TO: Medical Care Advisory Committee

DATE: August 11, 2022

FROM: Dana Williamson
Director of Policy and Program

SUBJECT: Texas Home Living (TxHmL) Services Program Update

Agenda Item No.:

Repeal and New Rules: The proposal repeals §§9.551, 9.552, 9.554, 9.556, 9.558, 9.560 - 9.563, 9.566 - 9.568, 9.570, 9.571, 9.573 – 9.575, 9.582, and 9.583 in Texas Administrative Code (TAC) Title 40, Part 1, Chapter 9, Subchapter N, relating to the Texas Home Living (TxHmL) Program and proposes new rules in 26 TAC Chapter 262, relating to Texas Home Living (TxHmL) Program and Community First Choice (CFC).

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

The Texas Health and Human Services Commission proposes the repeal of Sections 9.551, 9.552, 9.554, 9.556, 9.558, 9.560 - 9.563, 9.566 - 9.568, 9.570, 9.571, 9.573 – 9.575, 9.582 and 9.583 in 40 TAC, Part 1, Chapter 9, Subchapter N, relating to the Texas Home Living (TxHmL) Program and Community First Choice (CFC) and proposes new rules in 26 TAC Chapter 262, relating to Texas Home Living (TxHmL) Program and Community First Choice (CFC).

The TxHmL 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 TxHmL Program rules from 40 TAC Chapter 9, Subchapter N to 26 TAC Chapter 262.

This rule proposal does not include program provider certification principles that are currently in §§9.572, 9.576, 9.578 - 9.581, and 9.584 – 9.587 that are reviewed through the survey process. Rules containing the certification standards for the TxHmL Program will be proposed in a future issue of the *Texas Register*.

Another purpose of the proposed new rules is to ensure that the TxHmL 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 planning process, for

Community First Choice (CFC) services because CFC services are available in the TxHmL 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 TxHmL 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 TxHmL 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 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 current practice related to individuals transferring to another program provider or choosing a different service delivery option in the TxHmL 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:

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 in proposed new §262.101 regarding eligibility criteria the provision in 40 TAC §9.553(65)(H) describing a prohibited residential setting and, instead, including provisions in proposed new §262.202 that are consistent with 42 CFR §441.301(c)(5)(v) regarding settings 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, 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 the comments received) expressed that the provision in proposed new §262.101 regarding 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 TxHmL 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 §262.202 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.

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 TxHmL Program services. In addition, HHSC included a provision in the draft rules that allows a LIDDA to request reconsideration of an LON assignment in response to a request from a commenter to include this provision.

Some commenters requested that HHSC remove the individual plan of care cost limit and the service limits for some TxHmL 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 level of need (LON) to the next LON due to an individual's dangerous behavior.

HHSC did not make changes in response to these comments because implementing this recommendation would require additional research.

A few commenters requested that the person-centered planning process involve the individual and legally authorized representative (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.

FISCAL IMPACT:

☐ None ☒ Yes

	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 Texas Register
December 2022	Publish adopted rules in *Texas Register*
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 N TEXAS HOME LIVING (TXHML) 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 40 TAC, 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 40 TAC, Part 1. Therefore, the Executive Commissioner of HHSC proposes the repeal of §§9.551, 9.552, 9.554, 9.556, 9.558, 9.560 - 9.563, 9.566 - 9.568, 9.570, 9.571, 9.573 – 9.575, 9.582 and 9.583 in 40 TAC Chapter 9, Subchapter N, concerning Texas Home Living (TxHmL) Program and Community First Choice (CFC).

BACKGROUND AND PURPOSE

The purpose of the proposal is to repeal obsolete rules for the TxHmL 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 N govern the provision of TxHmL Program services. HHSC is proposing new rules regarding the TxHmL Program in 26 TAC Chapter 262 elsewhere in this issue of the *Texas Register*. The proposed rules address certain aspects of the TxHmL Program, including eligibility criteria; the maintenance of the TxHmL interest list; the process for the enrollment of applicants in the TxHmL 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 N that address the topics covered by the proposed new rules in 26 TAC Chapter 262 are no longer needed.

SECTION-BY-SECTION SUMMARY

The proposed repeal of §§9.551, 9.552, 9.554, 9.556, 9.558, 9.560 - 9.563, 9.566 - 9.568, 9.570, 9.571, 9.573 – 9.575, 9.582 and 9.583 removes rules covering topics that are addressed in the proposed new rules in 26 TAC Chapter 262.

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 rules 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 TxHmL 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 701 W. 51st Street, 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 21R057” 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 and TxHmL Programs.

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 N	TEXAS HOME LIVING (TXHML) PROGRAM AND COMMUNITY FIRST CHOICE (CFC)

[~~§9.551. Purpose.~~

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

~~(1) the eligibility criteria and process for enrollment in the TxHmL Program;~~

~~(2) the CFC service eligibility criteria for applicants and individuals;~~

~~(3) the requirements for TxHmL Program provider certification and process for certifying and sanctioning program providers in the TxHmL Program;~~

~~(4) the requirements for reimbursement of program providers; and~~

~~(5) the requirements for LIDDAs and the process for correcting practices found to be out of compliance with the TxHmL Program principles for a LIDDA.~~]

[~~§9.552. Application.~~

~~This subchapter applies to:~~

~~(1) LIDDAs;~~

~~(2) program providers;~~

~~(3) applicants and their LARs; and~~

~~(4) individuals and their LARs.~~]

[~~§9.554. Description of the TxHmL Program and CFC.~~

~~(a) The TxHmL 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 who live in their own homes or in their family homes. The TxHmL Program is operated by DADS under the authority of HHSC.~~

~~(b) DADS has grouped the counties of the state of Texas 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 available at www.dads.state.tx.us.~~

~~(1) A program provider may provide TxHmL Program services and CFC services only to persons residing in the counties specified in its contract.~~

~~(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.~~

~~(c) A LIDDA must provide service coordination to an individual who is enrolled in the TxHmL Program in accordance with this subchapter.~~

~~(d) TxHmL Program services, as described in §9.555 of this subchapter (relating to Description of TxHmL Program Services), are selected by the service planning team for inclusion in an applicant's or individual's IPC to:~~

~~(1) ensure the applicant's or individual's health and welfare in the community;~~

~~(2) supplement rather than replace the applicant's or individual's natural supports and other non-TxHmL Program sources for which the applicant or individual may be eligible; and~~

~~(3) prevent the applicant's or individual's admission to institutional services.~~

~~(e) A program provider may only provide and bill for community support if the activity provided is transportation as described in §9.555(a)(1)(B) of this subchapter (relating to Description of TxHmL Program Services).~~

~~(f) 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.~~

~~(g) The CDS option is a service delivery option, as 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).~~

~~(h) A program provider must comply with all applicable state and federal laws, rules, and regulations, including Chapter 49 of this title (relating to Contracting for Community Services).~~]

[~~§9.556. Eligibility Criteria for TxHmL Program Services and CFC Services.~~

~~(a) An applicant or individual is eligible for TxHmL Program services if:~~

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

~~(2) the applicant or individual 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 §9.560 of this subchapter (relating to Level of Care (LOC) Determination), qualifies for an ICF/IID LOC I as defined in §9.238 of this chapter (relating to Level of Care I Criteria); or~~

~~(B) 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 §9.560 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 (relating to ICF/MR Level of Care VIII Criteria);~~

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

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

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

~~(iii) is offered TxHmL 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 TxHmL Program waiver application approved by CMS and found at www.dads.state.tx.us;~~

~~(3) the applicant or individual has been assigned an LON 1, 5, 8, or 6 in accordance with §9.562 of this subchapter (relating to Level of Need (LON) Assignment);~~

~~(4) the applicant or individual has an IPC cost that does not exceed $17,000;~~

~~(5) the applicant or individual 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 TxHmL Program, as identified in the Mutually Exclusive Services table in Appendix I of the HCS Handbook available at www.dads.state.tx.us;~~

~~(6) the applicant or individual has chosen, or the applicant's or individual's LAR has chosen, participation in the TxHmL Program over participation in the ICF/IID Program;~~

~~(7) the applicant's or individual's service planning team concurs that the TxHmL Program services and, if applicable, non-TxHmL Program services for which the applicant or individual may be eligible are sufficient to ensure the applicant's or individual's health and welfare in the community;~~

~~(8) the applicant or individual lives in the applicant's or individual's own home or family home; and~~

~~(9) the applicant or individual requires the provision of:~~

~~(A) at least one TxHmL Program service per month or a monthly monitoring visit by a service coordinator as described in §9.583(p) of this subchapter (relating to TxHmL Program Principles for LIDDAs); and~~

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

~~(b) Except as provided in subsection (c) of this section, 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; and~~

~~(2) requires the provision of the CFC service.~~

~~(c) 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 (b) of this section, receive a TxHmL 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 §9.583(p) of this subchapter.~~

~~§9.558. Individual Plan of Care (IPC).~~

~~(a) An IPC must be developed for each applicant in accordance with §9.567 of this subchapter (relating to Process for Enrollment) and reviewed and revised for each individual whenever the individual's needs for services and supports change, but no less than annually, in accordance with §9.568 of this subchapter (relating to Revisions and Renewals of Individual Plans of Care (IPCs), Levels of Care (LOCs), and Levels of Need (LONs) for Enrolled Individuals).~~

~~(b) An IPC must be based on the PDP and specify the type and amount of each TxHmL Program service and CFC service to be provided to the individual, as well as non-TxHmL Program and non-CFC services and supports to be provided during the IPC year. The type and amount of each TxHmL Program service and CFC service in the IPC must be supported by:~~

~~(1) documentation that non-TxHmL Program and non-CFC sources for the service are unavailable and the service supplements rather than replaces natural supports or non-TxHmL Program and non-CFC services;~~

~~(2) assessments of the individual, including the DADS HCS/TxHmL CFC PAS/HAB Assessment form, that identify specific services necessary for the individual to continue living in the community, to ensure the individual's health and welfare in the community, and to prevent the individual's admission to institutional services; and~~

~~(3) documentation of the deliberations and conclusions of the service planning team that the TxHmL Program services and CFC services are necessary for the individual to live in the community; are necessary to prevent the individual's admission to institutional services, and are sufficient, when combined with services or supports available from non-TxHmL Program and non-CFC sources (if applicable), to ensure the individual's health and welfare in the community.~~

~~(c) Before electronic transmission to DADS, an individual's IPC must be signed and dated by the required service planning team members indicating concurrence that the services recommended in the IPC meet the requirements of subsection (b) of this section.~~

~~(d) DADS reviews an electronically transmitted initial, revised, or renewal IPC and approves, modifies, or does not approve the IPC.~~

~~(e) An electronically transmitted IPC must contain information identical to the information contained on the signed copy of the IPC described in subsection (c) of this section.~~

~~(f) DADS may review an IPC at any time to determine if the type and amount of each service specified in the IPC are appropriate. The service coordinator must submit documentation supporting the IPC to DADS in accordance with a request from DADS for documentation.~~

~~(g) If an 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 individual will receive support consultation, CFC support consultation instead of support consultation.~~]

[~~§9.560. Level of Care (LOC) Determination.~~

~~(a) A LIDDA must request an LOC determination for an applicant or individual by electronically transmitting a completed ID/RC Assessment to DADS, indicating the recommended LOC. The electronically transmitted ID/RC Assessment must contain information identical to that on the signed ID/RC Assessment.~~

~~(b) DADS makes an LOC determination in accordance with §9.237(c) of this chapter (relating to Level of Care).~~

~~(c) 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.~~

~~(d) The LIDDA must maintain the signed ID/RC Assessment and documentation supporting the recommended LOC in the applicant's or individual's record.~~

~~(e) DADS approves and enters the appropriate LOC into the automated billing and enrollment system or sends written notification to the service coordinator that an LOC has been denied.~~

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

[~~§9.561. Lapsed Level of Care (LOC).~~

~~(a) To reinstate authorization for payment for days when services were delivered to an individual without a current LOC determination, a LIDDA must:~~

~~(1) electronically transmit to DADS an ID/RC Assessment that is signed and dated by the service coordinator;~~

~~(2) 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~~

~~(3) ensure that the electronically transmitted ID/RC Assessment contains information that is identical to the information on the signed and dated ID/RC Assessment.~~

~~(b) DADS notifies the LIDDA 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 in accordance with subsection (a) of this section.~~

~~(c) The LIDDA must maintain in the individual's record:~~

~~(1) a copy of the individual's most recent ID/RC Assessment approved by DADS; and~~

~~(2) an ID/RC Assessment identical to that electronically transmitted in accordance with subsection (a) of this section for each period of time for which there was a lapsed LOC.~~

~~(d) DADS does not grant a request for reinstatement of an LOC determination:~~

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

~~(2) to renew an LOC determination;~~

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

~~(4) to revise an LON; or~~

~~(5) for a period of time for which an individual's IPC is or was not current.~~]

[~~§9.562. Level of Need (LON) Assignment.~~

~~(a) A LIDDA must request DADS to assign an LON for an applicant or individual by electronically transmitting a completed ID/RC Assessment to DADS, indicating the recommended LON and, as appropriate, submitting supporting documentation in accordance with §9.563(b) and (c) of this subchapter (relating to DADS Review of Level of Need (LON)).~~

~~(b) A LIDDA must maintain the applicant's or individual's Inventory for Client and Agency Planning (ICAP) Assessment Booklet supporting the recommended LON in the applicant's or individual's record and other documentation supporting the requested LON, including:~~

~~(1) the individual's PDP, including the deliberations and conclusions of the applicant's or individual's service planning team;~~

~~(2) assessments and interventions by qualified professionals; and~~

~~(3) behavioral intervention plans.~~

~~(c) If an LON 9 is recommended, a LIDDA must maintain documentation that proves:~~

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

~~(2) a written behavior intervention 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 extremely dangerous behavior occurs;~~

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

~~(4) the person supervising the individual has no other duties or activities during the period of supervision; and~~

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

~~(d) DADS assigns an LON for an individual based on the individual's ICAP service level score, information reported on the individual's ID/RC Assessment, and required supporting documentation.~~

~~(e) A LIDDA must submit documentation supporting a recommended LON to DADS in accordance with DADS instructions regarding LON packet submission found at www.dads.state.tx.us.~~

~~(f) DADS assigns one of five LONs in accordance with §9.161 of this chapter (relating to Level of Need Assignment).~~]

[~~§9.563. DADS Review of Level of Need (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 by the LIDDA to DADS in accordance with DADS request. Based on its review, DADS may modify an LON.~~

~~(b) If an LON 9 is requested, DADS may review documentation supporting the requested LON.~~

~~(c) Documentation supporting a recommended LON described in subsection (b) of~~

~~this section must be submitted by the LIDDA to DADS in accordance with this subchapter and received by DADS within seven calendar days after the LIDDA has electronically transmitted the recommended LON.~~

~~(d) Within 21 calendar days after receiving the supporting documentation, DADS:~~

~~(1) requests additional documentation;~~

~~(2) electronically approves the recommended LON and establishes the effective date; or~~

~~(3) sends written notification that the recommended LON has been denied.~~

~~(e) DADS reviews any additional documentation submitted in accordance with DADS request and electronically approves the recommended LON or sends written notification to the LIDDA that the recommended LON has been denied.~~]

[~~§9.566. TxHmL Interest List.~~

~~(a) A LIDDA must maintain an up-to-date interest list of applicants interested in receiving TxHmL 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 TxHmL 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 TxHmL 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) For an applicant determined diagnostically or functionally ineligible for another DADS waiver program, DADS adds the applicant's name to the TxHmL interest list with a request date based on one of the following, whichever is earlier:~~

~~(1) the request date of the interest list for the other waiver program; or~~

~~(2) an existing request date for the TxHmL Program for the applicant.~~

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

~~(1) the applicant or LAR requests in writing that the applicant's name be removed from the interest list;~~

~~(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 TxHmL Program services or, as described in §9.567(f) of this subchapter (relating to Process for Enrollment), an offer of TxHmL Program services is withdrawn, 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;~~

~~(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 TxHmL Program and the applicant or LAR has had an opportunity to exercise the applicant's right to appeal the decision in accordance with §9.571 of this subchapter (relating to Fair Hearings) 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 TxHmL 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 TxHmL interest list in accordance with subsection (e)(1) - (4) of this section and, more than 90 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 TxHmL 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.~~]

[~~§9.567. Process for Enrollment.~~

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

~~(1) whose interest list request date, assigned in accordance with §9.566(c)(2) or (d) of this subchapter (relating to TxHmL Interest List), is earliest on the statewide interest list for the TxHmL Program as maintained by DADS;~~

~~(2) whose name is not coded in the DADS data system as having been determined ineligible for the TxHmL Program and who is receiving services from the LIDDA that are funded by general revenue in an amount that would allow DADS to fund the services through the TxHmL Program; or~~

~~(3) who is a member of a target group identified in the approved TxHmL waiver application.~~

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

~~(c) A LIDDA must make the offer of TxHmL Program services to an applicant described in subsection (a)(2) or (3) 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 TxHmL Program services within 30 calendar days after the LIDDA's written offer, the LIDDA withdraws the offer of TxHmL Program services; 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 TxHmL Program services, the LIDDA terminates those services that are similar to services provided under the TxHmL Program; and~~

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

~~(e) If an applicant or LAR responds to an offer of TxHmL 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 a 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 Explanation of Services and Supports document which is available 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 TxHmL Program services and CFC services; and~~

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

~~(f) The LIDDA must withdraw an offer of TxHmL 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 TxHmL Program services;~~

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

~~(3) within 30 calendar days after the applicant or LAR receives the contact information regarding all available program providers in the LIDDA 's local service area in accordance with subsection (n)(1) of this section, the applicant or LAR does not document a 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 TxHmL 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 TxHmL Program services, the LIDDA must terminate those services that are similar to services provided under the TxHmL 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) The LIDDA must retain in the applicant's record:~~

~~(1) the Verification of Freedom of Choice 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 program provider; and~~

~~(3) any correspondence related to the offer of TxHmL Program services.~~

~~(k) If an applicant or LAR chooses participation in the TxHmL Program, the LIDDA must compile and maintain information necessary to process the applicant's enrollment in the TxHmL Program.~~

~~(1) The LIDDA must complete an ID/RC Assessment.~~

~~(A) The LIDDA must:~~

~~(i) determine or validate 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 Inventory for Client and Agency Planning (ICAP) or validate a current ICAP and recommend an LON assignment to DADS in accordance with §9.562 of this subchapter (relating to Level of Need (LON) Assignment).~~

~~(2) The LIDDA must:~~

~~(A) provide names and contact information to the applicant or LAR regarding all program providers in the LIDDA's local service area;~~

~~(B) arrange for meetings or visits with potential program providers as desired by the applicant or the LAR; and~~

~~(C) ensure that the applicant's or LAR's choice of a program provider is documented, signed by the applicant or LAR, and retained by the LIDDA in the applicant's record.~~

~~(3) The LIDDA must assign a service coordinator who, together with other members of the service planning team, must:~~

~~(A) develop a PDP; and~~

~~(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.~~

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

~~(1) in accordance with Chapter 41, Subchapter D of this title (relating to Enrollment, Transfer, Suspension, and Termination):~~

~~(A) inform the applicant or LAR of the applicant's right to participate in the CDS option; and~~

~~(B) inform the applicant or LAR that the applicant or LAR may choose to have one or more services provided through the CDS option, as described in §41.108 of this title (relating to Services Available Through the CDS Option); and~~

~~(2) if the applicant or LAR chooses to participate in the CDS option, comply with §9.583(s) of this subchapter (relating to TxHmL Program Principles for LIDDAs).~~

~~(m) The service coordinator must develop a proposed IPC with the applicant or LAR based on the PDP and in accordance with §9.558 of this subchapter (relating to Individual Plan of Care (IPC)).~~

~~(n) If an applicant or LAR chooses to receive a TxHmL Program service or CFC service provided by a program provider, the service coordinator must review the proposed IPC with potential program providers selected by the applicant or the LAR.~~

~~(o) If transportation as a community support activity is included on the PDP, a transportation plan must be developed by:~~

~~(1) the program provider if the individual chooses a program provider to provide transportation as a community support activity; or~~

~~(2) the service planning team if the individual chooses to receive transportation as a community support activity through the CDS option.~~

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

~~(1) ensure that the proposed IPC includes a sufficient number of RN nursing units for the program provider's RN to perform an initial nursing assessment, unless, as described in §9.578(q) of this subchapter (relating to Program Provider Certification Principles: Service Delivery):~~

~~(A) nursing services are not on the proposed 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 DADS form "Nursing Task Screening Tool"; or~~

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

~~(2) if an applicant or LAR refuses to include a sufficient number of RN nursing units on the proposed IPC for the program provider's RN to perform an initial nursing assessment as required by paragraph (1) 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 community support, day habilitation, employment assistance, supported employment, respite, or CFC PAS/HAB from the~~

~~program provider, will result in the applicant not receiving the service unless, as described in §9.578(r) 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; and~~

~~(3) negotiate and finalize the proposed IPC with the selected program provider.~~

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

~~(1) using a DADS form, provide an oral and written explanation to an applicant or LAR of:~~

~~(A) the eligibility requirements for TxHmL Program services as described in §9.556(a) of this subchapter (relating to Eligibility Criteria for TxHmL Program Services and CFC Services); and~~

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

~~(i) the eligibility requirements for CFC services as described in §9.556(b) of this subchapter to applicants who do not receive MAO Medicaid;~~

~~(ii) the eligibility requirements for CFC services as described in §9.556(c) of this subchapter to applicants who receive MAO Medicaid; and~~

~~(2) provide an oral and written explanation to the applicant or LAR of:~~

~~(A) the reasons TxHmL Program services may be terminated as described in §9.570(a)(1) of this subchapter (relating to Termination and Suspension of TxHmL Program Services and CFC Services); and~~

~~(B) if the applicant's PDP includes CFC services, the reasons CFC services may be terminated as described in §9.570(a)(2) of this subchapter.~~

~~(r) After the selected program provider agrees to provide the services listed on the IPC, the LIDDA must submit enrollment information, including the completed ID/RC Assessment and the proposed IPC to DADS. DADS notifies the applicant or LAR, the selected program provider and FMSA, if applicable, and the LIDDA of its approval or denial of the applicant's program enrollment based on the eligibility criteria described in §9.556 of this subchapter.~~

~~(s) 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 IPC, and the applicant's PDP, and if CFC PAS/HAB is included on the PDP, a copy of the completed DADS HCS/TxHmL CFC PAS/HAB Assessment form.~~

~~(t) If a selected program provider initiates services before DADS notification of enrollment approval, the program provider may not be reimbursed in accordance with §9.573(a)(5)(M) of this subchapter (relating to Reimbursement).~~]

[~~§9.568. Revisions and Renewals of Individual Plans of Care (IPCs), Levels of Care (LOCs), and Levels of Need (LONs) for Enrolled Individuals.~~

~~(a) At least annually, and before the expiration of an individual's IPC, the service planning team and the program provider must review the PDP and IPC to determine whether individual outcomes and services previously identified remain relevant.~~

~~(1) The service coordinator, in collaboration with the service planning team, initiates revisions to the PDP and the IPC in response to changes in the individual's needs and identified outcomes.~~

~~(2) If CFC PAS/HAB is included on the PDP, 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:~~

~~(A) at least annually and before the expiration of the individual's IPC; and~~

~~(B) if the IPC needs to be revised to add CFC PAS/HAB or change the amount of CFC PAS/HAB.~~

~~(3) The service coordinator must electronically transmit annual renewals and necessary revisions of the IPC to DADS for approval and retain documentation as described in §9.567 of this subchapter (relating to Process for Enrollment) and §9.558 of this subchapter (relating to Individual Plan of Care (IPC)).~~

~~(4) The service coordinator must send the program provider and FMSA, if applicable, a copy of:~~

~~(A) the revised PDP;~~

~~(B) the current IPC; and~~

~~(C) if CFC PAS/HAB is included on the PDP, the completed DADS HCS/TxHmL CFC PAS/HAB Assessment form.~~

~~(b) The service coordinator must electronically transmit annual evaluations of LOC~~

~~or revisions of LOC to DADS for approval in accordance with §9.560 of this subchapter (relating to Level of Care (LOC) Determination).~~

~~(c) A LIDDA must re-administer the ICAP to an individual in accordance with paragraph (1) of this subsection and must electronically transmit an ID/RC Assessment to DADS recommending a revision of the individual's LON assignment if the ICAP results indicate a change of the individual's LON assignment may be appropriate.~~

~~(1) The ICAP must be re-administered three years after an individual's enrollment and every third year thereafter unless, before that date:~~

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

~~(B) the individual's skills and behavior are inconsistent with the individual's assigned LON.~~

~~(2) As appropriate, the service coordinator must submit supporting documentation to DADS in accordance with §9.563 of this subchapter (relating to DADS Review of Level of Need (LON)).~~

~~(3) A LIDDA must retain in the individual's record results and recommendations of individualized assessments and other pertinent records documenting the recommended LON assignment.~~

~~(d) If an individual or LAR requests 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.~~]

[~~§9.570. Termination and Suspension of TxHmL Program Services and CFC Services.~~

~~(a) DADS may terminate:~~

~~(1) an individual's TxHmL Program services if:~~

~~(A) the individual no longer meets the eligibility criteria specified in §9.556(a) of this subchapter (relating to Eligibility Criteria for TxHmL Program Services and CFC Services);~~

~~(B) the individual or LAR requests that TxHmL Program services be terminated; or~~

~~(C) the individual or LAR refuses to cooperate in the provision or planning of services and:~~

~~(i) the refusal is documented by the program provider and the service coordinator; and~~

~~(ii) the service coordinator has explained to the individual or LAR, in writing, that the refusal may result in termination of TxHmL Program services; or~~

~~(2) an individual's CFC services if:~~

~~(A) the individual no longer meets the eligibility criteria described in §9.556(b) or (c) of this subchapter; or~~

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

~~(b) DADS proposed termination of an individual's TxHmL Program services or CFC services may be based on a LIDDA's recommendation as described in subsection (c) of this section.~~

~~(c) To recommend that DADS terminate an individual's TxHmL Program services or CFC services, the individual's service coordinator must, within 14 calendar days after determining that one of the reasons in subsection (a) of this section exists, submit a written recommendation containing the following information to DADS and provide a copy of the recommendation to the individual or LAR:~~

~~(1) the reason termination is recommended;~~

~~(2) a plan documenting:~~

~~(A) that, before submission of a recommendation for termination, the individual or LAR was informed of:~~

~~(i) the consequences of termination, including the ability of the individual to receive TxHmL Program services or CFC services in the future; and~~

~~(ii) the individual's option to transfer to another program provider if the recommendation is based on a reason other than the individual's eligibility; and~~

~~(B) the individual or LAR was informed of the potential service resources to use following termination of the individual's TxHmL Program services or CFC services, including CFC services through a managed care organization; and~~

~~(3) if termination is recommended for the reason stated in subsection (a)(1)(C) of this section:~~

~~(A) a description of the action by the individual or LAR demonstrating refusal to cooperate in the provision or planning of services and the effect of such action on the planning or provision of services;~~

~~(B) a description of the attempts by the program provider and service coordinator, including face-to-face meetings between the service coordinator and individual or LAR, to resolve the circumstances causing the individual's or LAR's refusal to cooperate; and~~

~~(C) a copy of a written explanation sent by the service coordinator to the individual or LAR explaining the consequences of the individual's or LAR's refusal to cooperate.~~

~~(d) If DADS proposes termination of an individual's TxHmL Program services or CFC services, DADS sends a written notice of the proposed termination and the right to request a fair hearing required by §9.571 of this subchapter (relating to Fair Hearings) to the individual or LAR, the program provider, and the LIDDA.~~

~~(e) If the reason for the proposed termination is that the individual no longer meets the eligibility criteria described in §9.556(a)(4) and (7) of this subchapter, the service coordinator must, at DADS request:~~

~~(1) inform the individual or LAR that DADS, based on availability, offers the individual a program vacancy in the HCS Program in accordance with §9.158(a)(2) of this chapter (relating to Process for Enrollment of Applicants); and~~

~~(2) offer to assist the individual or LAR to apply for other services for which the individual may be eligible including other home and community-based service programs and ICF/IID Program services.~~

~~(f) If an individual is temporarily admitted to one of the following settings, DADS suspends TxHmL Program services and CFC services 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 Department of State Health Services;~~

~~(6) a facility operated by the Department of Assistive and Rehabilitative Services;~~

~~(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.~~]

[~~§9.571. Fair Hearings.~~

~~An applicant or individual whose request for eligibility for the TxHmL Program is denied or is not acted upon with reasonable promptness, or whose TxHmL Program services or CFC services have been terminated, suspended, or reduced by DADS, or the applicant's or individual's LAR, 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).~~]

[~~§9.573. Reimbursement.~~

~~(a) Program provider reimbursement.~~

~~(1) DADS pays a program provider for services as described in this paragraph.~~

~~(A) DADS pays for community support, nursing, respite, day habilitation, employment assistance, supported employment, behavioral support, professional therapies, and CFC PAS/HAB in accordance with the reimbursement rate for the specific service.~~

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

~~(C) DADS 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 §49.311 of this title (relating to Claims Payment) and the *TxHmL Program Billing Guidelines* or the *CFC Billing Guidelines for HCS and TxHmL Program Providers.*~~

~~(3) If an individual's TxHmL 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 the program provider may submit a claim for a service provided on the first calendar day of the suspension or termination.~~

~~(4) 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 *TxHmL Program Billing Guidelines* and other documentation as required by the *TxHmL Program Billing Guidelines.*~~

~~(5) DADS does not pay the program provider for a service or recoups any payments made to the program provider for a service if:~~

~~(A) the individual receiving the service was, at the time the service was provided, ineligible for the TxHmL Program or Medicaid benefits, or was an inpatient of a hospital, nursing facility, or ICF/IID;~~

~~(B) the service was not included on the signed and dated IPC of the individual in effect at the time the service was provided;~~

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

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

~~(E) the claim for the service was not prepared and submitted in accordance with the *TxHmL Program Billing Guidelines* or the *CFC Billing Guidelines for HCS and TxHmL Program Providers;*~~

~~(F) the program provider does not have the documentation described in paragraph (4);~~

~~(G) 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.);~~

~~(H) 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.);~~

~~(I) DADS determines that the service would have been paid for by a source other than the TxHmL Program;~~

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

~~(K) the service was not provided in accordance with a signed and dated IPC meeting the requirements set forth in §9.558 of this subchapter (relating to~~

~~Individual Plan of Care (IPC));~~

~~(L) the service was not provided in accordance with the PDP or the implementation plan;~~

~~(M) the service was provided before the individual's enrollment date into the TxHmL Program;~~

~~(N) for transportation as a community support activity, the service is not provided in accordance with a transportation plan; or~~

~~(O) the service was not provided.~~

~~(6) The program provider must refund to DADS any overpayment made to the program provider within 60 days after the program provider's discovery of the overpayment or receipt of a notice of such discovery from DADS, whichever is earlier.~~

~~(7) Payments by DADS to a program provider are not withheld in the event the LIDDA erroneously fails to electronically transmit a renewal of an enrolled individual's LOC or IPC and the program provider continues to provide services in accordance with the most recent IPC approved by DADS.~~

~~(b) Billing and payment reviews.~~

~~(1) DADS conducts billing and payment reviews to monitor a program provider's~~ compliance with this subchapter and the ~~*TxHmL Program Billing Guidelines*~~ and the ~~*CFC Billing Guidelines for HCS and TxHmL Program Providers.*~~ DADS conducts such reviews in accordance with the ~~*TxHmL Billing and Payment Review Protocol*~~ set forth in the ~~*TxHmL 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.~~

~~(2) A corrective action plan required by DADS in accordance with paragraph (1)(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 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.~~

~~(3) Within 30 calendar days after the corrective action plan is received by DADS, DADS notifies the program provider if the corrective action plan is approved or if changes to the plan are required.~~

~~(4) If DADS requires a program provider to develop and submit a corrective action plan in accordance with paragraph (1)(B) of this subsection and the program provider requests an administrative hearing for the recoupment in accordance with §9.575 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. 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.~~

~~(5) If the program provider does not submit the corrective action plan or complete the required corrective action within the time frames described in paragraph (2) of this subsection, DADS may impose a vendor hold on payments due to the program provider under the contract until the program provider takes the corrective action.~~

~~(6) 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 (5) of this subsection, DADS may terminate the contract.~~]

[~~§9.574. Record Retention.~~

~~(a) A program provider must comply with §49.307 of this title (relating to Record Retention and Disposition).~~

~~(b) A LIDDA must retain original records described in this subchapter necessary to disclose the extent of the services provided to the individual and, on request, provide DADS, at no cost to DADS, any such records until the latest of the following occurs:~~

~~(1) six years elapse from the date the records were created;~~

~~(2) any audit exception or litigation involving the records is resolved; or~~

~~(3) the individual becomes 21 years of age.~~]

[~~§9.575. 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 request for payment.~~

~~(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 §9.568 of this subchapter (relating to Revisions and Renewals of Individual Plans of Care (IPCs), Levels of Care (LOCs), and Levels of Need (LONs) for Enrolled Individuals).~~]

[~~§9.582. Compliance with TxHmL Program Principles for LIDDAs.~~

~~(a) A LIDDA must be in compliance with:~~

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

~~(2) §9.583 of this subchapter (relating to TxHmL Program Principles for LIDDAs); and~~

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

~~(b) DADS conducts a compliance review at least annually of each LIDDA participating in the TxHmL Program.~~

~~(c) If any item of noncompliance remains uncorrected by the LIDDA at the time of the review exit conference, the LIDDA must, within 30 calendar days after the exit conference, submit to DADS a plan of correction with timelines to implement the plan after approval by DADS. DADS may take action as specified in the performance contract if the LIDDA fails to submit or implement an approved plan of correction.~~]

[~~§9.583. TxHmL Program Principles for LIDDAs.~~

~~(a) A LIDDA must offer TxHmL Program services to an applicant in accordance with §9.567 of this subchapter (relating to Process for Enrollment).~~

~~(b) A LIDDA must process enrollments in the TxHmL Program in accordance with §9.567 of this subchapter.~~

~~(c) A LIDDA must have a mechanism to ensure objectivity in the process to assist an individual or LAR in the selection of a program provider and a system for training all LIDDA staff who may assist an individual or LAR in such process.~~

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

~~(1) the telephone number of the LIDDA to file a complaint;~~

~~(2) the toll-free telephone number of the HHSC Complaint and Incident Intake, 1-800-458-9858, to file a complaint; and~~

~~(3) the toll-free telephone number of DFPS, 1-800-647-7418, to report an allegation of abuse, neglect, or exploitation.~~

~~(e) A LIDDA must maintain for each individual for an IPC year:~~

~~(1) a copy of the IPC;~~

~~(2) the PDP and, if CFC PAS/HAB is included on the PDP, the completed HHSC HCS/TxHmL CFC PAS/HAB Assessment form;~~

~~(3) a copy of the ID/RC Assessment;~~

~~(4) documentation of the activities performed by the service coordinator in providing service coordination; and~~

~~(5) any other pertinent information related to the individual.~~

~~(f) For an individual receiving TxHmL Program services and CFC services within a LIDDA's local service area, the LIDDA must provide the individual's program provider a copy of the individual's current PDP, IPC, and ID/RC Assessment.~~

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

~~(1) meet the minimum qualifications and staff training requirements specified in Chapter 2, Subchapter L of this title (relating to Service Coordination for Individuals with an Intellectual Disability); and~~

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

~~(A) the TxHmL Program and CFC, including:~~

~~(i) the requirements of this subchapter;~~

~~(ii) the CFC services as described in §9.554 of this subchapter (relating to Description of the TxHmL Program and CFC); and~~

~~(iii) the TxHmL Program services as described in §9.555 of this subchapter (relating to Description of TxHmL Program Services); and~~

~~(B) Chapter 41 of this title (relating to Consumer Directed Services Option).~~

~~(h) A LIDDA must ensure that a service coordinator:~~

~~(1) initiates, coordinates, and facilitates the person-directed planning process to meet the desires and needs as identified by an individual and LAR in the individual's PDP, including:~~

~~(A) scheduling service planning team meetings; and~~

~~(B) documenting on the PDP whether, for each TxHmL Program service or CFC service identified on the PDP, the service is critical to meeting the individual's health and safety as determined by the service planning team;~~

~~(2) coordinates the development and implementation of the individual's PDP;~~

~~(3) coordinates and develops an individual's IPC based on the individual's PDP;~~

~~(4) coordinates and monitors the delivery of TxHmL Program services and CFC services and non-TxHmL Program and non-CFC services;~~

~~(5) records each individual's progress; and~~

~~(6) develops a plan required by §9.570(c)(2) of this subchapter (relating to Termination and Suspension of TxHmL Program Services and CFC Services) that addresses assistance for the individual after termination of the individual's TxHmL Program services and CFC services.~~

~~(i) A LIDDA must ensure that an individual or LAR is informed of the name of the individual's service coordinator and how to contact the service coordinator.~~

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

~~(1) assist the 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 booklet, *Your Rights in the Texas Home Living (TxHmL) Program* , available on the HHSC website, and an oral explanation of the rights described in the booklet:~~

~~(A) upon the individual's enrollment in the TxHmL 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 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) assist the individual's LAR or family members to encourage the individual to exercise the individual's rights;~~

~~(5) ensure that the individual and LAR participate in developing a personalized PDP and IPC that meet the individual's identified needs and service outcomes and that the individual's PDP is updated when the individual's needs or outcomes change but not less than annually;~~

~~(6) ensure that a restriction affecting the individual is approved by the individual's service planning team before the imposition of the restriction;~~

~~(7) if notified by the program provider that an individual or LAR has refused a nursing assessment and that the program provider has determined that it cannot ensure the individual's health, safety, and welfare in the provision of a service as described in §9.578(s) of this subchapter (relating to Program Provider Certification Principles: Service Delivery):~~

~~(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) community support, day habilitation, employment assistance, supported employment, respite, or CFC PAS/HAB, if the individual needs one of those services and the program provider has determined that it cannot ensure the health, safety, and welfare 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;~~

~~(8) ensure that the individual or LAR is informed of decisions regarding denial or termination of services and the individual's or LAR's right to request a fair hearing as described in §9.571 of this subchapter (relating to Fair Hearings);~~

~~(9) ensure that, if needed, the individual or LAR participates in developing a plan required by §9.570(c)(2) of this subchapter that addresses assistance for the individual after termination of the individual's TxHmL Program services; and~~

~~(10) in accordance with HHSC instructions, manage the process to transfer an individual's TxHmL 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 TxHmL 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 TxHmL Program providers and FMSAs in the geographic location preferred by the individual or LAR.~~

~~(k) When a change to an individual's PDP or IPC is indicated, the service coordinator must discuss the need for the change with the individual or LAR, the individual's program provider, and other appropriate persons as necessary.~~

~~(l) At least 30 calendar days before the expiration of an individual's IPC, the service coordinator must:~~

~~(1) update the individual's PDP in conjunction with the individual's service planning team; and~~

~~(2) if the individual receives a TxHmL Program service or a CFC service from a program provider, submit to the program provider:~~

~~(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.~~

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

~~(1) review the status of an individual whose services have been suspended at least every 90 calendar days following the effective date of the suspension and document in the individual's record the reasons for continuing the suspension; and~~

~~(2) if the suspension continues 270 calendar days, submit written documentation of the 90, 180, and 270 calendar day reviews to HHSC for review and approval to continue the suspension status.~~

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

~~(1) inform the individual or LAR orally and in writing, of the requirements described in subsection (j) of this section:~~

~~(A) upon receipt of HHSC approval of the enrollment of the individual;~~

~~(B) if the requirements described in subsection (j) of this section are revised;~~

~~(C) at the request of the individual or LAR; and~~

~~(D) if the legal status of the individual changes; and~~

~~(2) document that the information described in paragraph (1) of this subsection was provided to the individual or LAR.~~

~~(o) A service coordinator must conduct:~~

~~(1) a pre-move site review for an applicant 21 years of age or older who is enrolling in the TxHmL Program from a nursing facility; and~~

~~(2) post-move monitoring visits for an individual 21 years of age or older who enrolled in the TxHmL Program from a nursing facility or has enrolled in the TxHmL Program as a diversion from admission to a nursing facility.~~

~~(p) A service coordinator must 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 a TxHmL Program service unless:~~

~~(1) the individual's TxHmL Program services have been suspended; or~~

~~(2) 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).~~

~~(q) 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; 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.~~

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

~~(1) at least annually, in accordance with Chapter 41, Subchapter D of this title (relating to Enrollment, Transfer, Suspension, and Termination):~~

~~(A) inform the individual or LAR of the individual's right to participate in the CDS option; and~~

~~(B) inform the individual or LAR that the individual or LAR may choose to have one or more services provided through the CDS option, as described in §41.108 of this title (relating to Services Available Through the CDS Option); and~~

~~(2) document compliance with paragraph (1) of this subsection in the individual's record.~~

~~(s) 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 Form 1584;~~

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

~~(4) document, in the individual's PDP, a description of the individual's service backup plan; and~~

~~(5) ensure the service planning team develops a transportation plan if an individual's PDP includes transportation as a community support activity to be~~

~~delivered through the CDS option.~~

~~(t) For an individual participating in the CDS option, a service coordinator must recommend that HHSC terminate the individual's participation in the CDS option 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, safety or welfare; 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).~~

~~(u) To make a recommendation as described in subsection (t) of this section, a service coordinator must submit the following documentation to HHSC:~~

~~(1) the services the individual receives through the CDS option;~~

~~(2) the reason why the recommendation is made;~~

~~(3) a description of the attempts to resolve the issues before making the recommendation; and~~

~~(4) any other supporting documentation, as appropriate.~~

~~(v) At least annually, a service coordinator must:~~

~~(1) using an HHSC form, provide an oral and written explanation to an individual or LAR of:~~

~~(A) the eligibility requirements for TxHmL Program services as described in §9.556(a) of this subchapter (relating to Eligibility Criteria for TxHmL Program Services and CFC Services); and~~

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

~~(i) the eligibility requirements for CFC services as described in §9.556(b) of this subchapter to individuals who do not receive MAO Medicaid; and~~

~~(ii) the eligibility requirements for CFC services as described in §9.556(c) of this subchapter to individuals who receive MAO Medicaid;~~

~~(2) using an HHSC form, provide an oral and written explanation to an individual or LAR of all TxHmL Program services and CFC services; and~~

~~(3) using an HHSC form, provide an oral and written explanation to an individual or LAR of:~~

~~(A) the reasons an individual's TxHmL Program services may be terminated as described in §9.570(a)(1) of this subchapter (relating to Termination and Suspension of TxHmL Program Services and CFC Services); and~~

~~(B) if the individual's PDP includes CFC services, the reasons CFC services may be terminated as described in §9.570(a)(2) of this subchapter.~~]

TITLE 26 HEALTH AND HUMAN SERVICES
PART 1 HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 262 TEXAS HOME LIVING (TxHmL) 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 262, Texas Home Living (TxHmL) Program and Community First Choice (CFC), Subchapters A – I, comprised of §§262.1 – 262.9, 262.101 – 262.107, 262.201, 262.202, 262.301 – 262.304, 262.401, 262.501 - 262.508, 262.601, 262.602, 262.701, and 262.801.

BACKGROUND AND PURPOSE

The TxHmL 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 TxHmL Program rules from 40 TAC Chapter 9, Subchapter N to 26 TAC Chapter 262. The repeal of §§9.551, 9.552, 9.554, 9.556, 9.558, 9.560 - 9.563, 9.566 - 9.568, 9.570, 9.571, 9.573 – 9.575, 9.582, and 9.583 in 40 TAC Chapter 9, Subchapter N are proposed elsewhere in this issue of the *Texas Register*.

This rule proposal does not include §§9.572, 9.576, 9.578 – 9.581, and §§9.584 – 9.587 that are currently reviewed through the survey process. Rules containing the certification standards for the TxHmL Program will be proposed in a future issue of the *Texas Register*.

Another purpose of the proposed new rules is to ensure that the TxHmL 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 TxHmL 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 TxHmL 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 TxHmL 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 current practice related to individuals transferring to another program provider or choosing a different service delivery option in the TxHmL 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 §262.1, Purpose, describes the purpose of the rules.

Proposed new §262.2, Application, describes the persons to whom Chapter 262 applies.

Proposed new §262.3, 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," "synchronous audio-visual," "TAC--Texas Administrative Code," "telehealth service," "transfer IPC" and "videoconferencing."

Proposed new §262.4, Description of the TxHmL Program and CFC, provides descriptions of the TxHmL Program and CFC including provisions about waiver contract areas and the consumer directed services option.

Proposed new §262.5, Description of TxHmL Program Services, provides a description of the TxHmL Program services available through the TxHmL Program.

Proposed new §262.6, Description of CFC Services, provides a description of the CFC services available through the TxHmL Program.

Proposed new §262.7, Requirement for Translation, requires program providers and local intellectual and developmental disability authorities 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 §262.8, 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 §262.9, 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 unless the service is required to be provided in person in accordance with the Texas Medicaid Provider Procedures Manual. The proposed new rule describes the requirements for providing PT, OT, or speech and language pathology as a telehealth service, including obtaining the individual's or LAR's consent before the provision of the telehealth service. The proposed new rule also sets forth the PT, OT, or speech and language pathology services that must be provided to an individual in person.

New Subchapter B, Eligibility, Enrollment, and Review

Proposed new §262.101, Eligibility Criteria for TxHmL Program Services and CFC Services, describes the eligibility criteria for TxHmL 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. HHSC included provisions in proposed new §262.202, Requirements for Service Settings, that are consistent with 42 CFR §441.301(c)(5)(v) regarding settings that are presumed to have the qualities of an institution.

Proposed new §262.102, TxHmL Interest List, describes how HHSC maintains the interest list for individuals interested in receiving services in the TxHmL 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 TxHmL 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 TxHmL 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 this change is to remove an incentive for an applicant to repeatedly decline a written offer of TxHmL Program services.

Proposed new §262.103, Process for Enrollment of Applicants, describes the process for offering an applicant enrollment and enrolling an applicant into the TxHmL Program.

Proposed new §262.104, 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 §262.105, 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 process for an individual's LON to be increased because of the individual's dangerous behavior.

Proposed new §262.106, HHSC Review of LON, describes the process by which HHSC reviews an LON.

Proposed new §262.107, Reconsideration of LON Assignment, describes the process by which a LIDDA may request a reconsideration by HHSC of an LON assignment.

New Subchapter C, Person-Centered Planning

Proposed new §262.201, 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.

Proposed new §262.202, Requirements for Service Settings, requires a program provider to ensure that a setting in which individual receives TxHmL 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 TxHmL Program service is not located in a building that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to a public institution, or that has the effect of isolating individuals from the broader community of persons not receiving Medicaid HCBS, unless 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.

New Subchapter D, Development and Review of an IPC

Proposed new §262.301, IPC Requirements, describes the requirements of an IPC.

Proposed new §262.302, 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 including requiring the service coordinator to convene a meeting to update the PDP and develop a renewal IPC, or 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 requires the program provider to convene a meeting with the individual or LAR to develop the implementation plans the TxHmL Program services except for community support; CFC services except for CFC support management; and transportation plan. In addition, 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).

Proposed new §262.303, 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 §262.301, IPC Requirements, and to determine if the IPC exceeds the cost limit as described in §262.101(a)(4), Eligibility Criteria for TxHmL Program Services and CFC Services. In addition, the proposed rule codifies current practice that HHSC may deny or reduce a TxHmL or CFC service if an IPC does not meet requirements in §262.301 or the cost limits described in §262.101(a)(4).

Proposed new §262.304, Service Limits, lists the service limits for certain TxHmL Program services provided to an individual. 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 policy, 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 also provides that a program provider may request authorization of a requisition fee for an adaptive aid, dental treatment and MHM, that is in addition to the service limits for these services to codify current practice.

New Subchapter E, Reimbursement by HHSC

Proposed new §262.401, Program Provider Reimbursement, describes how a program provider is reimbursed for services provided in the TxHmL 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, Claims Payment, and the TxHmL 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, Records, or providing CFC PAS/HAB, in-home day habilitation or in-home respite and the service claim does not match the EVV visit transaction. The proposed rule provides that HHSC conducts fiscal compliance reviews and describes the actions HHSC may take as the result of a review.

New Subchapter F, Transfer, Denials, Suspension, Reduction and Termination

Proposed new §262.501, 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 §262.502, 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 consumer directed services (CDS) option to a program provider.

Proposed new §262.503, Denial of a Request for Enrollment into the TxHmL Program, describes the basis and process for HHSC to deny an individual's request for enrollment into the TxHmL Program.

Proposed new §262.504, Denial of TxHmL Program Services or CFC Services, describes the basis and process for HHSC to deny an TxHmL Program Service or CFC Service.

Proposed new §262.505, Suspension of TxHmL Program Services and CFC Services, describes the basis and process for HHSC to suspend an individual's TxHmL Program services and CFC service.

Proposed new §262.506, Reduction of TxHmL Program Services or CFC Services, describes the basis and process for HHSC to reduce an individual's TxHmL Program service or CFC service.

Proposed new §262.507, Termination of TxHmL Program Services and CFC Services with Advance Notice, describes the basis and process for HHSC to terminate an individual's TxHmL Program Services and CFC Services when advance notice of the termination is required.

Proposed new §262.508, Termination of TxHmL Program Services and CFC Services Without Advance Notice, describes the basis and process for HHSC to terminate an individual's TxHmL Program Services and CFC Services when advance notice of the termination is not required.

New Subchapter G, Hearings

Proposed new §262.601, 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, Uniform Fair Hearing Rules.

Proposed new §262.602, Program Provider's Right to Administrative Hearing, describes when a program provider may request an administrative hearing.

New Subchapter H,LIDDA Requirements

Proposed new §262.701, LIDDA Requirements for Providing Service Coordination in the TxHmL 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 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. The proposed rule also describes the requirements for a service coordinator to inform applicants and individuals about responsibilities related to EVV.

New Subchapter I, Declaration of Disaster

Proposed new §262.801, 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.

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. However, there are multiple complexities and uncertainties related to the fiscal impact of this requirement 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 531 TxHmL 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 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 of the requirement for a program provider and LIDDA 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. 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 21R057" 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
CHAPTER 262	TEXAS HOME LIVING (TxHmL) PROGRAM AND COMMUNITY FIRST CHOICE (CFC)
SUBCHAPTER A	GENERAL PROVISIONS

§262.1. Purpose.

The purpose of this subchapter is to describe certain policies, procedures, and requirements of the TxHmL Program.

§262.2. 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.

§262.3. Definitions.

The following words and terms, when used in this subchapter, 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) Applicant--A Texas resident seeking services in the Texas Home Living (TxHmL) Program.

(6) Audio-only--An interactive, two-way audio communication platform that only uses sound.

(7) 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.

(8) Business day--Any day except a Saturday, a Sunday, or a national or state holiday listed in Texas Government Code §662.003(a) or (b).

(9) Calendar day--Any day, including weekends and holidays.

(10) CDS option--Consumer directed services option. A service delivery option as defined in 40 TAC §41.103 (relating to Definitions).

(11) CFC--Community First Choice.

(12) CFC ERS--CFC emergency response services.

(13) 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)/habilitiation (HAB) through the CDS option.

(14) 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.

(15) 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.

(16) Competitive employment--Employment that pays an individual at least minimum wage if the individual is not self-employed.

(17) 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).

(18) Contract--A provisional contract or a standard contract.

(19) Delegated nursing task--A nursing task delegated by a registered nurse 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).

(20) DFPS--The Department of Family and Protective Services.

(21) DID--Determination of intellectual disability. This term has the meaning set forth in §304.102 of this title (relating to Definitions).

(22) DID report--Determination of intellectual disability report. This term has the meaning set forth in §304.102 of this title.

(23) EVV--Electronic visit verification. This term has the meaning set forth in 1 TAC §354.4003 (relating to Definitions).

(24) 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.

(25) FMS--Financial management services.

(26) FMSA--Financial management services agency. As defined in 40 TAC §41.103, an entity that provides FMS to an individual participating in the CDS option.

(27) 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.

(28) HCS--Home and Community-based Services. Services provided through the HCS Program operated by the Texas Health and Human Services Commission (HHSC) as authorized by CMS in accordance with §1915(c) of the Social Security Act.

(29) Health maintenance activities--This term has the meaning set forth in 22 TAC §225.4 (relating to Definitions).

(30) 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.

(31) HHSC--The Texas Health and Human Services Commission.

(32) 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.

(33) 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.

(34) ICAP--Inventory for Client and Agency Planning. An instrument designed to assess a person’s needs, skills, and abilities.

(35) 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.

(36) 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.

(37) ID/RC Assessment--Intellectual Disability/Related Conditions Program Assessment. A form used by HHSC for level of care determination and level of need assignment.

(38) Implementation plan--A written document developed by a program provider for an individual that, for each TxHmL Program service and CFC service on the individual's IPC to be provided by the program provider except for community support and CFC support management, includes:

(A) a list of outcomes identified in the person-directed plan that will be addressed using TxHmL 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 TxHmL Program services and CFC services needed to complete each objective;

(E) the frequency and duration of TxHmL Program services and CFC services needed to complete each objective; and

(F) the signature and date of the individual, legally authorized representative (LAR), and the program provider.

(39) Individual--A person enrolled in the TxHmL Program.

(40) Initial IPC--The first IPC for an individual developed before the individual's enrollment into the TxHmL Program.

(41) Inpatient chemical dependency treatment facility--A facility licensed in accordance with THSC Chapter 464, Facilities Treating Persons with a Chemical Dependency.

(42) 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.

(43) Intellectual disability--This term has the meaning set forth in §304.102 of this title.

(44) IPC--Individual plan of care. A written plan that:

(A) states:

(i) the type and amount of each TxHmL Program service and each CFC service, except for CFC support management, to be provided to an individual during an IPC year;

(ii) the services and supports to be provided to the individual through resources other than TxHmL 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.

(45) IPC cost--Estimated annual cost of TxHmL Program services included on an IPC.

(46) 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.

(47) LAR--Legally authorized representative. A person authorized by law to act on behalf of a person with regard to a matter described in this subchapter, 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.

(48) LIDDA--Local intellectual and developmental disability authority. An entity designated by the executive commissioner of HHSC, in accordance with THSC §533A.035.

(49) 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.

(50) LON--Level of need. An assignment given by HHSC to an applicant or individual that is derived from the ICAP service level score and from selected items on the ID/RC Assessment.

(51) Managed care organization--This term has the meaning set forth in Texas Government Code §536.001.

(52) 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.

(53) 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.

(54) Mental health facility--A facility licensed in accordance with THSC Chapter 577, Private Mental Hospitals and Other Mental Health Facilities.

(55) 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.

(56) 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.

(57) Natural supports--Unpaid persons, including family members, volunteers, neighbors, and friends, who voluntarily assist an individual to achieve the individual's identified goals.

(58) 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.

(59) Nursing facility--A facility licensed in accordance with THSC Chapter 242.

(60) 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.

(61) Performance contract--A written agreement between HHSC and a LIDDA for the performance of delegated functions, including those described in THSC §533A.035.

(62) 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.

(63) Platform--This term has the meaning set forth in Texas Government Code §531.001(4-d).

(64) 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.

(65) Pre-move site review--A review conducted by the service coordinator in accordance with HHSC's IDD PASRR Handbook.

(66) Professional therapies--Services that consist of the following:

(A) audiology services;

(B) behavioral support;

(C) dietary services;

(D) occupational therapy services;

(E) physical therapy services; and

(F) speech and language pathology.

(67) Program provider--A person, as defined in 40 TAC §49.102 (relating to Definitions), that has a contract with HHSC to provide TxHmL Program services, excluding an FMSA.

(68) 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).

(69) 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.

(70) 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 TxHmL Program Billing Requirements.

(71) Renewal IPC--An IPC developed for an individual in accordance with §262.302(a) of this chapter (relating to Renewal and Revision of an Individual's IPC).

(72) Residential child care facility--The term has the meaning set forth in Texas Human Resources Code §42.002.

(73) Revised IPC--An IPC that is revised during an IPC year in accordance with §262.302 of this chapter to add a new TxHmL Program service or CFC service or change the amount of an existing service.

(74) RN--Registered nurse. A person licensed to practice professional nursing in accordance with Texas Occupations Code Chapter 301.

(75) Service backup plan--A plan that ensures continuity of a service that is critical to an individual's health and safety if service delivery is interrupted.

(76) Service coordination--A service as defined in 40 TAC Chapter 2, Subchapter L (relating to Service Coordination for Individuals with an Intellectual Disability).

(77) Service coordinator--An employee of a LIDDA who provides service coordination to an individual.

(78) 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) the service coordinator; and

(iii) other persons chosen by the applicant, 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 TxHmL Program, a planning team consisting of:

(i) the applicant and LAR;

(ii) 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 TxHmL program from a nursing facility or has enrolled in the TxHmL Program as a diversion from admission to a nursing facility, for 180 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.

(79) Service provider--A person, who may be a staff member, who directly provides a TxHmL Program service or CFC service to an individual.

(80) 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.

(81) Sexual activity--An activity that is sexual in nature, including kissing, hugging, stroking, or fondling with sexual intent.

(82) 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.

(83) Staff member--An employee or contractor of a TxHmL Program provider.

(84) 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 40 TAC §49.209(d).

(85) 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.

(86) Store and forward technology--This term has the meaning set forth in Texas Occupations Code §111.001(2).

(87) 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.

(88) 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.

(89) Telehealth service--This term has the meaning set forth in Texas Occupations Code §111.001.

(90) Temporary Admission--A stay in a facility listed in §262.505(a) of this chapter (relating to Suspension of TxHmL Program Services and CFC Services) for 270 calendar days or less or, if an extension is granted in accordance with §262.505(h) of this chapter, a stay in such a facility for more than 270 calendar days.

(91) THSC--Texas Health and Safety Code. Texas statute relating to health and safety.

(92) Transfer IPC--An IPC that is developed in accordance with §262.501 of this chapter (relating to Process for Individual to Transfer to a Different Program

Provider or FMSA) or §262.502 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.

(93) 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 TxHmL Program.

(94) Transportation plan--A written plan based on person-directed planning and developed with an applicant or individual using HHSC Individual Transportation Plan form available on the HHSC website. A transportation plan is used to document how community support will be delivered to support an individual's desired outcomes and purposes for transportation as identified in the PDP.

(95) TxHmL Program--The Texas Home Living Program operated by HHSC as authorized by CMS in accordance with §1915(c) of the Social Security Act. The TxHmL Program provides community-based services and supports to eligible individuals who live in their own homes or in their family homes.

(96) Vendor hold--A temporary suspension of payments that are due to a program provider under a contract.

(97) 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.

(98) 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.

(99) Volunteer--A person who works for a program provider without compensation, other than reimbursement for actual expenses.

§262.4. Description of the TxHmL Program and CFC.

(a) The TxHmL 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 who live in their own homes or in their family homes.

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

(c) TxHmL Program services described in §262.5 of this subchapter (relating to Description of TxHmL Program Services) are selected for inclusion in an individual's IPC to ensure the individual's health, safety, welfare, and integration in the community. TxHmL 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) 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.

(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 TxHmL 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).

§262.5. Description of TxHmL Program Services.

(a) TxHmL Program services are described in this section and in Appendix C of the TxHmL Program waiver application approved by CMS.

(1) Adaptive aids include 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 is 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) 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.

(9) In-home day habilitation is assistance with acquiring, retaining, or improving self-help, socialization, and adaptive skills provided in the individual's residence.

(10) Dental treatment is:

(A) emergency dental treatment;

(B) preventive dental treatment;

(C) therapeutic dental treatment; and

(D) orthodontic dental treatment, excluding cosmetic orthodontia.

(11) Minor home modifications are physical adaptations to an individual's residence to address specific needs identified by an individual's service planning team.

(12) Licensed vocational nursing is the provision of licensed vocational nursing, as defined in the Texas Occupations Code Chapter 301.

(13) Registered nursing is the provision of professional nursing, as defined in the Texas Occupations Code Chapter 301.

(14) Specialized registered nursing is the provision of registered nursing to an individual who has a tracheostomy or is dependent on a ventilator.

(15) Specialized licensed vocational nursing is the provision of licensed vocational nursing to an individual who has a tracheostomy or is dependent on a ventilator.

(16) Community support provides transportation to an individual.

(17) Respite provides temporary relief for an unpaid caregiver of an individual in a location other than the individual's residence.

(18) In-home respite provides temporary relief for an unpaid caregiver of an individual in the individual's residence.

(19) Employment assistance provides assistance to help an individual locate paid employment in the community.

(20) Supported employment provides 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.

(b) The services described in this subsection are for an individual who is receiving at least one TxHmL 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.

§262.6. 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 TxHmL Handbook, if:

(A) the individual is receiving CFC PAS/HAB; and

(B) the individual or LAR requests to receive CFC support management; and

(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.

§262.7. 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.

§262.8. 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 §262.103(o)(1) 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.

§262.9. 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 certain 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 262 TEXAS HOME LIVING (TxHmL) PROGRAM AND COMMUNITY FIRST CHOICE (CFC)
SUBCHAPTER B ELIGIBILITY, ENROLLMENT, AND REVIEW

§262.101. Eligibility Criteria for TxHmL Program Services and CFC Services.

(a) An applicant or individual is eligible for TxHmL Program services if:

(1) the applicant or individual meets the financial eligibility criteria as described in Appendix B of the TxHmL waiver application approved by CMS and available on the HHSC website;

(2) the applicant or individual meets one of the following criteria:

(A) based on a DID and as determined by HHSC in accordance with §262.104 of this subchapter (relating to LOC Determination), the applicant or individual qualifies for an ICF/IID LOC I as defined in §261.238 of this title (relating to ICF/MR Level of Care I Criteria); or

(B) meets the following criteria:

(i) based on a DID and as determined by HHSC in accordance with §262.105 of this subchapter (relating to LON Assignment), 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 (relating to ICF/MR Level of Care VIII Criteria);

(ii) meets one of the following:

(I) resides in a nursing facility immediately before enrolling in the TxHmL Program; or

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

(iii) is offered TxHmL 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 TxHmL Program waiver application approved by CMS and available on the HHSC website;

(3) the applicant or individual has been assigned an LON in accordance with §262.105 of this subchapter;

(4) the applicant or individual has an IPC cost that does not exceed $17,000;

(5) the applicant or individual 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 TxHmL Program, as identified in the Mutually Exclusive Services table in Appendix I of the TxHmL Handbook available on the HHSC website;

(6) the applicant or individual has chosen, or the applicant's or individual's LAR has chosen, participation in the TxHmL Program over participation in the ICF/IID Program;

(7) the applicant's or individual's service planning team concurs that the TxHmL Program services and, if applicable, non-TxHmL Program services for which the applicant or individual may be eligible are sufficient to ensure the applicant's or individual's health and welfare in the community;

(8) the applicant or individual does not reside in:

(A) a hospital;

(B) an ICF/IID;

(C) a nursing facility;

(D) an assisted living facility licensed or subject to being licensed in accordance with THSC Chapter 247;

(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

(9) the applicant or individual requires the provision of:

(A) at least one TxHmL Program service per month or a monthly monitoring visit by a service coordinator as described in §262.701(o) of this chapter (relating to LIDDA Requirements for Providing Service Coordination in the TxHmL Program); and

(B) at least one TxHmL Program service per IPC year.

(b) Except as provided in subsection (c) of this section, 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; and

(2) requires the provision of the CFC service.

(c) 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 (b) of this section, receive a TxHmL 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 §262.701(o)(1) and (2) of this chapter.

§262.102. TxHmL Interest List.

(a) A LIDDA must maintain an up-to-date interest list of applicants interested in receiving TxHmL 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 TxHmL 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 TxHmL interest list using the date the LIDDA receives the request as the TxHmL interest list date.

(d) 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 TxHmL interest list, at the request of the applicant or LAR, HHSC adds the applicant’s name to the TxHmL interest list using the applicant’s interest list date for the program for which the applicant was determined ineligible as the TxHmL interest list date;

(2) if the applicant’s name is on the TxHmL 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 TxHmL interest list date, at the request of the applicant or LAR, HHSC changes the applicant’s TxHmL interest list date to the applicant’s interest list date for the program for which the applicant was determined ineligible as the TxHmL interest list date; or

(3) if the applicant's name is on the TxHmL interest list and the applicant's TxHmL 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 TxHmL interest list date.

(e) This subsection applies to an applicant who was enrolled in MDCP and, because the individual 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 TxHmL interest list:

(A) using the MDCP interest list date as the TxHmL interest list date, if the applicant's name is not on the TxHmL interest list but it was previously on the TxHmL interest list; or

(B) using the date HHSC receives the request as the TxHmL interest list date, if the applicant's name is not on the TxHmL interest list and it never has been on the TxHmL interest list.

(2) At the request of the applicant or LAR, HHSC changes the TxHmL interest list date to the MDCP interest list date if the applicant's MDCP interest list date is earlier than the applicant's TxHmL interest list date.

(f) HHSC or the LIDDA removes an applicant's name from the TxHmL interest list if:

(1) the applicant or LAR requests in writing that the applicant's name be removed from the TxHmL interest list;

(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 TxHmL Program services or, as described in §262.103(f) of this subchapter (relating to Process for Enrollment of Applicants), an offer of TxHmL Program services is withdrawn, 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;

(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 TxHmL Program and the applicant or LAR has had an opportunity to exercise the applicant's right to appeal the decision in accordance with §262.601 of this chapter (relating to Fair Hearing) and did not appeal the decision, or appealed and did not prevail.

(g) If HHSC or the LIDDA removes an applicant's name from the TxHmL interest list in accordance with subsection (f)(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 add the applicant's name to the TxHmL interest list:

(1) the LIDDA must notify HHSC of the request; and

(2) HHSC:

(A) adds the applicant's name to the TxHmL interest list using the TxHmL interest list date that was in effect at the time the applicant’s name was removed from the TxHmL interest list; and

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

(h) If HHSC or the LIDDA removes an applicant's name from the TxHmL interest list in accordance with subsection (f)(1)-(4) of this section, the LIDDA receives an oral or written request from a person to add the applicant's name to the TxHmL 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 TxHmL interest list using the TxHmL interest list date that was in effect at the time the applicant’s name was removed from the TxHmL interest list; and

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

(i) If HHSC or the LIDDA removes an applicant's name from the TxHmL interest list in accordance with subsection (f)(1)-(4) of this section, the LIDDA receives an oral

or written request from a person to add the applicant's name to the TxHmL 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 TxHmL interest list using the date the LIDDA receives the oral or written request as the TxHmL interest list date; or

(B) if HHSC determines that extenuating circumstances exist, HHSC adds the applicant’s name to the TxHmL interest list using the TxHmL interest list date that was in effect at the time the applicant’s name was removed from the TxHmL interest list as the TxHmL interest list date; and

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

(j) If HHSC or the LIDDA removes an applicant's name from the TxHmL interest list in accordance with subsection (f)(1)-(4) of this section, the LIDDA receives an oral or written request from a person to add the applicant's name to the TxHmL interest list, and the request is not the applicant’s first request:

(1) the LIDDA adds the applicant’s name to the TxHmL interest list using the date the LIDDA receives the oral or written request as the TxHmL interest list date; and

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

(k) If HHSC or the LIDDA removes an applicant's name from the TxHmL interest list in accordance with subsection (f)(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 TxHmL interest list:

(1) the LIDDA must add the applicant's name to the TxHmL interest list using the date the LIDDA receives the oral or written request as the TxHmL interest list date; and

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

§262.103. Process for Enrollment of Applicants.

(a) HHSC notifies a LIDDA, in writing, when the opportunity for enrollment in the TxHmL Program becomes available in the LIDDA's local service area and directs the LIDDA to offer enrollment to the applicant:

(1) whose interest list date, assigned in accordance with §262.102 of this subchapter (relating to TxHmL Interest List), is earliest on the statewide interest list for the TxHmL Program as maintained by HHSC;

(2) whose name is not coded in the HHSC data system as having been determined ineligible for the TxHmL Program and who is receiving services from the LIDDA that are funded by general revenue in an amount that would allow HHSC to fund the services through the TxHmL Program; or

(3) who is a member of a target group identified in the approved TxHmL waiver application.

(b) Except as provided in subsection (c) of this section, a LIDDA must offer enrollment in the TxHmL 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 TxHmL Program to an applicant described in subsection (a)(2) or (3) 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 TxHmL 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 TxHmL Program, the LIDDA terminates those services that are similar to services provided in the TxHmL 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 TxHmL 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 a 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 TxHmL 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 TxHmL Program or the ICF/IID Program.

(f) A LIDDA must withdraw an offer of enrollment in the TxHmL 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 TxHmL 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 of the TxHmL Program;

(3) within 30 calendar days after the applicant or LAR receives the contact information regarding all available program providers in the LIDDA’s local service area in accordance with subsection (k)(2)(A) of this section, the applicant or LAR does not document a 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 TxHmL 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 declines the offer of enrollment in the TxHmL Program, the LIDDA must terminate those services that are similar to services provided in the TxHmL 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) 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;

(3) the HHSC Deadline Notification form; and

(4) any correspondence related to the offer of enrollment in the TxHmL Program.

(k) If an applicant or LAR accepts the offer of enrollment in the TxHmL Program, the LIDDA must compile and maintain information necessary to process the applicant's request for enrollment in the TxHmL Program.

(1) The LIDDA must complete an ID/RC Assessment in accordance with §262.104(a)(1) of this subchapter (relating to LOC Determination).

(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 §262.105 of this subchapter (relating to LON Assignment).

(C) The LIDDA must enter the information from the completed ID/RC Assessment in the HHSC data system and electronically submit the information to HHSC in accordance with §262.104(a)(2) of this subchapter and §262.105(a) of this subchapter and submit supporting documentation as required by §262.106 of this subchapter (relating to HHSC Review of LON).

(2) The LIDDA must:

(A) provide names and contact information to the applicant or LAR for all program providers in the LIDDA's local service area;

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

(C) 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 and retained by the LIDDA in the applicant's record.

(3) The LIDDA must assign a service coordinator who, together with other members of the service planning team, must:

(A) develop a PDP; and

(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.

(4) The CFC PAS/HAB assessment form required by paragraph (3)(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.

(l) A service coordinator must:

(1) in accordance with 40 TAC Chapter 41, Subchapter D (relating to Enrollment, Transfer, Suspension, and Termination):

(A) inform the applicant or LAR of the applicant's right to participate in the CDS option; and

(B) inform the applicant or LAR that the applicant or LAR may choose to have one or more services provided through the CDS option, as described in 40 TAC §41.108 (relating to Services Available Through the CDS Option); and

(2) if the applicant or LAR chooses to participate in the CDS option, comply with §262.701(r) of this chapter (relating to LIDDA Requirements for Providing Service Coordination in the TxHmL Program).

(m) The service coordinator must develop an initial IPC with the applicant or LAR based on the PDP and in accordance with §262.301 of this chapter (relating to IPC Requirements).

(n) If an applicant or LAR chooses to receive a TxHmL Program service or CFC service provided by a program provider, the service coordinator must review the initial IPC with potential program providers as requested by the applicant or the LAR.

(o) A service coordinator must:

(1) 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 initial 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;

(2) if an applicant or LAR refuses to include a sufficient number of RN nursing units on the initial IPC for the program provider's RN to perform a comprehensive nursing assessment as required by paragraph (1) 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 community support, day habilitation, employment assistance, supported employment, respite, or CFC PAS/HAB from the program provider, will result in the applicant not receiving the 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;

(3) 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;

(4) ensure that the applicant or LAR signs and dates the initial IPC in person, electronically, by fax, or by United States mail;

(5) ensure that the selected program provider signs and dates the initial IPC, demonstrating agreement that the services will be provided to the applicant; and

(6) sign and date the initial IPC to demonstrate that the service coordinator agrees that the requirements described in §262.301(c) of this chapter have been met.

(p) A service coordinator must:

(1) provide an oral and written explanation to the applicant or LAR of the following information using the HHSC Understanding Program Eligibility and Services form, which is available on the HHSC website:

(A) the eligibility requirements for TxHmL Program services as described in §262.101(a) of this subchapter (relating to Eligibility Criteria for TxHmL Program Services and CFC Services); and

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

(i) the eligibility requirements for CFC services as described in §262.101(b) of this subchapter to applicants who do not receive MAO Medicaid; and

(ii) the eligibility requirements for CFC services as described in §262.101(c) of this subchapter to applicants who receive MAO Medicaid; and

(2) provide an oral and written explanation to the applicant or LAR of:

(A) the reasons TxHmL Program services may be terminated as described in §262.507 of this chapter (relating to Termination of TxHmL Program Services and CFC Services with Advance Notice) and §262.508 of this chapter (relating to Termination of TxHmL Program Services and CFC Services without Advance Notice); and

(B) if the applicant's PDP includes CFC services, the reasons CFC services may be terminated as described in §262.507 and §262.508 of this chapter.

(q) After an initial IPC is finalized and signed in accordance with subsection (o) of this section, the LIDDA must:

(1) enter the information from the initial IPC in the HHSC data system and electronically submit the information 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;

(r) 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. If the enrollment is approved, HHSC authorizes the applicant's enrollment in the TxHmL 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 TxHmL Program.

(s) The selected program provider and the individual or LAR must develop:

(1) an implementation plan for:

(A) TxHmL Program services, except for community support, that is based on the individual's PDP and initial 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 community support is included on the PDP.

(t) Before the applicant's service begin date, a 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 IPC;

(4) the applicant's PDP; and

(5) if CFC PAS/HAB is included on the PDP, a copy of the completed HHSC HCS/TxHmL CFC PAS/HAB Assessment form.

(u) In accordance with §262.401(a)(5)(N) of this chapter (relating to Program Provider Reimbursement), if a selected program provider provides services before the date of an applicant’s enrollment into the TxHmL Program, HHSC does not pay the program provider for the services.

§262.104. 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 TxHmL 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 in accordance with paragraph (2) of this subsection 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 LIDDA 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 LIDDA 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 TxHmL Program waiver application approved by CMS; and

(ii) is signed and dated 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 to HHSC.

(2) A LIDDA must:

(A) 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;

(B) within three calendar days after entering the information in the HHSC data system and electronically submitting the information to HHSC, provide the program provider 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 LIDDA enters information from a completed ID/RC Assessment in the HHSC data system and electronically submits the information to HHSC on a date that is more than 180 calendar days after the expiration date of the previous ID/RC Assessment, the LIDDA 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 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 program provider 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) 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 LIDDA must maintain the signed and dated ID/RC Assessment and documentation supporting the recommended LOC in an applicant's or individual's record.

(d) 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 §262.101(a)(2) of this subchapter (relating to Eligibility Criteria for TxHmL Program Services and CFC Services).

(e) 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 TxHmL Program services or CFC services and provides the applicant, individual, or LAR with an opportunity to request a fair hearing in accordance with §262.601 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.

(f) 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.

(g) 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.

§262.105. LON Assignment.

(a) A LIDDA must request that HHSC assign an LON for an applicant or individual by entering the information from the completed ID/RC Assessment in the HHSC data system and electronically submitting the information to HHSC that includes the recommended LON and, as appropriate, submitting supporting documentation in accordance with §262.106(b) of this subchapter (relating to HHSC Review of LON). The electronically submitted ID/RC Assessment must contain information identical to the information on the signed and dated ID/RC Assessment.

(b) A LIDDA must, in accordance with §262.106(a) of this subchapter, submit supporting documentation to HHSC as requested by HHSC for a review of a recommended or assigned LON.

(c) A LIDDA must maintain the applicant's or individual's ICAP assessment booklet supporting the recommended LON in the applicant's or individual's record and other documentation supporting the requested LON, including:

(1) the individual's PDP, including the deliberations and conclusions of the applicant's or individual's service planning team;

(2) assessments and interventions by qualified professionals; and

(3) behavior support plans.

(d) If a pervasive plus LON (LON 9) is recommended, a LIDDA must maintain documentation that proves:

(1) the applicant or individual exhibits extremely dangerous behavior that could be life threatening to the applicant or 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 extremely dangerous behavior occurs;

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

(4) the person supervising the individual has no other duties or activities during the period of supervision; and

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

(e) HHSC assigns an LON for an individual based on the individual's ICAP service level score, information reported on the individual's ID/RC Assessment, and required supporting documentation.

(f) A LIDDA must submit documentation supporting a recommended LON to HHSC in accordance with HHSC instructions regarding LON packet submission available on the HHSC website.

(g) 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, an 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 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.

(i) 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.

(j) A service coordinator must conduct an ICAP assessment in accordance with this subsection.

(1) A service coordinator 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 service coordinator must submit a completed ID/RC Assessment to HHSC recommending a revision of the individual's LON assignment.

(k) A LIDDA must retain in the individual's record results and recommendations of individualized assessments and other pertinent records documenting the recommended LON assignment.

§262.106. 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, a LIDDA must submit documentation supporting the LON to HHSC in accordance with HHSC's request. Based on its review, HHSC may modify an LON.

(b) Documentation supporting a recommended LON must be submitted by the LIDDA and received by HHSC within seven calendar days after the LIDDA has entered the information from the completed ID/RC Assessment in the HHSC data system and electronically submitted the information to HHSC.

(c) Within 21 calendar days after receiving the supporting documentation, HHSC:

(1) requests additional documentation;

(2) electronically approves the recommended LON and establishes the effective date; or

(3) sends written notification that the recommended LON has been denied.

(d) HHSC reviews any additional documentation submitted in accordance with HHSC request and electronically approves the recommended LON or sends written notification to the LIDDA that the recommended LON has been denied.

§262.107. Reconsideration of LON Assignment.

(a) A LIDDA may request that HHSC reconsider an LON assignment.

(b) A LIDDA may receive reconsideration only if the LIDDA submitted documentation supporting the recommended LON as required by §262.106(b) of this subchapter (relating to HHSC Review of LON).

(c) To request reconsideration of an LON assignment, the LIDDA 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 LIDDA may send HHSC documentation, in addition to that required by §262.106(b) 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 service coordinator.

TITLE 26 HEALTH AND HUMAN SERVICES
PART 1 HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 262 TEXAS HOME LIVING (TxHmL) PROGRAM AND COMMUNITY FIRST CHOICE (CFC)
SUBCHAPTER C PERSON-CENTERED PLANNING AND SERVICE SETTINGS

§262.201. 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 TxHmL 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.

§262.202. Requirements for Service Settings.

(a) A program provider must ensure that a setting in which an individual receives a TxHmL 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 TxHmL 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 instituition 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 a TxHmL 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.

TITLE 26 HEALTH AND HUMAN SERVICES
PART 1 HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 262 TEXAS HOME LIVING (TxHmL) PROGRAM AND COMMUNITY FIRST CHOICE (CFC)
SUBCHAPTER D DEVELOPMENT AND REVIEW OF AN IPC

§262.301. IPC Requirements.

(a) An IPC must be based on the PDP and specify:

(1) the type and amount of each TxHmL Program service and CFC service to be provided to the individual during an IPC year;

(2) the services and supports to be provided to the individual through resources other than TxHmL 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 TxHmL 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 TxHmL 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 TxHmL *Program Billing Requirements;* and

(B) be within the service limit described in §262.304 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 *TxHmL 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 *TxHmL Program Billing Requirements;*

(9) if dental treatment, must be within the service limit described in §262.304 of this subchapter; and

(10) if CFC PAS/HAB, must be supported by the HHSC HCS/TxHmL CFC PAS/HAB Assessment form.

§262.302. Renewal and Revision of an Individual's IPC

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

(1) At least 30 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 with the service planning team to:

(i) review and update the individual's PDP and develop a renewal IPC; 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;

(C) ensure the individual or LAR signs the finalized PDP; and

(D) use the HHSC Understanding Program Eligibility and Services form to provide an individual or LAR both an oral and a written explanation of:

(i) the eligibility requirements for the TxHmL Program as described in §262.101(a) of this chapter (relating to Eligibility Criteria for TxHmL Program Services and CFC Services);

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

(I) the eligibility requirements for CFC services as described in §262.101(b) of this chapter to individuals who do not receive MAO Medicaid; and

(II) the eligibility requirements for CFC services as described in §262.101(c) of this chapter to individuals who receive MAO Medicaid;

(iii) all TxHmL Program services as described in §262.5 of this chapter (relating to Description of TxHmL Program Services) and all CFC services as described in §262.6 of this chapter (relating to Description of CFC Services);

(iv) the reasons TxHmL Program services may be terminated as described in §262.507 of this chapter (relating to Termination of TxHmL Program Services and CFC Services with Advance Notice) and §262.508 of this chapter (relating to Termination of TxHmL Program Services and CFC Services without advance notice) or suspended as described in §262.505 of this chapter (relating to Suspension of TxHmL Program Services and CFC Services); and

(v) if the individual's PDP includes CFC services, the reasons CFC services may be terminated as described §262.507 of this chapter and §262.508 of this chapter or suspended as described in §262.505 of this chapter.

(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 must convene a meeting with the service planning team to develop a revised IPC and update the PDP if:

(A) a new service is being added to or a current service is being removed from the IPC; or

(B) 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.

(4) The service coordinator must ensure that the updated finalized PDP is signed by the individual or LAR.

(5) If the amount of an existing service on an IPC is being increased or decreased or a requisition fee is added or removed and the addition of, removal of, or a change to an outcome in the PDP is not required, the service coordinator is not required to convene a meeting with the service planning team to develop a revised IPC, but must document the reasons for the revised IPC.

(6) A service coordinator 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) ensure that the program provider signs and dates the renewal or revised IPC demonstrating agreement that the services will be provided to the individual;

(D) 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;

(E) ensure that the information entered in the HHSC data system and electronically submitted to HHSC is identical to the information on 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.

(7) 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;

(B) the renewal or revised IPC; and

(C) if CFC PAS/HAB is included on the PDP, the completed HHSC HCS/TxHmL CFC PAS/HAB Assessment form.

(8) The program provider must convene a meeting with the individual or LAR to develop, before the effective date of the renewal IPC or revised IPC:

(A) an implementation plan for:

(i) TxHmL Program services, except for community support, 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 or revised 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 community support is included on the PDP.

(b) If an individual or LAR requests support management during an IPC year, the service coordinator must revise the IPC as described in subsection (a)(3) of this section.

§262.303. HHSC Review of an IPC.

(a) HHSC may review an IPC to determine if:

(1) the type and amount of TxHmL Program services and CFC services specified in the IPC meet the requirements described in §262.301 of this subchapter (relating to IPC Requirements); and

(2) the IPC exceeds the cost limit as described in §262.101(a)(4) of this chapter (relating to Eligibility Criteria for TxHmL Program Services and CFC Services).

(b) If requested by HHSC for an IPC review described in subsection (a) of this section, a LIDDA must submit documentation supporting the IPC to HHSC.

(c) Based on a review of an IPC, HHSC may deny or reduce an TxHmL Program service or a CFC service in accordance with §262.504 of this chapter (relating to Denial of TxHmL Program Services or CFC Services) and §262.506 of this chapter (relating to Reduction of TxHmL Program Services or CFC Services).

§262.304. Service Limits.

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

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

(2) for dental treatment, $1,000 during an IPC year;

(3) for minor home modifications:

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

(B) a maximum of $300 for repair and maintenance during the IPC year; and

(4) for day habilitation and in-home day habilitation combined, 260 units during an IPC year.

(b) A program provider may request, in accordance with the *TxHmL Program Billing Requirements,* authorization of a requisition fee:

(1) for an adaptive aid that is in addition to the $10,000 service limit described in subsection (a)(1) of this section;

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

(3) 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 262 TEXAS HOME LIVING (TxHmL) PROGRAM AND COMMUNITY FIRST CHOICE (CFC)
SUBCHAPTER E REIMBURSEMENT BY HHSC

§262.401. Program Provider Reimbursement.

(a) Program provider reimbursement.

(1) HHSC pays a program provider for services as described in this paragraph.

(A) HHSC pays for community support, nursing, in-home respite, respite, day habilitation, in-home day habilitation, employment assistance, supported employment, professional therapies, and CFC PAS/HAB in accordance with the reimbursement rate for the specific service.

(B) HHSC pays for adaptive aids, minor home modifications, and dental treatment based on the actual cost of the item or service and, if requested, a requisition fee in accordance with the TxHmL Program Billing Requirements available on the HHSC website.

(C) 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 TxHmL Program Billing Requirements or the CFC Billing Requirements for HCS and TxHmL Program Providers.

(3) If an individual's TxHmL 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 the program provider may submit a claim for a service provided on the first calendar day of the suspension or termination.

(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 TxHmL Program Billing Requirements and other documentation as required by the TxHmL Program Billing Requirements.

(5) HHSC does not pay a program provider for a service or recoups any payments made to the program provider for a service if:

(A) the individual receiving the service was, at the time the service was provided, ineligible for the TxHmL Program or Medicaid benefits, or was an inpatient of a hospital, nursing facility, or ICF/IID;

(B) the service was not included on the signed and dated IPC of the individual in effect at the time the service was provided;

(C) the service was not provided in accordance with the TxHmL Program Billing Requirements or the CFC Billing Requirements for HCS and TxHmL Program Providers;

(D) the service was not documented in accordance with the TxHmL Program Billing Requirements or the CFC Billing Requirements for HCS and TxHmL Program Providers;

(E) the program provider does not comply with 40 TAC §49.305 (relating to Records);

(F) the claim for the service was not prepared and submitted in accordance with the TxHmL Program Billing Requirements or the CFC Billing Requirements Guidelines for HCS and TxHmL Program Providers;

(G) the program provider does not have the documentation described in subsection(a)(4) of this section;

(H) 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, as amended (29 U.S.C. §701 et seq.) or under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.);

(I) 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.);

(J) HHSC determines that the service would have been paid for by a source other than the TxHmL Program;

(K) the service was provided by a service provider who did not meet the qualifications to provide the service as described in the TxHmL Program Billing Requirements or the CFC Billing Requirements for HCS and TxHmL Program Providers;

(L) the service was not provided in accordance with a signed and dated IPC meeting the requirements set forth in §262.301 of this subchapter (relating to IPC Requirements);

(M) the service was not provided in accordance with the PDP or the implementation plan;

(N) the service was provided before the individual's date of enrollment into the TxHmL Program;

(O) for community support, the service is not provided in accordance with a transportation plan and §262.5(a)(16) of this chapter (relating to Description of TxHmL Program Services);

(P) the service was not provided; or

(Q) for CFC PAS/HAB, in-home day habilitation, and in-home respite, if the service claim for the service 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 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 subsection, if HHSC approves an LOC requested in accordance with §262.104(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 an ID/RC Assessment was submitted more than 180 calendar days after the expiration date of the previous ID/RC Assessment because of circumstances beyond a program provider’s control, HHSC may pay the program provider for a period of more than 180 calendar days after the individual’s previous ID/RC Assessment expires.

(9) HHSC does not withhold payments to a program provider if a LIDDA fails to enter information from an individual's renewal IPC and the program provider continues to provide services in accordance with the most recent IPC authorized by HHSC.

(b) Provider fiscal compliance reviews.

(1) HHSC conducts provider fiscal compliance reviews to determine a program provider is in compliance with:

(A) this chapter;

(B) the TxHmL Program Billing Requirements;

(C) the CFC Billing Requirements for HCS and TxHmL Program Providers;

(D) 40 TAC Chapter 49, Subchapter C; and

(E) the program provider's Community Services Contract-Provider Agreement.

(2) HHSC conducts provider fiscal compliance reviews in accordance with the Provider Fiscal Compliance Review Protocol set forth in the TxHmL 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.

(3) A corrective action plan required by HHSC in accordance with paragraph (2)(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.

(4) Within 30 calendar days after HHSC receives a corrective action plan, HHSC notifies the program provider if HHSC approved the corrective action plan or if the plan requires changes.

(5) If HHSC requires a program provider to develop and submit a corrective action plan in accordance with paragraph (2)(B) of this subsection and the program provider requests an administrative hearing for the recoupment in accordance with §262.602 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.

(6) If a program provider does not submit a corrective action plan or complete a required corrective action within the time frames described in paragraph (3) of this subsection, HHSC may impose a vendor hold on payments due to the program provider until the program provider takes the corrective action.

(7) 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 (6) of this subsection, HHSC may terminate the contract.

TITLE 26	HEALTH AND HUMAN SERVICES
PART 1	HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 262	TEXAS HOME LIVING (TxHmL) PROGRAM AND COMMUNITY FIRST CHOICE (CFC)
SUBCHAPTER F	TRANSFERS, DENIALS, SUSPENSIONS, REDUCTION AND TERMINATION

§262.501. 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 TxHmL 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 Assessment, 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 assessment booklet and computer scoring 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) 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 TxHmL 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.

§262.502. 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 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 FMSA.

(c) On or before the transfer effective date, the service coordinator must:

(1) take action to complete HHSC Request for Transfer of Waiver Program Services form in accordance with the TxHmL 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 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 TxHmL 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.

§262.503. Denial of a Request for Enrollment into the TxHmL Program.

(a) HHSC denies an individual's request for enrollment into the TxHmL Program if the individual does not meet the eligibility criteria described in §262.101 of this chapter (relating to Eligibility Criteria for TxHmL 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 TxHmL Program and includes in the notice the individual's right to request a fair hearing in accordance with §262.601 of this chapter (relating to Fair Hearing).

(c) HHSC sends a copy of the written notice to the individual's service coordinator and the program provider.

§262.504. Denial of TxHmL Program Services or CFC Services.

(a) HHSC denies a TxHmL Program service or CFC service on an individual's IPC, based on a review described in §262.303 of this chapter (relating to HHSC Review of an IPC) or §262.302 of this chapter (relating to Renewal and Revision of an Individual's IPC), if HHSC determines that the TxHmL Program service or CFC service does not meet the requirements described in §262.301(c) of this chapter (relating to IPC Requirements).

(b) If HHSC denies a TxHmL 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 §262.601 of this chapter (relating to Fair Hearing).

(c) HHSC sends a copy of the written notice to the individual's service coordinator and the program provider.

§262.505. Suspension of TxHmL Program Services and CFC Services.

(a) HHSC suspends an individual's TxHmL Program services or 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 assisted living facility licensed in accordance with Texas Health and Safety Code Chapter 247, Assisted Living Facilities;

(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 TxHmL Program services and CFC services in the HHSC data system.

(d) If a program provider enters a suspension of the individual's TxHmL 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 TxHmL 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 TxHmL 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.

§262.506. Reduction of TxHmL Program Services or CFC Services.

(a) HHSC proposes a reduction of a TxHmL Program service or CFC service on an individual's IPC, based on a review described in §262.303 of this chapter (relating to HHSC Review of an IPC) or §262.302 of this chapter (relating to Renewal and Revision of an Individual's IPC), if HHSC determines that the TxHmL Program service or CFC service does not meet the requirements described in §262.301(c) of this chapter (relating to IPC Requirements).

(b) If HHSC proposes a reduction of a TxHmL 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 §262.601 of this chapter (relating to 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 a TxHmL 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 a TxHmL Program service or CFC service, HHSC modifies the IPC in the HHSC data system.

§262.507. Termination of TxHmL Program Services and CFC Services with Advance Notice.

(a) HHSC terminates an individual's TxHmL Program services and CFC services if:

(1) the individual does not meet the eligibility criteria described in §262.101(a)(1) – (7) and (c) of this chapter (relating to Eligibility Criteria for TxHmL Program Services and CFC Services); or

(2) the individual or LAR refuses to cooperate in the provision or planning of services and:

(A) the refusal is documented by the program provider and the service coordinator; and

(B) the service coordinator has explained to the individual or LAR, in writing, that the refusal may result in termination of TxHmL 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 the basis of a service coordinator’s request to terminate the individual’s services is the reason described in subsection (a)(2) of this section, the service coordinator must include the following information with the completed HHSC Request for Termination of Services form submitted to HHSC:

(1) a detailed description of how the individual or LAR refused to cooperate in the provision or planning of services;

(2) a copy of the documentation of the refusal by the service coordinator and program provider as required by subsection (a)(2)(A) of this section; and

(3) a copy of the written explanation provided to the individual or LAR that the refusal may result in termination of TxHmL Program services and CFC services, as required by subsection (a)(2)(B) of this section.

(d) If HHSC receives a completed HHSC Request for Termination of Services form and, if required, the information described in subsection (b) of this section from a service coordinator, HHSC reviews the form and the information. If HHSC approves the request, HHSC sends written notice to the individual or LAR of the proposal to terminate TxHmL Program services and CFC services. The notice includes the individual's right to request a fair hearing in accordance with §262.601 of this chapter (relating to Fair Hearing).

(e) If the individual or LAR requests a fair hearing before the effective date of the termination of TxHmL 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

§262.508. Termination of TxHmL Program Services and CFC Services without Advance Notice.

(a) HHSC terminates an individual's TxHmL Program services and CFC services if any of the following situations exists:

(1) the individual is admitted to one of the facilities listed in §262.505(a)(1) - (9) of this subchapter (relating to Suspension of TxHmL 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 §262.505(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 TxHmL 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 TxHmL Program services and CFC services. The notice includes the individual's right to request a fair hearing in accordance with §262.601 of this chapter (relating to Fair Hearing).

TITLE 26 HEALTH AND HUMAN SERVICES
PART 1 HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 262 TEXAS HOME LIVING (TxHmL) PROGRAM AND COMMUNITY FIRST CHOICE (CFC)
SUBCHAPTER G HEARINGS

§262.601. Fair Hearing.

An applicant whose request for eligibility for the TxHmL Program is denied or is not acted upon with reasonable promptness, or an individual whose TxHmL 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).

§262.602. Program Provider's Right to Administrative Hearing.

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.

TITLE 26 HEALTH AND HUMAN SERVICES
PART 1 HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 262 TEXAS HOME LIVING (TxHmL) PROGRAM AND COMMUNITY FIRST CHOICE (CFC)
SUBCHAPTER H LIDDA REQUIREMENTS

§262.701. LIDDA Requirements for Providing Service Coordination in the TxHmL Program.

(a) A LIDDA must offer TxHmL Program services to an applicant in accordance with §262.103 of this chapter (relating to Process for Enrollment of Applicants).

(b) A LIDDA must process enrollments of individuals in the TxHmL Program in accordance with §262.103 of this chapter.

(c) A LIDDA must be objective in the process to assist an individual or LAR in the selection of a program provider or FMSA and train all LIDDA staff who may assist an individual or LAR in the process.

(d) A LIDDA must, upon the enrollment of an individual and annually thereafter, inform the individual or LAR orally and in writing of the following:

(1) the telephone number of the LIDDA to file a complaint;

(2) the toll-free telephone number of the HHSC IDD Ombudsman, 1-800-252-8154, to file a complaint; and

(3) the toll-free telephone number of DFPS, 1-800-647-7418, to report an allegation of abuse, neglect, or exploitation.

(e) A LIDDA must maintain for each individual for an IPC year:

(1) a copy of the IPC;

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

(3) a copy of the ID/RC Assessment;

(4) documentation of the activities performed by the service coordinator in providing service coordination; and

(5) any other pertinent information related to the individual.

(f) For an individual receiving TxHmL Program services and CFC services within a LIDDA's local service area, the LIDDA must provide the individual's program provider a copy of the individual's current PDP, IPC, and ID/RC Assessment.

(g) 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 (relating to Service Coordination for Individuals with an Intellectual Disability), except as described in paragraph (2) of this subsection.

(2) Notwithstanding 40 TAC §2.560(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 TxHmL Program and CFC; and

(B) 40 TAC Chapter 41 (relating to Consumer Directed Services Option).

(h) A LIDDA must ensure that a service coordinator:

(1) initiates, coordinates, and facilitates the person-centered planning process to meet the desires and needs as identified by an individual and LAR in the individual's PDP, including:

(A) scheduling service planning team meetings; and

(B) documenting on the PDP whether, for each TxHmL Program service or CFC service identified on the PDP, the service is critical to meeting the individual's health and safety as determined by the service planning team;

(2) coordinates the development and implementation of the individual's PDP;

(3) coordinates and develops an individual's IPC based on the individual's PDP;

(4) coordinates and monitors the delivery of TxHmL Program services and CFC services and non-TxHmL Program and non-CFC services; and

(5) document whether an individual progresses toward desired outcomes identified on the individual's PDP from the individual's and LAR's perspectives.

(i) A LIDDA must inform an individual or LAR of the name of the individual's service coordinator and how to contact the service coordinator.

(j) A service coordinator must:

(1) assist the individual or LAR or actively involved person in exercising the legal rights of the individual;

(2) provide an individual, LAR, or family member with a written copy of the booklet, *Your Rights in the Texas Home Living (TxHmL) Program*, available on the HHSC website, and an oral explanation of the rights described in the booklet:

(A) at the time the individual enrolls in the TxHmL Program;

(B) when the booklet is revised;

(C) upon request of the individual, LAR, or family member; 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 compliance with paragraph (2) of this subsection in the individual's record and include:

(A) the signature of the individual or LAR; and

(B) the signature of the service coordinator;

(4) ensure that the individual and LAR participate in developing a PDP and IPC that meet the individual's identified needs and service outcomes and that the individual's PDP is updated annually and if the individual's needs or outcomes change;

(5) if a behavioral support plan includes techniques that involve restriction of individual rights or intrusive techniques, discuss with the service planning team to determine whether the techniques will be approved by the service planning team;

(6) if notified by the program provider that an individual or LAR has refused a comprehensive nursing assessment and that the program provider has determined that it cannot ensure the individual's health, safety, and welfare in the provision of community support, day habilitation, in-home day habilitation, employment assistance, supported employment, respite, 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 not receiving:

(i) nursing services; or

(ii) community support, day habilitation, in-home day habilitation, employment assistance, supported employment, respite, or CFC PAS/HAB, if the individual needs one of those services and the program provider has determined that it cannot ensure the health, safety, and welfare 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;

(7) inform the individual or LAR of decisions regarding denial, suspension, reduction, or termination of services and the individual's or LAR's right to request a fair hearing as described in §262.601 of this chapter (relating to Fair Hearing); and

(8) in accordance with §262.501 (relating to Process for Individual to Transfer to a Different Program Provider or FMSA), manage the process to transfer an individual's TxHmL Program services and CFC services from one program provider to another or transfer from one FMSA to another.

(k) When a service coordinator becomes aware that a change to an individual's PDP or IPC may be needed, the service coordinator must discuss the need for the change with the individual or LAR, the individual's program provider, and other appropriate persons.

(l) At least 30 calendar days before the expiration of an individual's IPC, the service coordinator must:

(1) update the individual's PDP with the individual's service planning team; and

(2) if the individual receives a TxHmL Program service or a CFC service from a program provider, submit to the program provider and the individual or LAR:

(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.

(m) A service coordinator must:

(1) complete the HHSC TxHmL Service Coordination Notification form with the individual or LAR and provide a copy of the completed form to the individual or LAR:

(A) upon receipt of HHSC approval of the enrollment of the individual;

(B) if the form is revised;

(C) at the request of the individual or LAR; 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; and

(2) retain a copy of the completed form in the individual's record.

(n) A service coordinator must conduct:

(1) a pre-move site review for an applicant 21 years of age or older who is enrolling in the TxHmL Program from a nursing facility or as a diversion from admission to a nursing facility; and

(2) post-move monitoring visits for an individual 21 years of age or older who enrolled in the TxHmL Program from a nursing facility or has enrolled in the TxHmL Program as a diversion from admission to a nursing facility.

(o) A service coordinator must 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 a TxHmL Program service unless:

(1) the individual's TxHmL Program services have been suspended; or

(2) 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).

(p) 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 subchapter;

(B) 40 TAC Chapter 41; 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, as 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.

(q) A service coordinator must:

(1) at least annually, in accordance with 40 TAC Chapter 41, Subchapter D (relating to Enrollment, Transfer, Suspension, and Termination):

(A) inform the individual or LAR of the individual's right to participate in the CDS option; and

(B) inform the individual or LAR that the individual or LAR may choose to have one or more services provided through the CDS option, as described in 40 TAC §41.108 (relating to Services Available Through the CDS Option); and

(2) document compliance with paragraph (1) of this subsection in the individual's record.

(r) 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 of all FMSAs providing services in the LIDDA's local service area;

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

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

(4) develop with the individual or LAR and other members of the service planning team a transportation plan if an individual's PDP includes community support to be delivered through the CDS option.

(s) For an individual participating in the CDS option, a service coordinator must recommend that HHSC terminate the individual's participation in the CDS option 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, safety or welfare; or

(2) the individual, LAR or designated representative has not complied with 40 TAC Chapter 41, Subchapter B (relating to Responsibilities of Employers and Designated Representatives).

(t) To make a recommendation described in subsection (s) of this section, a service coordinator must submit the following documentation to HHSC:

(1) the services the individual receives through the CDS option;

(2) the reason why the recommendation is made;

(3) a description of the attempts to resolve the issues before making the recommendation; and

(4) any other supporting documentation, as appropriate.

(u) A service coordinator must do the following regarding responsibilities related to EVV:

(1) for an applicant who will receive a service that requires the use of EVV from the program provider or through the CDS option:

(A) orally explain the information in the HHSC Electronic Visit Verification Responsibilities and Additional Information form to the applicant or LAR;

(B) 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;

(C) provide the individual or LAR with a copy of the signed form;

(D) perform the activities described in subparagraph (A)-(C) of this paragraph before the individual's enrollment; and

(E) maintain the completed HHSC Electronic Visit Verification Responsibilities and Additional Information form in the individual's record;

(2) 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:

(A) orally explain the information in the HHSC Electronic Visit Verification Responsibilities and Additional Information form to the individual or LAR;

(B) 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;

(C) provide the individual or LAR with a copy of the signed form;

(D) perform the activities described in subparagraphs (A)--(C) of this paragraph on or before the effective date of the transfer to another program provider or LIDDA; and

(E) maintain the completed HHSC Electronic Visit Verification Responsibilities and Additional Information form in the individual's record; and

(3) 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:

(A) orally explain the information in the HHSC Electronic Visit Verification Responsibilities and Additional Information form to the individual or LAR;

(B) 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;

(C) provide the individual or LAR with a copy of the signed form;

(D) perform the activities described in subparagraphs (A)-(C) of this paragraph before the individual receives the EVV required service through the CDS option or on or before the effective date of the transfer to another FMSA; and

(E) maintain the completed HHSC Electronic Visit Verification Responsibilities and Additional Information form in the individual's record.

TITLE 26 HEALTH AND HUMAN SERVICES
PART 1 HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 262 TEXAS HOME LIVING (TxHmL) PROGRAM AND COMMUNITY FIRST CHOICE (CFC)
SUBCHAPTER I DECLARATION OF DISASTER

§262.801. 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 §262.3 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 §262.302(a)(8) of this chapter (relating to Renewal and Revision of an Individual's 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 §262.8(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 §262.103(k)(1)(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 §262.103(k)(1)(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 §262.302(a)(1)(C) and (a)(4) 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 §262.302(a)(1)(B) and (a)(3) 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.

(h) Notwithstanding §262.302(a)(6)(B) of this chapter, a service coordinator 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 §262.302(a)(1)(B) and (a)(3) of this chapter is conducted by videoconferencing or telephone;

(2) the service coordinator 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 service coordinator documents the individual's or LAR's oral agreement on the renewal or the revised IPC.

(i) Notwithstanding §262.304(a)(1) of this chapter (relating to Service Limits), the service limit for 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 TxHmL program services being exceeded as described in §262.101(a)(4) of this chapter (relating to Eligibility Criteria for TxHmL Program Services 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.

(j) Notwithstanding §262.304(a)(3) of this chapter, the service limit for 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 TxHmL program services being exceeded as described in §262.101(a)(4) 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.