living, if the supported home living, is not provided in accordance with a transportation plan and §263.5(a)(18) of this chapter (relating to Description of HCS Program Services); or

(J) CFC PAS/HAB, in-home day habilitation provided to an individual with a residential type of "own/family home," or in-home respite, if the CFC PAS/HAB, in-home day habilitation, or in-home respite, does not match the EVV visit transaction as required by 1 TAC §354.4009(a)(4) (relating to Requirements for Claims Submission and Approval).

(6) A program provider must refund to HHSC any overpayment made to the program provider within 60 calendar days after the program provider's discovery of the overpayment or receipt of a notice of such discovery from HHSC, whichever is earlier.

(7) Except as provided in paragraph (8) of this section, if HHSC approves an LOC requested in accordance with §263.105(b)(3) of this chapter (relating to LOC Determination), HHSC pays a program provider for services provided to an individual for a period of not more than 180 calendar days after the individual's previous ID/RC Assessment expires.

(8) If HHSC determines that a program provider submitted an ID/RC Assessment more than 180 calendar days after the expiration date of the previous ID/RC Assessment, because of circumstances beyond the program provider's control, HHSC may pay the program provider for a period of more than 180 calendar days after the date the individual's previous ID/RC Assessment expired.

(9) HHSC conducts provider fiscal compliance reviews to determine whether a program provider is in compliance with:

(A) this chapter;

(B) the HCS Program Billing Requirements;

(C) the CFC Billing Requirements for HCS and TxHmL Program Providers;

(D) 40 TAC §§49.301-49.313; and

(E) the program provider's Community Services Contract-Provider Agreement.

(10) HHSC conducts provider fiscal compliance reviews in accordance with the Provider Fiscal Compliance Review Protocol set forth in the HCS Program Billing Requirements and the CFC Billing Requirements for HCS and TxHmL Program Providers. As a result of a provider fiscal compliance review, HHSC may:

(A) recoup payments from a program provider; and

(B) based on the amount of unverified claims, require a program provider to develop and submit, in accordance with HHSC's instructions, a corrective action plan that improves the program provider's billing practices.

(11) A corrective action plan required by HHSC in accordance with paragraph (10)(B) of this subsection must:

(A) include:

(i) the reason the corrective action plan is required;

(ii) the corrective action to be taken;

(iii) the person responsible for taking each corrective action; and

(iv) a date by which the corrective action will be completed that is no later than 90 calendar days after the date the program provider is notified the corrective action plan is required;

(B) be submitted to HHSC within 30 calendar days after the date the program provider is notified the corrective action plan is required; and

(C) be approved by HHSC before implementation.

(12) Within 30 calendar days after HHSC receives a corrective action plan, HHSC notifies the program provider if HHSC approves the corrective action plan or if the plan requires changes.

(13) If HHSC requires a program provider to develop and submit a corrective action plan in accordance with paragraph (10)(B) of this subsection and the program provider requests an administrative hearing for the recoupment in accordance with §263.802 of this chapter (relating to Program Provider's Right to Administrative Hearing), the program provider is not required to develop or submit a corrective action plan while a hearing decision is pending. HHSC notifies the program provider if the requirement to submit a corrective action plan or the content of such a plan changes based on the outcome of the hearing.

(14) If a program provider does not submit a corrective action plan or complete a required corrective action within the time frames described in paragraph (11) of

this subsection, HHSC may impose a vendor hold on payments due to the program provider until the program provider takes the corrective action.

(15) If a program provider does not submit a corrective action plan or complete a required corrective action within 30 calendar days after the date a vendor hold is imposed in accordance with paragraph (14) of this subsection, HHSC may terminate the contract.

TITLE 26	HEALTH AND HUMAN SERVICES
PART 1	HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 263	<u>HOME AND COMMUNITY-BASED SERVICES (HCS)</u>
	<u>PROGRAM AND COMMUNITY FIRST CHOICE (CFC)</u>
SUBCHAPTER H	<u>TRANSFER, DENIALS, SUSPENSION, REDUCTION, AND</u>
	<u>TERMINATION</u>

§263.701. Process for Individual to Transfer to a Different Program Provider or FMSA.

(a) If a service coordinator receives information that an individual or LAR wants to transfer to a different program provider or FMSA, the service coordinator must:

(1) document the date the information was received in the individual's record;

(2) if the information was received by a person other than the individual or LAR, within three business days after the information was received:

(A) contact the individual or LAR to confirm whether the individual wants to transfer to a different program provider or FMSA; and

(B) if the service coordinator confirms that the individual or LAR wants to transfer, document such confirmation in the individual's record; and

(3) within three business days after confirming that the individual or LAR wants to transfer:

(A) explain to the individual or LAR that the individual may transfer to a program provider or FMSA of the individual's or LAR's choice whose enrollment has not reached its service capacity in the HHSC data system; and

(B) provide the individual or LAR the names and contact information of all program providers or FMSAs in the geographic location preferred by the individual or LAR.

(b) After the individual or LAR selects a different program provider or FMSA, the service coordinator must coordinate with the individual, LAR, the transferring program provider or FMSA and the receiving program provider or FMSA to determine a transfer effective date that is:

(1) not earlier than the date of the meeting described in subsection (c)(2) of this section; and

(2) agreed to by the service coordinator, the individual or LAR, and the receiving program provider.

(c) On or before the transfer effective date, the service coordinator must:

(1) take action to complete the HHSC Request for Transfer of Waiver Program Services form in accordance with the HCS Handbook;

(2) convene a meeting with the individual or LAR and the receiving program provider or receiving FMSA to develop a transfer IPC;

(3) send the individual's IPC, ID/RC, and PDP to the receiving program provider or the receiving FMSA;

(4) if the individual is transferring to a different program provider, request the following records of the individual from the transferring program provider;

(A) pertinent medication records and medical information;

(B) Medicaid card;

(C) Medicare information, if applicable;

(D) the ICAP booklet and summary sheet;

(E) trust fund/financial records and any money due the individual;

(F) behavior support plan, if applicable;

(G) guardianship information, if applicable; and

(H) any other pertinent information to ensure health and safety or continuity of services;

(5) within two business days after receipt of the records requested in accordance with paragraph (4) of this subsection, send the records to the receiving program provider; and

(6) if, within three business days after requesting that the program provider provide records as described in paragraph (4) of this subsection, the service coordinator does not receive all of the records requested, notify HHSC that the records were not received.

(d) If an individual was evicted by a program provider or service provider of host home/companion care and the individual or LAR has not paid the delinquent room or board, but wants to include residential support, supervised living, or host home/companion care on the individual's IPC, the service coordinator must inform the individual or LAR at the meeting described in subsection (c)(2) of this section that HHSC will deny residential support, supervised living, or host home/companion care, if included on the individual's IPC, until the individual pays the delinquent room or board.

(e) Within 10 business days after the transfer effective date, the service coordinator must:

(1) complete data entry into the HHSC data system in accordance with the HCS Handbook after the activities described in subsection (c) of this section are completed; and

(2) send the transfer IPC and HHSC Request for Transfer of Waiver Program Services form to HHSC.

§263.702. Process for Individual to Receive a Service Through the CDS Option that the Individual is Receiving from a Program Provider.

(a) If a service coordinator receives information that an individual or LAR wants to receive a service through the CDS option that the individual is receiving from a program provider, the service coordinator must:

(1) document the date the information was received in the individual's record;

(2) if the information was received by a person other than the individual or LAR, within three business days after the information was received:

(A) contact the individual or LAR to confirm whether the individual wants to receive a service through the CDS option that the individual is receiving from a program provider; and

(B) if the service coordinator confirms that the individual or LAR wants to receive a service through the CDS option that the individual is receiving from a program provider, document such confirmation in the individual's record; and

(3) within three business days after confirming that the individual or LAR wants to receive a service through the CDS option that the individual is receiving from a program provider:

(A) explain to the individual or LAR that the individual may select an FMSA of the individual's or LAR's choice; and

(B) provide the individual or LAR the names and contact information of all FMSAs in the geographic location preferred by the individual or LAR.

(b) After the individual or LAR selects a FMSA, the service coordinator must coordinate with the individual, LAR, the transferring program provider and the receiving FMSA to determine an transfer effective date that is:

(1) not earlier than the date of the meeting described in subsection (c)(2) of this section; and

(2) agreed to by the service coordinator, the individual or LAR, and the receiving FMSA.

(c) On or before the transfer effective date, the service coordinator must:

(1) take action to complete the HHSC Request for Transfer of Waiver Program Services form in accordance with the HCS Handbook;

(2) convene a meeting with the individual or LAR to develop a transfer IPC; and

(3) send the individual's IPC to the receiving FMSA and obtain the signature of the receiving FMSA on the IPC and the HHSC Request for Transfer of Waiver Program Services form.

(d) Within 10 business days after the transfer effective date, the service coordinator must:

(1) complete data entry in the HHSC data system in accordance with the HCS Handbook after the activities described in subsection (c) of this section are completed; and

(2) send the transfer IPC and the HHSC Request for Transfer of Waiver Program Services form to HHSC.

§263.703. Denial of a Request for Enrollment into the HCS Program.

(a) HHSC denies an individual's request for enrollment into the HCS Program if the individual does not meet the eligibility criteria described in §263.101 of this chapter (relating to Eligibility Criteria for HCS Program Services and CFC Services).

(b) If HHSC denies an individual's request for enrollment, HHSC sends written notice to the individual or LAR of the denial of the individual's request for enrollment into the HCS Program and includes in the notice the individual's right to request a fair hearing in accordance with §263.801 of this chapter (Fair Hearing).

(c) HHSC sends a copy of the written notice to the individual's service coordinator and the program provider.

§263.704. Denial of HCS Program Services or CFC Services.

(a) HHSC denies an HCS Program service or CFC service on an individual's IPC, based on a review described in §263.303 of this chapter (relating to HHSC Review of an IPC) or §263.302 of this chapter (relating to Renewal and Revision of an IPC), if HHSC determines that the HCS Program service or CFC service does not meet the requirements described in §263.301(c) of this chapter (relating to IPC Requirements).

(b) HHSC denies residential support, supervised living, or host home/companion care on an individual's IPC if:

(1) the individual was evicted from:

(A) a three-person residence;

(B) a four-person residence; or

(C) a residence in which host home/companion care is provided; and

(2) the individual has not paid the delinquent room or board.

(c) If HHSC denies an HCS Program service or CFC service on the individual's IPC, HHSC:

(1) modifies the IPC in the HHSC data system; and

(2) sends written notice to the individual or LAR of the denial of the service and includes in the notice the individual's right to request a fair hearing in accordance with §263.801 of this chapter (Fair Hearing).

(d) HHSC sends a copy of the written notice to the individual's service coordinator and the program provider.

§263.705. Suspension of HCS Program Services and CFC Services.

(a) HHSC suspends an individual's HCS Program services and CFC services if the individual is under a temporary admission to one of the following facilities:

(1) a hospital;

(2) an ICF/IID;

(3) a nursing facility;

(4) an ALF;

(5) a residential child care facility licensed by HHSC unless it is an agency foster home;

(6) an inpatient chemical dependency treatment facility;

(7) a mental health facility;

(8) a residential facility operated by the Texas Workforce Commission; or

(9) a residential facility operated by the Texas Juvenile Justice Department, a jail, or a prison.

(b) If a service coordinator becomes aware that an individual who is receiving a service from a program provider is under a temporary admission, the service coordinator must, within one business day after becoming aware of the temporary admission, notify the individual's program provider of the temporary admission.

(c) If a program provider becomes aware that an individual is under a temporary admission, the program provider must, within one business day after becoming aware of the temporary admission, enter a suspension of the individual's HCS Program services and CFC services in the HHSC data system.

(d) If a program provider enters a suspension of the individual's HCS Program services and CFC services in the HHSC data system, the program provider must notify the individual's service coordinator of the suspension within one business day after the suspension is entered in the system.

(e) During a temporary admission, an individual is not considered to be residing in the facility.

(f) If an individual's program services are suspended, the service coordinator must, at least every 30 calendar days after the effective date of the suspension, review the individual's circumstances and document in the individual's record:

(1) the reasons for continuing the suspension if the individual is likely to remain in the facility;

(2) whether the individual anticipates resuming participation in the HCS Program after the suspension ends; and

(3) the anticipated date the individual will be discharged from the facility, if the individual is not likely to remain in the facility.

(g) If a service coordinator determines that an individual's suspension should be extended, the service coordinator must request that HHSC extend the suspension by completing and submitting the HHSC Request to Continue Suspension of Waiver Program Services form to HHSC before:

(1) the end of the first 270 calendar days of the temporary admission; or

(2) the end of a 30 calendar-day extension previously granted by HHSC.

(h) HHSC may extend an individual's suspension for 30 calendar days based on a service coordinator's request as described in subsection (g) of this section.

(i) A program provider must remove the entry of a suspension of the individual's HCS Program services and CFC services from the HHSC data system and resume the provision of services to the individual if the program provider becomes aware that the individual is discharged from the facility to which the individual has been under temporary admission.

§263.706. Reduction of HCS Program Services or CFC Services.

(a) HHSC proposes a reduction of an HCS Program service or CFC service on an individual's IPC, based on a review described in §263.303 of this chapter (relating to HHSC Review of an IPC) or §263.302 of this chapter (relating to Renewal and Revision of an IPC), if HHSC determines that the HCS Program service or CFC service does not meet the requirements described in §263.301(c) of this chapter (relating to IPC Requirements).

(b) If HHSC proposes a reduction of an HCS Program service or CFC service on the individual's IPC, HHSC sends written notice to the individual or LAR of the proposed reduction of the service and includes in the notice the individual's right to request a fair hearing in accordance with §263.801 of this chapter (Fair Hearing).

(c) HHSC sends a copy of the written notice to the individual's service coordinator and the program provider.

(d) If the individual or LAR requests a fair hearing before the effective date of the reduction of an HCS Program service or CFC service, as specified in the written notice, the service is not reduced and the program provider must provide the service to the individual in the amount authorized in the current IPC while the appeal is pending.

(e) If the individual or LAR does not request a fair hearing before the effective date of the reduction of an HCS Program service or CFC service, HHSC modifies the IPC in the HHSC data system.

§263.707. Termination of HCS Program Services and CFC Services with Advance Notice.

(a) HHSC terminates an individual's HCS Program services and CFC services if the individual does not meet the eligibility criteria described in §263.101(a)(1) - (4), §263.101(a)(6), §263.101(c), and (d) of this chapter (relating to Eligibility Criteria for HCS Program Services and CFC Services).

(b) If a service coordinator becomes aware that a situation described in subsection (a) of this section exists, the service coordinator must, as soon as practicable, convene a service planning team meeting to discuss the situation. If after the meeting, the service coordinator determines that the situation cannot be resolved, the service coordinator must request that HHSC terminate the individual's services. To make this request, the service coordinator must complete HHSC Request for Termination of Services form and submit the form to HHSC.

(c) If HHSC receives a form from a service coordinator requesting that HHSC terminate the individual's services, HHSC sends written notice to the individual or LAR of the proposal to terminate HCS Program services and CFC services. The notice includes the individual's right to request a fair hearing in accordance with §263.801 of this chapter (relating to Fair Hearing).

(d) If the individual or LAR requests a fair hearing before the effective date of the termination of HCS Program services and CFC services, as specified in the written notice, the program provider must provide services to the individual in the amounts authorized in the IPC while the appeal is pending.

§263.708. Termination of HCS Program Services and CFC Services Without Advance Notice.

(a) HHSC terminates an individual's HCS Program services and CFC services if any of the following situations exists:

(1) the individual is admitted to one of the facilities listed in §263.705(a)(1) - (9) of this subchapter (relating to Suspension of HCS Program Services and CFC Services):

(A) for more than 270 consecutive calendar days; and

(B) HHSC has not extended the individual's suspension in accordance with §263.705(h) of this subchapter;

(2) the service coordinator or program provider has factual information confirming the death of the individual;

(3) the service coordinator or program provider receives a clear written statement signed by the individual that the individual no longer wants HCS Program services;

(4) the individual's whereabouts are unknown, and the post office returns mail directed to the individual by the service coordinator or program provider without indicating a forwarding address; or

(5) HHSC establishes that the individual has been accepted for Medicaid services by another state.

(b) If a service coordinator becomes aware that a situation described in subsection (a) of this section exists, the service coordinator must request that HHSC terminate the individual's services. To make this request, the service coordinator must complete HHSC Request for Termination of Services form and submit the form to HHSC.

(c) If HHSC receives a form from a service coordinator requesting that HHSC terminate the individual's services, HHSC sends written notice to the individual or LAR of the termination of HCS Program services and CFC services. The notice includes the individual's right to request a fair hearing in accordance with §263.801 of this chapter (relating to Fair Hearing).

TITLE 26	HEALTH AND HUMAN SERVICES
PART 1	HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 263	<u>HOME AND COMMUNITY-BASED SERVICES (HCS)</u>
	<u>PROGRAM AND COMMUNITY FIRST CHOICE (CFC)</u>
SUBCHAPTER I	<u>HEARINGS</u>

§263.801. Fair Hearing.

An applicant whose request for eligibility for the HCS Program is denied or is not acted upon with reasonable promptness, or an individual whose HCS Program services or CFC services have been terminated, suspended, denied, or reduced by HHSC receives notice of the right to request a fair hearing in accordance with 1 TAC Chapter 357, Subchapter A (relating to Uniform Fair Hearing Rules).

§263.802. Program Provider's Right to Administrative Hearing.

(a) A program provider may request an administrative hearing if HHSC takes or proposes to take the following action:

(1) vendor hold;

(2) contract termination;

(3) recoupment of payments made to the program provider; or

(4) denial of a program provider's claim for payment, including denial of a retroactive LOC and denial of a recommended LON.

(b) If the basis of an administrative hearing requested under this section is a dispute regarding an LON assignment, the program provider may receive an administrative hearing only if reconsideration was requested by the program provider in accordance with §263.108 of this chapter (relating to Reconsideration of LON Assignment).

TITLE 26	HEALTH AND HUMAN SERVICES
PART 1	HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 263	<u>HOME AND COMMUNITY-BASED SERVICES (HCS)</u>
	<u>PROGRAM AND COMMUNITY FIRST CHOICE (CFC)</u>
SUBCHAPTER J	<u>LIDDA REQUIREMENTS</u>

§263.901. LIDDA Requirements for Providing Service Coordination in the HCS Program.

(a) In addition to the requirements described in 40 TAC Chapter 2, Subchapter L (relating to Service Coordination for Individuals with an Intellectual Disability), a LIDDA must:

(1) comply with:

(A) this chapter;

(B) 40 TAC Chapter 41 (relating to Consumer Directed Services Option); and

(C) 40 TAC Chapter 4, Subchapter L (relating to Abuse, Neglect, and Exploitation in Local Authorities and Community Centers); and

(2) ensure that a rights protection officer required by 40 TAC §4.113 (relating to Rights Protection Officer at a State MR Facility or MRA), who receives a copy of an HHSC initial intake report or a final investigative report from an FMSA in accordance with 40 TAC §41.702 (relating to Requirements Related to HHSC Investigations When an Alleged Perpetrator is a Service Provider) or 40 TAC §41.703 (relating to Requirements Related to HHSC Investigations When an Alleged Perpetrator is a Staff Person or a Controlling Person of an FMSA), gives a copy of the report to the individual's service coordinator.

(b) A LIDDA must ensure that a service coordinator is an employee of the LIDDA and meets the requirements of this subsection.

(1) A service coordinator must meet the minimum qualifications and LIDDA staff training requirements described in 40 TAC Chapter 2, Subchapter L except as described in paragraph (2) of this subsection.

(2) Notwithstanding 40 TAC §2.560(b)(2)(B) (relating to Staff Person Training), a service coordinator must complete a comprehensive non-introductory person-centered service planning training developed or approved by HHSC within six months after the service coordinator's date of hire, unless an extension of the six month timeframe is granted by HHSC.

(3) A service coordinator must receive training about the following within the first 90 calendar days after beginning service coordination duties:

(A) rules governing the HCS Program and CFC; and

(B) 40 TAC Chapter 41.

(c) A LIDDA must have a process for receiving and resolving complaints from a program provider related to the LIDDA's provision of service coordination or the LIDDA's process to enroll an applicant in the HCS Program.

(d) If, as a result of monitoring, the service coordinator identifies a concern with the implementation of the PDP, the LIDDA must ensure that the concern is communicated to the program provider and attempts are made to resolve the concern. The LIDDA may refer an unresolved concern to HHSC by calling the HHSC IDD Ombudsman toll-free telephone number at 1-800-252-8154.

(e) A service coordinator must:

(1) assist an individual, LAR, or actively involved person in exercising the legal rights of the individual;

(2) provide an individual, LAR, or family member with the booklet *Your Rights In the Home and Community-based Services (HCS) Program*, available on the HHSC website, and the HHSC HCS Rights Addendum form, and an oral explanation of the rights in the booklet and the form:

(A) upon the individual's enrollment in the HCS Program;

(B) upon revision of the booklet or the form;

(C) upon request; and

(D) if one of the following occurs:

(i) the individual becomes 18 years of age;

(ii) a guardian is appointed for the individual; or

(iii) a guardianship for the individual ends;

(3) document the provision of the information required by paragraph (2) of this subsection, and ensure that the documentation is signed by:

(A) the individual or LAR; and

(B) the service coordinator;

(4) ensure that, upon enrollment of an individual and annually thereafter, the individual or LAR is informed orally and in writing of the following:

(A) the telephone number of the LIDDA to file a complaint;

(B) the toll-free telephone number of the HHSC IDD Ombudsman, 1-800-252-8154, to file a complaint; and

(C) the toll-free telephone number of DFPS, 1-800-647-7418, to report an allegation of abuse, neglect, or exploitation;

(5) maintain for an individual for an IPC year:

(A) a copy of the IPC;

(B) the PDP and, if CFC PAS/HAB is included on the PDP, the completed HHSC HCS/TxHmL CFC PAS/HAB Assessment form;

(C) a copy of the ID/RC Assessment;

(D) documentation of the activities performed by the service coordinator in providing service coordination; and

(E) any other pertinent information related to the individual;

(6) initiate, coordinate, and facilitate the person-centered planning process to meet the goals and outcomes identified by an individual and LAR in the individual's PDP, including scheduling service planning team meetings;

(7) to meet the needs of an individual as those needs are identified, develop for the individual a full range of services and resources using:

(A) providers for services other than HCS Program services and CFC services;
and

(B) advocates or other actively involved persons;

(8) ensure that the PDP for an applicant or individual:

(A) is developed, reviewed, and updated in accordance with:

(i) §263.104(j)(4)(A) of this chapter (relating to Process for Enrollment of Applicants);

(ii) §263.302 of this chapter (relating to Renewal and Revision of an IPC);
and

(iii) 40 TAC §2.556 (relating to LIDDA's Responsibilities); and

(B) document, for each HCS Program service, other than supervised living and residential support, and for each CFC service, whether the service is critical to the individual's health and safety as determined by the service planning team;

(9) ensure that the updated finalized PDP is signed by the individual or LAR;

(10) participate in the development, renewal, and revision of an individual's IPC in accordance with §263.104 and §263.302 of this chapter;

(11) ensure the service planning team participates in the renewal and revision of the IPC for an individual in accordance with §263.302 of this chapter and ensure the service planning team completes other responsibilities and activities as described in this chapter;

(12) notify the service planning team if the service coordinator receives notification from the program provider that:

(A) an individual's behavior requires the implementation of a behavior support plan; or

(B) based on an annual review by the program provider, an individual's behavior support plan needs to continue;

(13) if a change to an individual's PDP is needed, other than as required by §263.302 of this chapter:

(A) communicate the need for the change to the individual or LAR, the program provider, and other appropriate persons;

(B) update the PDP as necessary; and

(C) within 10 calendar days after the PDP is updated, send a copy of the updated PDP to the program provider, the individual or LAR and, if applicable, the FMSA;

(14) provide an individual's program provider a copy of the individual's current PDP;

(15) monitor the provision of HCS Program services, CFC services, and non-HCS Program and non-CFC services to an individual;

(16) document whether an individual or LAR perceives that the individual is progressing toward desired outcomes identified on the individual's PDP;

(17) together with the program provider, ensure the coordination and compatibility of HCS Program services and CFC services with non-HCS Program and non-CFC services, including, in coordination with the program provider, assisting an

individual in obtaining a neurobehavioral or neuropsychological assessment and plan of care from one of the following professionals:

(A) a psychologist licensed in accordance with Texas Occupations Code Chapter 501;

(B) a speech-language pathologist licensed in accordance with Texas Occupations Code Chapter 401; or

(C) an occupational therapist licensed in accordance with Texas Occupations Code Chapter 454;

(18) for an individual who has had a guardian appointed, determine, at least annually, if the letters of guardianship are current;

(19) if individual does not have a guardian:

(A) ensure that the service planning team determines whether the individual would benefit from having a guardian or a less restrictive alternative to a guardian;

(B) if the service planning team determines that the individual would benefit from having a less restrictive alternative to a guardian such as a supported decision making agreement, take appropriate actions to implement such an alternative; and

(C) if the service planning team determines that the individual would benefit from having a guardian, make a referral to the appropriate court if:

(i) the individual would not benefit from a less restrictive alternative to a guardian; or

(ii) the individual would benefit from having a less restrictive alternative to a guardian but implementing such an alternative is not feasible;

(20) immediately notify the program provider if the service coordinator becomes aware that an emergency necessitates the provision of an HCS Program service or a CFC service to ensure the individual's health or safety and the service is not on the IPC or exceeds the amount on the IPC;

(21) if notified by the program provider that a requirement described in §263.503(c)(16) of this chapter (relating to Residential Agreements) or §263.502(a)(1)-(6) of this chapter (relating to Requirements for Program Provider Owned or Controlled Residential Settings) needs to be modified, update the individual's PDP to include the following:

(A) a description of the specific and individualized assessed need that justifies the modification;

(B) a description of the positive interventions and supports that were tried but did not work;

(C) a description of the less intrusive methods of meeting the need that were tried but did not work;

(D) a description of the condition that is directly proportionate to the specific assessed need;

(E) a description of how data will be routinely collected and reviewed to measure the ongoing effectiveness of the modification;

(F) the established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;

(G) the individual's or LAR's signature evidencing informed consent to the modification; and

(H) the program provider's assurance that the modification will cause no harm to the individual;

(22) if notified by the program provider that an individual or LAR has refused a comprehensive nursing assessment and that the program provider has determined it cannot ensure the individual's health, safety, and welfare in the provision of host home/companion care, residential support, supervised living, supported home living, respite, employment assistance, supported employment, in-home day habilitation, day habilitation, or CFC PAS/HAB:

(A) inform the individual or LAR of the consequences and risks of refusing the assessment, including that the refusal will result in the individual's not receiving:

(i) nursing services; or

(ii) host home/companion care, residential support, supervised living, supported home living, respite, employment assistance, supported employment, in-home day habilitation, day habilitation, or CFC PAS/HAB, if the individual needs one of those services and the program provider has determined that it cannot ensure the health and safety of the individual in the provision of the service; and

(B) notify the program provider if the individual or LAR continues to refuse the assessment after the discussion with the service coordinator;

(23) if the service coordinator determines that HCS Program services or CFC services provided for an individual should be terminated, including for a reason described in §263.104(k)(14)(C) or (D) of this chapter:

(A) document a description of:

(i) the situation that resulted in the service coordinator's determination that services should be terminated; and

(ii) the attempts by the service coordinator to resolve the situation;

(B) send a written recommendation to terminate the individual's HCS Program services or CFC services to HHSC and include the documentation required by subparagraph (A) of this paragraph; and

(C) provide a copy of the written recommendation and the documentation required by subparagraph (A) of this paragraph to the program provider;

(24) if an individual requests termination of all HCS Program services or all CFC services, within ten calendar days after the individual's request:

(A) inform the individual or LAR of:

(i) the individual's option to transfer to another program provider;

(ii) the consequences of terminating HCS Program services and CFC services; and

(iii) possible service resources upon termination, including CFC services through a managed care organization; and

(B) submit documentation to HHSC that:

(i) states the reason the individual is making the request; and

(ii) demonstrates that the individual or LAR was provided the information required by subparagraph (A)(ii) and (iii) of this paragraph;

(25) be objective in assisting an individual or LAR in selecting a program provider or FMSA;

(26) at the time of assignment and as changes occur, ensure that an individual and LAR and program provider are informed of the name of the individual's service coordinator and how to contact the service coordinator;

(27) unless contraindications are documented with justification by the service planning team, ensure that a school-age individual receives educational services in

a six-hour-per-day program, five days per week, provided by the local school district and that no individual receives educational services at a state supported living center or at a state center;

(28) unless contraindications are documented with justification by the service planning team, ensure that a pre-school-age individual receives an early childhood education with appropriate activities and services, including small group and individual play with peers without disabilities;

(29) unless contraindications are documented with justification by the service planning team, ensure that an individual who is 18 years or older has opportunities to participate in day activities of the individual's or LAR's choice that promote achievement of PDP outcomes;

(30) unless contraindications are documented with justification by the service planning team, ensure that each individual is offered choices and opportunities for accessing and participating in community activities and experiences available to peers without disabilities;

(31) assist an individual to meet as many of the individual's needs as possible by using generic community services and resources in the same way and during the same hours as these generic services are used by the community at large;

(32) for an individual receiving host home/companion care, residential support, or supervised living, ensure that the individual or LAR is involved in planning the individual's residential relocation, except in a case of an emergency;

(33) if the program provider notifies the service coordinator that the program provider is unable to locate the parent or LAR to assist the LIDDA in conducting permanency planning or if notified by the LIDDA that the LIDDA is unable to locate the parent or LAR in accordance with §263.902(b)(2)(H) of this subchapter (relating to Permanency Planning):

(A) make reasonable attempts to locate the parent or LAR by contacting a person identified by the parent or LAR in the contact information described in paragraph (35)(A) and (B) of this subsection; and

(B) notify HHSC, no later than 30 calendar days after the date the service coordinator determines the service coordinator is unable to locate the parent or LAR, of the determination and request that HHSC initiate a search for the parent or LAR;

(34) if the service coordinator determines that a parent's or LAR's contact information described in paragraph (35)(A) of this subsection is no longer current:

(A) make reasonable attempts to locate the parent or LAR by contacting a person identified by the parent or LAR in the contact information described in paragraph (35)(B) of this subsection; and

(B) notify HHSC, no later than 30 calendar days after the date the service coordinator determines the service coordinator is unable to locate the parent or LAR, of the determination and request that HHSC initiate a search for the parent or LAR;

(35) request from and encourage the parent or LAR of an individual under 22 years of age requesting or receiving supervised living or residential support to provide the service coordinator with the following information:

(A) the parent's or LAR's:

(i) name;

(ii) address;

(iii) telephone number;

(iv) driver license number and state of issuance or personal identification card number issued by the Department of Public Safety; and

(v) place of employment and the employer's address and telephone number;

(B) name, address, and telephone number of a relative of the individual or other person whom HHSC or the service coordinator may contact in an emergency situation, a statement indicating the relationship between that person and the individual, and at the parent's or LAR's option:

(i) that person's driver license number and state of issuance or personal identification card number issued by the Department of Public Safety; and

(ii) the name, address, and telephone number of that person's employer;
and

(C) a signed acknowledgement of responsibility stating that the parent or LAR agrees to:

(i) notify the service coordinator of any changes to the contact information submitted; and

(ii) make reasonable efforts to participate in the individual's life and in planning activities for the individual;

(36) within three business days after initiating supervised living or residential support to an individual under 22 years of age:

(A) provide the information listed in subparagraph (B) of this paragraph to the following:

(i) the CRCG for the county in which the individual's LAR lives (see the HHSC website for a listing of CRCG chairpersons by county); and

(ii) the local school district for the area in which the individual's residence is located, if the individual is at least three years of age, or the early childhood intervention (ECI) program for the county in which the individual's residence is located, if the individual is under three years of age (see the HHSC website to search for an ECI program by zip code or by county); and

(B) as required by subparagraph (A) of this paragraph, provide the following information to the entities described in subparagraph (A) of this paragraph:

(i) the individual's full name;

(ii) the individual's sex;

(iii) the individual's ethnicity;

(iv) the individual's birth date;

(v) the individual's social security number;

(vi) the LAR's name, address, and county of residence;

(vii) the date of initiation of supervised living or residential support;

(viii) the address where supervised living or residential support is provided; and

(ix) the name and phone number of the person providing the information;

(37) for an applicant or individual under 22 years of age seeking or receiving supervised living or residential support:

(A) make reasonable accommodations to promote the participation of the LAR in all planning and decision making regarding the individual's care, including participating in:

(i) the initial development and annual review of the individual's PDP;

(ii) decision making regarding the individual's medical care;

(iii) routine service planning team meetings; and

(iv) decision making and other activities involving the individual's health and safety;

(B) ensure that reasonable accommodations include:

(i) conducting a meeting in person, by videoconferencing, or by telephone, as mutually agreed upon by the program provider and the LAR;

(ii) conducting a meeting at a time and location, if the meeting is in person, that is mutually agreed upon by the program provider and the LAR;

(iii) if the LAR has a disability, providing reasonable accommodations in accordance with the Americans with Disabilities Act, including providing an accessible meeting location or a sign language interpreter, if appropriate; and

(iv) providing a language interpreter, if appropriate;

(C) provide written notice to the LAR of a meeting to conduct an annual review of the individual's PDP at least 21 calendar days before the meeting date and request a response from the LAR regarding whether the LAR intends to participate in the annual review;

(D) before an individual who is under 18 years of age, or who is at least 18 years of age and under 22 years of age and has an LAR, moves to another residence operated by the program provider, attempt to obtain consent for the move from the LAR unless the move is made because of a serious risk to the health or safety of the individual or another person; and

(E) document compliance with subparagraphs (A) - (D) of this paragraph in the individual's record;

(38) in accordance with Chapter 303, Subchapter G of this title (relating to Transition Planning) conduct:

(A) a pre-move site review for an applicant 21 years of age or older who is enrolling in the HCS Program from a nursing facility or as a diversion from admission to a nursing facility; and

(B) post-move monitoring visits for an individual 21 years of age or older who enrolled in the HCS Program from a nursing facility or has enrolled in the HCS Program as a diversion from admission to a nursing facility;

(39) do the following to inform applicants and individuals about responsibilities related to EVV:

(A) for an applicant who will receive a service that requires the use of EVV from the program provider or through the CDS option:

(i) orally explain the information in the HHSC Electronic Visit Verification Responsibilities and Additional Information form to the applicant or LAR;

(ii) sign the HHSC Electronic Visit Verification Responsibilities and Additional Information form to attest to explaining the information and to providing a copy to the individual or LAR;

(iii) provide the individual or LAR with a copy of the signed form;

(iv) perform the activities described in clause (i)(iii) of this subparagraph before the individual's enrollment; and

(v) maintain the completed HHSC Electronic Visit Verification Responsibilities and Additional Information form in the individual's record;

(B) for an individual who will receive a service that requires the use of EVV from the program provider or who is transferring to another program provider or LIDDA and will receive a service that requires the use of EVV from the program provider or through the CDS option:

(i) orally explain the information in the HHSC Electronic Visit Verification Responsibilities and Additional Information form to the individual or LAR;

(ii) sign the HHSC Electronic Visit Verification Responsibilities and Additional Information form to attest to explaining the information and to providing a copy to the individual or LAR;

(iii) provide the individual or LAR with a copy of the signed form;

(iv) perform the activities described in clause (i)-(iii) of this subparagraph on or before the effective date of the IPC that includes the EVV required service or the effective date of the transfer to another program provider or LIDDA; and

(v) maintain the completed HHSC Electronic Visit Verification Responsibilities and Additional Information form in the individual's record; and

(C) for an individual who will receive a service that requires the use of EVV through the CDS option or who will transfer to another FMSA and is receiving a service requiring the use of EVV:

(i) orally explain the information in the HHSC Electronic Visit Verification Responsibilities and Additional Information form to the individual or LAR;

(ii) sign the HHSC Electronic Visit Verification Responsibilities and Additional Information form to attest to explaining the information and to providing a copy to the individual or LAR;

(iii) provide the individual or LAR with a copy of the signed form;

(iv) perform the activities described in clause (i)-(iii) of this subparagraph before the individual receiving the EVV required service through the CDS option or on or before the effective date of the transfer to another FMSA; and

(v) maintain the completed HHSC Electronic Visit Verification Responsibilities and Additional Information form in the individual's record;

(40) have contact with an individual in-person, by videoconferencing, or telephone to provide service coordination during a month in which it is anticipated that the individual will not receive an HCS Program service unless:

(A) the individual's HCS Program services have been suspended; or

(B) the service coordinator had an in-person contact with the individual that month to comply with 40 TAC §2.556(d) (relating to LIDDA's Responsibilities);

(41) within one business day after the meeting to revise an IPC described in §263.503(k) of this chapter (relating to Residential Agreements), submit the following documentation to HHSC if the individual or LAR wants to keep residential support, supervised living, or host home/companion care on the individual's IPC:

(A) a completed HHSC Notification of Service Coordinator Disagreement form;

(B) a copy of the written notice of proposed eviction described in §263.503(h)(3) of this chapter;

(C) a copy of the written notice to vacate described in §263.503(j)(3) of this chapter;

(D) progress notes from any meetings related to the eviction; and

(E) a copy of the individual's PDP; and

(42) within one business day after receiving the notice from a program provider described in §263.503(m) of this chapter, notify HHSC that the individual is no longer delinquent in room or board payments.

§263.902. Permanency Planning.

(a) Permanency planning at enrollment. The provisions contained in this subsection apply to an applicant under 22 years of age moving from a family setting and requesting supervised living or residential support.

(1) Information. A LIDDA must, during enrollment, inform the applicant and LAR:

(A) of the benefits of living in a family setting;

(B) that the placement of the applicant is considered temporary; and

(C) that an ongoing permanency planning process is required.

(2) Permanency planning activities.

(A) A LIDDA must convene a permanency planning meeting with the LAR and, if possible, the applicant, during enrollment.

(B) Before the permanency planning meeting, the LIDDA must review the applicant's records, and, if possible, meet the applicant.

(C) During the permanency planning meeting, the meeting participants must discuss and choose one of the following goals:

(i) for an applicant under 18 years of age:

(I) to live in the applicant's family home where the natural supports and strengths of the applicant's family are supplemented, as needed, by activities and supports provided or facilitated by the LIDDA or program provider; or

(II) to live in a family-based alternative in which a family other than the applicant's family:

(-a-) has received specialized training in the provision of support and in-home care for an individual under 18 years of age with an intellectual disability or a related condition;

(-b-) will provide a consistent and nurturing environment in a family home that supports a continued relationship with the applicant's family to the extent possible; and

(-c-) will provide an enduring, positive relationship with a specific adult who will be an advocate for the applicant; or

(ii) for an applicant at least 18 years of age and under 22 years of age:

(I) to live in a setting chosen by the applicant or LAR in which the applicant's natural supports and strengths are supplemented by activities and supports provided or facilitated by the LIDDA or program provider; and

(II) to achieve a consistent and nurturing environment in the least restrictive setting, as defined by the applicant and LAR.

(D) To accomplish the goal chosen in accordance with subparagraph (C) of this paragraph, the meeting participants must discuss and identify:

(i) the problems or issues that led the applicant or LAR to request supervised living or residential support;

(ii) the applicant's daily support needs;

(iii) for the applicant under 18 years of age:

(I) barriers to having the applicant reside in the family home;

(II) supports that would be necessary for the applicant to remain in the family home; and

(III) actions that must be taken to overcome the barriers and provide the necessary supports;

(iv) for an applicant at least 18 years of age and under 22 years of age, the barriers to moving to a consistent and nurturing environment as defined by the applicant and LAR;

(v) the importance for the applicant to live in a long-term nurturing relationship with a family;

(vi) alternatives to the applicant living in an institutional setting;

(vii) the applicant's and LAR's need for information and preferences regarding those alternatives;

(viii) how, after the applicant's enrollment, to facilitate regular contact between the applicant and the applicant's family, and, if desired by the applicant and family, between the applicant and advocates and friends in the community to continue supportive and nurturing relationships;

(ix) natural supports and family strengths that will assist in accomplishing the identified permanency planning goal;

(x) activities and supports that can be provided by the family, LIDDA, or program provider to achieve the permanency planning goal;

(xi) assistance needed by the applicant's family:

(I) in maintaining a nurturing relationship with the applicant; and

(II) preparing the family for the applicant's eventual return to the family home or move to a family-based alternative; and

(xii) action steps, both immediate and long term, for achieving the permanency plan goal.

(E) A LIDDA must make reasonable accommodations to promote the participation of the LAR in a permanency planning meeting, including:

(i) conducting a meeting in person, by videoconferencing, or by telephone, as mutually agreed upon by the LIDDA and LAR;

(ii) conducting a meeting at a time and, if the meeting is in person, at a location that is mutually agreed upon by the LIDDA and LAR;

(iii) if the LAR has a disability, providing reasonable accommodations in accordance with the Americans with Disabilities Act, including providing an accessible meeting location or a sign language interpreter, if appropriate; and

(iv) providing a language interpreter, if appropriate.

(F) A LIDDA must develop a permanency plan using the HHSC Permanency Planning Instrument for Children Under 22 Years of Age form found on the HHSC website.

(G) A LIDDA must:

(i) complete the Permanency Planning Review Screen in HHSC data system during enrollment to obtain approval for an applicant to receive residential support or supervised living;

(ii) keep a copy of the Permanency Planning Review Approval Status View Screen from HHSC data system in the applicant's record; and

(iii) provide a copy of the permanency plan to the program provider, the applicant, and the LAR.

(3) Volunteer advocate.

(A) A LIDDA must inform the applicant and LAR that they may request a volunteer advocate to assist in permanency planning. The applicant or LAR may:

(i) select a person who is not employed by or under contract with the LIDDA or a program provider; or

(ii) request the LIDDA to designate a volunteer advocate.

(B) If an applicant or LAR requests that the LIDDA designate a volunteer advocate or the LIDDA cannot locate the applicant's LAR, the LIDDA must attempt to designate a volunteer advocate to assist in permanency planning who is, in order of preference:

(i) an adult relative who is actively involved with the applicant;

(ii) a person who:

(I) is part of the applicant's natural supports; and

(II) is not employed by or under contract with the LIDDA or a program provider; or

(iii) a person or a child advocacy organization representative who:

(I) is knowledgeable about community services and supports;

(II) is familiar with the permanency planning philosophy and processes; and

(III) is not employed by or under contract with the LIDDA or a program provider.

(C) If a LIDDA is unable to locate a volunteer advocate locally, the LIDDA must request assistance from a statewide advocacy organization in identifying an available volunteer advocate who meets the requirements described in subparagraph (B)(iii) of this paragraph. If the statewide advocacy organization is unable to assist the LIDDA in identifying a volunteer advocate, the LIDDA must document all efforts to designate a volunteer advocate in accordance with subparagraph (B) of this paragraph.

(b) Permanency planning after enrollment. Until an individual either becomes 22 years of age or is no longer receiving supervised living or residential support, a LIDDA must comply with this subsection six months after the date of the initial permanency planning meeting and every six months thereafter.

(1) Written notice. A LIDDA must provide written notice to the LAR of a meeting to conduct a review of the individual's permanency plan no later than 21 calendar days before the meeting date and include a request for a response from the LAR.

(2) Permanency planning activities. A LIDDA must:

(A) convene a permanency planning meeting with the LAR and, if possible, the individual, to review the individual's current permanency plan in accordance with subsection (a)(2)(C)-(E) of this section, with an emphasis on changes or additional information gathered since the last permanency plan was developed;

(B) during the permanency planning meeting, develop a permanency plan using the Permanency Planning Instrument available on the HHSC website;

(C) perform the actions regarding a volunteer advocate as described in subsection (a)(3) of this section;

(D) complete the Permanency Planning Review Screen in the HHSC data system within 10 calendar days after the date of the permanency planning meeting;

(E) ensure that approval for the individual to continue to receive residential support or supervised living is obtained every six months from the HHSC executive commissioner or designee;

(F) keep a copy of the Permanency Planning Review Approval Status View Screen from the HHSC data system in the individual's record;

(G) provide a copy of the permanency plan to the program provider, the individual, and the LAR; and

(H) if the LIDDA determines it is unable to locate the parent or LAR, notify the service coordinator of such determination.

(c) Provision of supervised living or residential support after enrollment. If a LIDDA receives information that an individual under 22 years of age who has been enrolled in the HCS Program moved from a family setting and started receiving supervised living or residential support, the LIDDA must, within the timeframes described in the performance contract between HHSC and the LIDDA:

(1) provide an explanation of services and supports and other information in accordance with §263.104(e)(1) of this chapter (relating to Process for Enrollment of Applicants); and

(2) take actions to conduct permanency planning as described in subsection (a) of this section.

§263.903. Referral from HHSC to DFPS.

If, within one year after the date HHSC receives the notification described in §263.901(e)(33)(B) or (34)(B) of this subchapter (relating to LIDDA Requirements for Providing Service Coordination in the HCS Program), HHSC is unable to locate the parent or LAR, HHSC refers the case to:

(1) the Child Protective Services Division of DFPS if the individual is under 18 years of age; or

(2) the Adult Protective Services Division of DFPS if the individual is at least 18 years of age and under 22 years of age.

TITLE 26	HEALTH AND HUMAN SERVICES
PART 1	HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 263	<u>HOME AND COMMUNITY-BASED SERVICES (HCS)</u>
	<u>PROGRAM AND COMMUNITY FIRST CHOICE (CFC)</u>
SUBCHAPTER K	<u>DECLARATION OF DISASTER</u>

§263.1000. Exceptions to Certain Requirements During Declaration of Disaster.

(a) HHSC may allow program providers and service coordinators to use one or more of the exceptions described in subsections (c) – (j) of this section while an executive order or proclamation declaring a state of disaster under Texas Government Code §418.014 is in effect. HHSC notifies program providers and LIDDAs:

(1) if it allows an exception to be used; and

(2) if an exception is allowed to be used, the date the exception must no longer be used, which may be before the declaration of a state of disaster expires.

(b) In this section “disaster area” means the area of the state specified in an executive order or proclamation described in subsection (a) of this section.

(c) Notwithstanding the definition of “implementation plan” in §263.3 of this chapter (relating to Definitions), the signature of an individual who resides in the disaster area is not required on the individual’s implementation plan, if:

(1) the meeting required by §263.302(a)(5)(A) of this chapter (relating to Renewal and Revision of an IPC) is conducted by videoconferencing or telephone;

(2) the individual or LAR orally agrees with the implementation plan; and

(3) the program provider documents the individual’s or LAR’s oral agreement on the implementation plan.

(d) Notwithstanding §263.8(b) of this chapter (relating to Comprehensive Nursing Assessment), the comprehensive nursing assessment completed by an RN is not required to be completed in person for an applicant or individual who resides in the disaster area, if the RN conducts the assessment as a telehealth service or by telephone, except as provided in subsection (e) of this section.

(e) Notwithstanding §263.104(j)(2)(A)(i)(I)(-a-) and (-b-), of this chapter (relating to Process for Enrollment of Applicants), a LIDDA is not required to conduct a standardized measure of intellectual functioning in person, and to conduct a standardized measure of adaptive abilities in person for an individual who resides in the disaster area, if the LIDDA conducts the standardized measures by videoconferencing.

(f) Notwithstanding §263.104(j)(2)(B)(i) of this chapter, a LIDDA is not required to conduct an ICAP assessment in person for an individual who resides in the disaster area if the LIDDA conducts the ICAP assessment by videoconferencing.

(g) Notwithstanding §263.302(e)(1)(B) of this chapter, a program provider is not required to ensure that an individual who resides in the disaster area or LAR signs and dates a renewal or revised IPC, if:

(1) the meeting required by §263.302(a)(4) and (b)(3)(D)(ii) of this chapter is conducted by videoconferencing or telephone;

(2) the program provider documents on the renewal or IPC the reason for and the topics discussed at the meeting;

(3) the individual or LAR orally agrees with the renewal or revised IPC; and

(4) the program provider documents the individual's or LAR's oral agreement on the renewal or the revised IPC.

(h) Notwithstanding §263.304(a)(1) of this chapter (relating to Service Limits), the service limit of adaptive aids for an individual who resides in the disaster area may be exceeded if:

(1) the requested adaptive aid that causes the service limit to be exceeded is:

(A) an adaptive aid that replaces an adaptive aid destroyed as a result of the disaster; or

(B) the repair of an adaptive aid that was damaged as a result of the disaster;

(2) the addition of the requested adaptive aid to the individual's IPC does not result in:

(A) the service limit of adaptive aids being exceeded by more than \$5,000;
or

(B) the individual's IPC cost limit for HCS program services being exceeded as described in §263.101(a)(3)(A)(B)(C) of this chapter (relating to Eligibility Criteria for HCS Program Service and CFC Services);

(3) the program provider:

(A) includes the cost of the requested adaptive aid on the revised IPC; and

(B) submits to HHSC, within 180 days after the effective date of the order or proclamation described in subsection (a) of this section, a written request to HHSC to approve the requested adaptive aid that includes:

(i) a description of the adaptive aid that is replacing the adaptive aid destroyed as a result of the disaster, which may include pictures or other descriptive information from a catalog, web-site or brochure;

(ii) a description of the repair to an adaptive aid that was damaged as a result of the disaster;

(iii) one bid for the requested adaptive aid from a vendor that includes:

(I) the total cost of the requested adaptive aid; and

(II) the name, address and telephone number of the vendor who must not be a relative of the individual; and

(iv) a statement from the program provider that the adaptive aid is not available through a third party resource; and

(4) the requested adaptive aid is approved by HHSC.

(i) Notwithstanding §263.304(a)(3)(A) and (B) of this chapter, the service limit of minor home modifications for an individual who resides in the disaster area may be exceeded if:

(1) the requested minor home modification that causes the service limit to be exceeded is:

(A) a minor home modification that replaces a minor home modification that was destroyed as a result of the disaster; or

(B) the repair of a minor home modification that was damaged as a result of the disaster;

(2) the addition of the requested minor home modification to the individual's IPC does not result in:

(A) the service limit of minor home modification being exceeded by more than \$3,750; or

(B) the individual's IPC cost limit for HCS program services being exceeded as described in §263.101(a)(3)(A), (B), or (C) of this chapter;

(3) the program provider:

(A) includes the cost of the requested minor home modification on the revised IPC;

(B) submits to HHSC, within 180 days after the effective date of the order or proclamation described in subsection (a) of this section, a written request to HHSC to approve the requested minor home modification that includes:

(i) a description of the minor home modification that is replacing the minor home modification destroyed as a result of the disaster, which may include pictures or other descriptive information from a catalog, web-site, or brochure;

(ii) a description of the repair to a minor home modification that was damaged as a result of the disaster;

(iii) one bid for the requested minor home modification from a vendor that includes:

(I) the total cost of the requested minor home modification; and

(II) the name, address and telephone number of the vendor who must not be a relative of the individual; and

(iv) a statement from the program provider that the minor home modification is not available through a third party resource; and

(4) the requested minor home modification is approved by HHSC.

(j) Notwithstanding §263.901(e)(9) of this chapter, a service coordinator is not required to ensure that an individual who resides in the disaster area or LAR sign the PDP, if:

(1) the meeting required by §263.302(a)(1)(B) and (b)(3)(D)(i) of this chapter is conducted by videoconferencing or telephone;

(2) the service coordinator documents on the PDP the reason for and the topics discussed at the meeting;

(3) the individual or LAR orally agrees with the PDP; and

(4) the service coordinator documents the individual's or LAR's oral agreement on the PDP.