Adopted rules include new rules, amendments to existing rules, and repeals of existing rules. A rule adopted by a state agency takes effect 20 days after the date on which it is filed with the Secretary of State unless a later date is required by statute or specified in the rule (Government Code, §2001.036). If a rule is adopted without change to the text of the proposed rule, then the *Texas Register* does not republish the rule text here. If a rule is adopted with change to the text of the proposed rule, then the final rule text is included here. The final rule text will appear in the Texas Administrative Code on the effective date.

TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 371. MEDICAID AND OTHER HEALTH AND HUMAN SERVICES FRAUD AND ABUSE PROGRAM INTEGRITY

SUBCHAPTER G. ADMINISTRATIVE ACTIONS AND SANCTIONS

DIVISION 3. ADMINISTRATIVE ACTIONS AND SANCTIONS

1 TAC §371.1721

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC), on behalf of the Office of Inspector General (OIG), adopts in the Texas Administrative Code (TAC), Title 1, Part 15, Chapter 371, Subchapter G, Division 3, new §371.1721, concerning Recoupment of Overpayments Identified by Inspection.

New §371.1721 is adopted without changes to the proposed text as published in the June 14, 2024, issue of the *Texas Register* (49 TexReg 4119). This rule will not be republished.

BACKGROUND AND JUSTIFICATION

New §371.1721 describes OIG's inspection procedures related to records requests, inspection processes, notices, final reports, and due process.

Texas Government Code §531.102 authorizes OIG to conduct inspections related to the provision and delivery of all health and human services in Texas to identify fraud, waste, or abuse.

COMMENTS

The 31-day comment period ended July 15, 2024.

During this period, OIG received comments regarding the proposed rule from seven commenters: Texas Academy of Pediatric Dentistry, Texas Medical Association, Texas Hospital Association, Texas Organization of Rural and Community Hospitals, Teaching Hospitals of Texas, Children's Hospital Association of Texas, and Texas Association for Home Care & Hospice. A summary of comments relating to §371.1721 and OIG's responses follow.

Comment: One commenter expressed concern that there is no express statutory authority for OIG to recover overpayments identified by inspections. The commenter asserted that recovering overpayments through an inspection versus an investigation would circumvent the Legislative intent of Senate Bill (S.B.) 1803, 83rd Legislature, Regular Session, 2013 and S.B. 207, 84th Legislature, Regular Session, 2015. Additionally, the commenter stated that OIG lacks implied authority to recover overpayments identified by inspection because recovering overpayments is (1) not necessary to carry out the express responsibilities given to OIG by the Legislature and (2) inconsistent with Texas Government Code Chapter 531 Subchapter C's general statutory objective. Further, the commenter stated that the recovery of overpayments identified by inspections is not necessary for OIG to carry out its responsibilities relating to preventing, detecting, and taking enforcement against fraud, waste, and abuse in the state's health and human services programs because the Legislature has already established a statutory framework for OIG to recover overpayments, and that framework contemplates recoveries identified by investigation. The commenter further asserted that the provisions of Subchapter C balance the OIG's enforcement efforts with due process and other protections for providers, but these protections and due process are contemplated in the context of an investigation, which is the only method of overpayment recovery expressly discussed in Subchapter C. Additionally, the commenter stated that the proposed rule does not contain these protections and due process, and is not in harmony with the general objectives of Subchapter C, and, therefore, exceed OIG's rulemaking authority. The commenter recommends that the proposed rules be amended to remove the provisions addressing the recovery of overpayments identified by inspections.

Response: OIG declines to revise the rule in response to these comments. Texas Government Code §531.102(a) grants OIG responsibility for the prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse in the provision and delivery of all health and human services in the state and the enforcement of state law relating to the provision of those services. The Legislature chooses statutory words and phrases deliberately and purposefully. Audits, inspections, reviews, and investigations are different types of examinations OIG is expressly authorized by the Legislature to perform. Each of these types of examinations include the opportunity to detect health and human services payments made to persons or providers to which they were not entitled. Recovery of overpayments prevents fraud, waste, and abuse by recovering misspent state and federal dollars so they may be spent appropriately to care for persons in need and by deterring persons inclined to commit fraud, waste, and abuse.

When the Legislature expressly grants power to an agency, it also implicitly intends that the agency have the authority reasonably necessary to accomplish its express responsibilities. The Legislature's express statutory authority related to one type of examination (investigation) does not limit implied powers that are reasonably necessary to carry out other express responsibilities given by the Legislature to OIG. When OIG detects an overpay-

ment during an inspection of a healthcare provider, the recovery of the overpayment fulfills the Legislature's mandate to prevent fraud, waste, and abuse.

HHSC's rulemaking authority is broad. Texas Government Code §531.033 requires the Executive Commissioner to adopt rules necessary to carry out the commission's duties under Chapter 531. Texas Government Code §531.0055(e) and Texas Human Resources Code §32.021 and §32.032 provide the HHSC Executive Commissioner with rulemaking authority for the operation of health and human services in Texas. Texas Human Resources Code §32.021 gives the HHSC Executive Commissioner authority to adopt necessary rules for the proper and efficient operation of the Medicaid program. Texas Human Resources Code §32.032 requires the HHSC Executive Commissioner to adopt reasonable rules for minimizing the opportunity for fraud and abuse and for establishing and maintaining methods for detecting and identifying situations in which a question of fraud or abuse in the program may exist.

Additionally, Texas Government Code §531.1131(c-2) states, in part, that if OIG discovers fraud, waste, or abuse in the performance of its duties, OIG may recover payments made as a result of the fraud, waste, or abuse as otherwise provided by Texas Government Code, Chapter 531, Subchapter C. Section 531.1131(e) requires the Executive Commissioner to adopt rules necessary to implement §531.1131. OIG's statutory duties under Texas Government Code §531.102(a) include conducting inspections and preventing and detecting fraud, waste, and abuse.

Senate Bill 1803 was passed in 2013 at a time when OIG did not conduct inspections. Similarly, S.B. 207, passed in 2015, focused largely on implementing the recommendations of the Sunset Advisory Commission review, which was conducted at a time when OIG did not perform inspections. Additionally, much of S.B. 1803 and S.B. 207 focused on protections related to an OIG payment hold, a different process than recovery of an overpayment.

Further, Title 42 United States Code (U.S.C.) §1396a(a)(30), in part, requires HHSC to have a State plan for Medicaid that provides methods and procedures relating to the utilization of, and payment for, care and services available under the plan as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care. Title 42 Code of Federal Regulations (C.F.R.) §456.3 requires the Medicaid state agency to implement a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments. HHSC's Medicaid State Plan states, in part, that HHSC has implemented a statewide program of surveillance and utilization control that safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments.

New §371.1721 implements a method for detecting and identifying fraud, waste, and abuse, increases the efficiency of the Medicaid program by recovering payments to which a person or provider was not entitled, and minimizes the opportunity for fraud, waste, and abuse by deterring bad actors. The Statutory Authority section of this Adoption Preamble describes additional statutory authority and HHSC rulemaking authority for §371.1721.

Comment: Four commenters stated that new §371.1721 appears to extend beyond OIG's statutory authority. The commenters asserted that OIG's authority under Texas Government Code §531.102(a) and Texas Administrative Code (TAC) §371.11 limit OIG inspections to the inspection of fraud, waste, and abuse and would not include overpayments caused by error, such as billing or payment errors, or misunderstanding. The commenters stated that §371.1721 should be revised to define inspections in a way that limits inspections to fraud, waste, and abuse and to not include any overpayment allegation arising outside of fraud, waste, or abuse. Additionally, the commenters asserted that §371.1721 is improper because an inspection is not bounded by OIG's limited statutory authority to police fraud, waste, and abuse.

Response: OIG declines to revise the rule in response to these comments. Texas Government Code §531.102(a) grants OIG responsibility for the prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse in the provision and delivery of all health and human services in the state and the enforcement of state law relating to the provision of those services. The Legislature chooses statutory words and phrases deliberately and purposefully. Audits, inspections, reviews, and investigations are different types of examinations that OIG is expressly authorized by the Legislature to perform. Each of these types of examinations include the opportunity to detect health and human services payments made to persons or providers to which they were not entitled. Recovery of overpayments prevents fraud, waste, and abuse by recovering misspent state and federal dollars so they may be spent appropriately to care for persons in need and by deterring persons inclined to commit fraud, waste, and abuse.

When the Legislature expressly grants power to an agency, it also implicitly intends that the agency have the authority reasonably necessary to accomplish its express responsibilities. When OIG detects an overpayment during an inspection of a healthcare provider, the recovery of the overpayment fulfills the Legislature's mandate to prevent fraud, waste, and abuse.

HHSC's rulemaking authority is broad. Texas Government Code §531.033 requires the Executive Commissioner to adopt rules necessary to carry out the commission's duties under Chapter 531. Texas Government Code §531.0055(e) and Texas Human Resources Code §32.021 and §32.032 provide the HHSC Executive Commissioner with rulemaking authority for the operation of health and human services in Texas. Texas Human Resources Code §32.021 gives the HHSC Executive Commissioner authority to adopt necessary rules for the proper and efficient operation of the Medicaid program. Texas Human Resources Code §32.032 requires the HHSC Executive Commissioner to adopt reasonable rules for minimizing the opportunity for fraud and abuse and for establishing and maintaining methods for detecting and identifying situations in which a question of fraud or abuse in the program may exist.

Additionally, Texas Government Code §531.1131(c-2) states, in part, that if OIG discovers fraud, waste, or abuse in the performance of its duties, OIG may recover payments made as a result of the fraud, waste, or abuse as otherwise provided by Texas Government Code, Chapter 531, Subchapter C. Section 531.1131(e) requires the Executive Commissioner to adopt rules necessary to implement §531.1131. OIG's statutory duties under Texas Government Code §531.102(a) include conducting inspections and preventing and detecting fraud, waste, and abuse.

Further, 42 U.S.C. §1396a(a)(30), in part, requires HHSC to have a State plan for Medicaid that provides methods and procedures relating to the utilization of, and payment for, care and services available under the plan as may be necessary to safeguard

against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care. Title 42 C.F.R. §456.3 requires the Medicaid state agency to implement a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments. HHSC's Medicaid State Plan states, in part, that HHSC has implemented a statewide program of surveillance and utilization control that safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments.

Title 42 C.F.R §433.304, §438.2, and 1 TAC §371.1(55) define "overpayment" without any relationship to, or confinement within, the terms fraud, waste, and abuse. A search for fraud, waste, or abuse in Medicaid may lead to a payment made to a person to which the person was not entitled under Medicaid - an overpayment.

New §371.1721 implements a method for detecting and identifying fraud, waste, and abuse, increases the efficiency of the Medicaid program by recovering payments to which a person or provider was not entitled, and minimizes the opportunity for fraud, waste, and abuse by deterring bad actors. The Statutory Authority section of this Adoption Preamble describes additional statutory authority and HHSC rulemaking authority for §371.1721.

Comment: Four commenters asserted that OIG's statutory authority for inspections for fraud, waste, and abuse does not encompass alleged overpayment determinations arising from contractual agreements between managed care organizations (MCOs) and providers that use different payment models, methodologies or rates than Medicaid fee-for-service. The commenters stated that use of new §371.1721 to recover overpayments made by an MCO to a provider based on a negotiated contract methodology would be beyond OIG's statutory authority, be inconsistent with federal regulations, case law, and Texas Medicaid authorities, and, absent a showing of fraud, waste, or abuse, constitute a prohibited constitutional taking and a violation of the Contracts Clause under the United States and Texas constitutions. The commenters stated that OIG's statutory authority does not support an inspection process that deprives managed care providers of the protections included in the contracts negotiated between providers and MCOs that specifically address contractual reimbursement disputes. The commenters further asserted that the federal and state regulatory structure for MCO-delivered services demands more predicate for an inspection or audit than a payment being inconsistent with Texas fee-for-service Medicaid coverage or payment requirements. The commenters stated that §371.1721 binds providers and MCOs to fee for service rules, coverages, and payment amounts in clear opposition to the state's long-standing goals for and operational authority within managed care and fails to identify how OIG will fulfill its responsibilities for oversight of MCOs' waste, fraud, and abuse. The commenters expressed concern that §371.1721 would interfere with Medicaid participating hospitals and Medicaid MCOs' contracts. The commenters requested that new §371.1721 make clear that the inspection process will not be used to conduct inspections that involve disagreements over the appropriate reimbursement methodologies or contractual payment arrangements for services under a managed care agreement. The commenters further requested that new §371.1721 be narrowed to provide that OIG will only conduct inspections where there is a clear violation of billing rules applicable to managed care payments (e.g., submitting duplicate claims, etc.) or other meaningful showing of fraud, waste, or abuse.

Response: OIG declines to revise the rule in response to these comments. Title 42 C.F.R. §438.2 defines "overpayment" as, in part, any payment made to a network provider by a MCO to which the network provider is not entitled under Title XIX of the [Social Security] Act. The Uniform Managed Care Contract (UMCC) uses the definition from C.F.R. §438.2 to define "overpayment." The definitions of "overpayment" in 42 C.F.R. §438.2, the UMCC, and 1 TAC §371.1(55) do not refer to the terms fraud, waste, or abuse. By these definitions, an overpayment includes an amount a person is paid to which the person was not entitled under Medicaid. The criteria by which entitlement of funds is measured in Medicaid may arise from multiple sources, including federal or state statute, federal or state rule, or contract. A network provider contract with a MCO may not circumvent law or HHSC contract to authorize a payment to a network provider to which the network provider is not entitled under Medicaid. OIG inspections will use valid fee-for-service and managed care criteria, as applicable, to evaluate payments to persons subject to an inspection, including managed care network providers.

OIG is unable to answer the part of the comment that refers to federal regulations, case law, Texas Medicaid authorities, and, potentially, a violation of the Contracts Clause under the United States and Texas constitutions, because that part of the comment is too vague and too broad.

Comment: Four commenters asked how the changes in §371.1721 would apply to inspections in progress as of the effective date of the rule. The commenters asserted that the Administrative Procedures Act in Texas Government Code chapter 2001 requires that this information be specified in the proposal rule and when the final rule is adopted.

Response: Publication of final rule §371.1721 in the *Texas Register* will include the effective date. The provisions in §371.1721 will be effective for all inspections begun on or after the effective date. OIG disagrees that the Administrative Procedures Act in Texas Government Code chapter 2001 requires that the proposal rule include information about how the rule would apply to inspections in progress as of the effective date of the rule.

Comment: Four commenters stated that §371.1721 does not define "inspection," does not provide specifics or boundaries on what an inspection may entail, and, therefore, inspection targets are deprived of adequate notice of what should be expected under §371.1721. The commenters requested that OIG revise §371.1721 to include a definition of inspection consistent with its statutory authority to pursue only matters involving fraud, waste, and abuse.

Response: OIG declines to revise the rule in response to this comment. Section 371.1721 does provide specifics, boundaries, and a description of what an inspection encompasses. In part, §371.1721 includes a summary of the statutory scope of an inspection (subsection (a)); the standards OIG inspections follow, which include standards for independence, competence, planning, evidence collection and analysis, reporting, follow-up, and quality control (subsection (c)(1)); procedures, time deadlines, and potential penalties related to records requests; the scope of time an inspection may examine (subsection (c)(2)); the types of notices provided to persons subject to an inspection (subsection (c)(3) and (d)); the elements included in an inspection final report (subsection (e)); the opportunity to produce documentation to address any finding found during an inspection (subsec-

tion (c)(4)); the due process available to a person subject to an inspection, including the time deadlines and requirements for requesting an administrative hearing appeal (subsection (f)); and the scope, effect, and timelines related to a final inspection report (subsection (g)). The specifics, boundaries, and description contained in the rule effectively define an OIG inspection and provide adequate notice of what persons should expect from the rule.

Comment: One commenter asked whether OIG inspections are conducted on-site, off-site, or both.

Response: Section 371.1721 allows on-site and off-site inspections.

Comment: One commenter asked whether a records request is based on sampling.

Response: Ordinarily, OIG requests a full population of records for the scope period and then selects a sample from that population.

Comment: One commenter asked whether the number of records requested is supposed to be reasonable and how that term is defined. The commenter stated that there is no method in the rule for the provider to extend the period for submission of records if the number of records requested is unreasonable or overburdensome.

Response: The rule requires a provider to provide records within the time period requested by OIG or ten calendar days from the date of receipt of the request, whichever is later. An OIG record request may provide for a due date beyond ten days, but not less than ten days. The volume of records requested for an inspection should be reasonable. Additionally, OIG is receptive to requests for extension when an extension is warranted.

Comment: One commenter stated that the rule could allow OIG to request records to be submitted along with the required affidavit within one day to maintain the element of surprise. The commenter requested that element of surprise be defined to ensure there is a clear understanding of what this means in the context of the rule.

Response: OIG declines to revise the rule in response to this comment. An example of an element of surprise would be the circumstance in which there was compelling evidence that a provider was in the process of destroying records that had been requested for an OIG inspection. In that example, OIG could request that the records be provided immediately.

Comment: One commenter stated that since the inspection period allows the OIG to go back five years, some records could be off-site. The commenter asserts that §371.1721(b)(1) is too broad and without provider protections; and there is the opportunity for provider noncompliance related to factors outside the provider's control.

Response: OIG declines to revise the rule in response to this comment. OIG is receptive to requests for extension when an extension is warranted.

Comment: Four commenters stated that, under §371.1721(b)(1), while the proposed rule recognizes the discretion of the OIG to establish a longer document response deadline, a ten-day default period to produce records or risk enforcement action is unreasonable and draconian - and particularly punitive for rural and community hospitals with limited resources and workforce. The commenters recommended the default period should be extended to 30 days, at a minimum, or should be tiered based on the size and date range of the record request and the rule should create a process to request an extension based on extenuating circumstances. Additionally, the commenters recommended that OIG revise the rule to give a provider written notice and an opportunity to cure any deficiencies before enforcement action is taken under §371.1721(b)(3).

Response: OIG declines to revise the rule in response to these comments. As noted by the commenters, the rule requires a provider to submit records within the time period requested by OIG or ten calendar days from the date of receipt of the request, whichever is later. An OIG record request may provide for a due date beyond ten days, but not less than ten days. Additionally, OIG is receptive to requests for extension when an extension is warranted.

Comment: One commenter stated that producing five years of records in 10 calendar days is difficult and overburdensome for a pediatric dentist who practices in multiple locations, including the hospital setting. The commenter proposed revising the deadline to 30 calendar days.

Response: OIG declines to revise the rule in response to this comment. The rule requires a provider to submit records within the time period requested by OIG or ten calendar days from the date of receipt of the request, whichever is later. An OIG record request may provide for a due date beyond ten days, but not less than ten days. Additionally, OIG is receptive to requests for extension when an extension is warranted.

Comment: A commenter expressed concern that the rule requirements for a business records affidavit could place persons in a compliance catch-22 situation if the requested document did not qualify as a business record under the Texas Rules of Evidence. The commenter was also concerned about requiring a person to sign and notarize a document that was prepared by OIG and not the person's legal counsel. Additionally, the commenter recommended that the requirements in §371.1721(b) relating to the records affidavit be removed.

Response: OIG declines to revise the rule in response to this comment. If the "catch-22" scenario described in the comment occurred, OIG would consider the person's objection that the requested record in the person's possession was not, in fact, a business record under the Texas Rules of Evidence. The OIG-approved business records affidavit was prepared by OIG and based on the "Form of Affidavit" provided in the Texas Rules of Evidence. If the person who received the OIG records request preferred to have the person's attorney prepare the affidavit, OIG would assess whether the affidavit met the requirements specified in the Texas Rules of Evidence.

Comment: Four commenters stated that the affidavit requirement in §371.1721(b)(2) is too strict, burdensome, and unreasonable and may lead to unfair rejections of medical record submissions. Additionally, the commenters asserted that an administratively deficient affidavit, without an opportunity to cure, should not lead to an enforcement action under §371.1721(b)(3).

Response: OIG declines to revise the rule in response to these comments. When a records affidavit is requested by OIG for an inspection, OIG would provide the OIG-approved records affidavit referred to in §371.1721(b)(2) to the subject of the inspection along with the records request. The affidavit was prepared by OIG and based on the "Form of Affidavit" provided in the Texas Rules of Evidence Rule. If the person who received the OIG records request preferred to have the person's attorney pre-

pare the affidavit, OIG would assess whether the affidavit met the requirements specified in the Texas Rules of Evidence.

Comment: A commenter expressed concern about electronic notices being sent without a recipient's awareness. This commenter recommended that the rule be amended so that email notices must be consented to by the recipient and that the rule be revised to include, by reference, OIG's other methods of service in §371.1609. Additionally, four commenters stated that §371.1721(d)(3) is unduly burdensome to providers or otherwise unreasonable because it does not specify how an appropriate email notice will be determined or whether OIG will commit to receiving information, including appeal requests by electronic mail.

Response: OIG declines to revise the rule in response to this comment. Electronic mail, including secure or encrypted email for confidential or HIPAA information, is an appropriate and reliable alternative method to send notices. Before sending the inspection announcement email, OIG will contact the person who is the subject of the inspection by telephone to obtain the best email address or addresses for sending email notices. Subsequent notices will be sent by email to the email address provided by the subject of the inspection.

Comment: Four commenters stated that the five-year limit in subsection §371.1721(c)(2) is unclear because it does not adequately define the starting or ending point of the five-year period. The commenters asserted that OIG does not have authority to apply a longer period to recover alleged overpayments than any limitations period set forth in a contract with an MCO or with Texas law applicable to contracts (which, at its longest, creates a four-year statute of limitations). The commenters recommended that §371.1721 should (1) clarify that any inspection of payments made by MCOs to providers under network participation agreements is subject to the applicable contractual lookback periods unless there is evidence of fraud, waste, or abuse; (2) establish the parameters around the limitations period along with an example of how the limitations period is applied; and (3) incorporate an appropriate backstop time period, such as the one set forth in the Texas Medicaid Fraud Prevention Act--which generally does not allow recoveries beyond six years from the date of the act.

Response: OIG declines to revise the rule in response to this comment. Section 371.1721(c)(2) refers to the time scope of the records and conduct an OIG inspection may examine. For example, an OIG inspection may examine records and conduct covering state fiscal years (SFYs) 2020 through 2024, but not SFYs 2019 through 2024. The latter covers a six year period. OIG is unable to answer the comments related to "any limitations period set forth in a contract with an MCO or with Texas law applicable to contracts" and "under network participation agreements" because these comments are hypothetical and too vague.

Comment: One commenter stated that a person should be allowed a defined amount of time in §371.1721(c)(4), such as 10 days, to produce documentation to address a finding found during an inspection.

Response: OIG declines to revise the rule in response to this comment. The date specified by OIG permitting a person to produce documentation to address any finding will vary depending on factors such as the complexity, scope, and issues involved in the inspection.

Comment: One commenter requested that any notice from OIG be sent by certified mail. The commenter stated that time periods are short to provide records, pediatric dentists receive numerous emails a day, lower-level staff are often in charge of the email box and pediatric dentists do not want to miss an email from OIG when OIG has the ability to penalize the dentist for being nonresponsive.

Response: OIG declines to revise the rule in response to this comment. Electronic mail, including secure or encrypted email for confidential or HIPAA information, is an appropriate and reliable alternative method to send notices. Before sending the inspection announcement email, OIG will contact the person who is the subject of the inspection by telephone to obtain the best email address or addresses for sending email notices. Subsequent notices will be sent by email to the email address provided by the subject of the inspection.

Comment: One commenter stated that audits of pediatric dentists often show under-billing and underpayments. The commenter stated that, although dentists will not be reimbursed for underpayments, it is helpful to know that they have missed filing claims so they can correct these clerical errors in the future. The commenter requested that the inspection final report include a finding of underpayments, if any were found.

Response: OIG declines to revise the rule in response to this comment. When an OIG inspection identifies overpayments and underpayments, those amounts will be offset and result in one finding of underpayment or overpayment. OIG will provide the detail of claims findings as part of the inspection process. When an OIG inspection identifies only underpayments, there will be a finding of an underpayment.

Comment: Four commenters observed that §371.1723 does not include any timeframes or deadlines for OIG to diligently complete the inspection process. The commenters state that inspection targets should not be held to stringent deadlines while OIG is not required to meet any timeframe requirements in various stages of the inspection process.

Response: OIG declines to revise the rule in response to these comments. The length of the inspection process varies depending on the responsiveness of the subject of the inspection, the completeness and clarity of the documentation provided, and the time involved for meetings between the parties when criteria clarification is needed.

Comment: One commenter requested that draft inspection reports be completed no later than one year from the time OIG receives all requested information and that the rule be revised to add a time limit on when an inspection final report can be issued by OIG. The commenter asserted that pediatric dentists report that it has taken OIG up to two years to respond to a dental audit.

Response: OIG declines to revise the rule in response to this comment. The length of time it takes for OIG to complete draft and final inspection reports varies depending on factors, such as the complexity, scope, and issues involved in the inspection. OIG is not aware of any dental audits that have remained ongoing for up to two years since, at least May of 2017, when OIG began publishing its final audit reports on its website.

Comment: Four commenters stated that it is unfair and unduly burdensome that §371.1721(f)(1) does not include a minimum time period for the target of an inspection to provide a written response to the draft inspection report. Another commenter stated that there should be a standard time set for receipt of the management response, such as within 10 days or the date specified by the OIG, whichever is longer.

Response: OIG declines to revise the rule in response to these comments. Providing a management response is voluntary under §371.1721(f)(1). The subject of a completed inspection who agrees with the inspection findings may not wish to submit a management response. The date specified by OIG to submit a management response will vary depending on factors such as the complexity, scope, and issues in the draft inspection report and how long the subject of the inspection has known about the issues.

Comment: Four commenters requested that the language in §371.1721(f)(2)(C) be clarified to state that the hearing process is not within the HHSC Appeals Division, but instead is through the State Office of Administrative Hearings (SOAH).

Response: OIG declines to revise the rule in response to this comment. The phrase "administrative hearing at the HHSC Appeals Division" in §371.1721(f)(2)(C) refers to an administrative hearing appeal at (i.e., "within") the HHSC Appeals Division. Section 371.1721 does not require a SOAH hearing. OIG believes an administrative hearing at the HHSC Appeals Division is the appropriate setting for the appeal of inspection findings. Texas Government Code, Chapter 2001, Subchapter G, provides for judicial review of agency decisions in a contested case.

Comment: One commenter asked why there is a separate process for collection of an overpayment as a result of an inspection rather than referring to §371.1711 for the collection process.

Response: OIG declines to revise the rule in response to this comment. The only process related to the collection of an overpayment in §371.1711 relates to subsection (c), notice requirements. The notice requirements specified in TAC Chapter 371 vary according to the different types of OIG examinations, such as investigations, audits, retrospective payment reviews, and utilization reviews. The notice requirements specific to OIG inspections are contained in §371.1721(d).

Comment: One commenter stated that the request for a payment plan agreement should be the same as in §371.1711.

Response: Section 371.1711 does not refer to payment plans. No revision to the rule is made in response to this comment.

Comment: One commenter stated that all other rules related to paying an overpayment and appeals should follow the process already outlined in §371.1711.

Response: This comment is beyond the scope of this rule because it relates to other rules.

Comment: One commenter asked what the delivery method and time frame is for receipt of the draft inspection report following completion of the field work and the final inspection report following the initial draft inspection report.

Response: Before sending the inspection announcement email, OIG will contact the person who is the subject of the inspection by telephone to obtain the best email address or addresses for sending email notices. The draft and final inspection reports will be sent by email to the email address provided by the person subject to inspection. The time frame between fieldwork and delivery of the draft inspection report and between the draft and final inspection reports may vary depending on factors, such as the complexity, scope, and issues involved in the inspection.

Comment: One commenter stated that all due process protections and procedures should be the same.

Response: OIG declines to revise the rule in response to this comment. The due process protections and procedures specified in TAC Chapter 371 vary according to the different types of OIG examinations, such as investigations, audits, retrospective payment reviews, and utilization reviews. OIG believes the due process protections and procedures in §371.1721 are appropriate for OIG inspections.

Comment: Four commenters stated that the 15-day period to request an appeal under §371.1721(f)(4) is not only unreasonable, but potentially impossible, if there are hundreds of claims at issue. The commenters requested that the rule provide 30 days for a provider to request an appeal and permit a provider to request an extension based on extenuating circumstances.

Response: OIG declines to revise the rule in response to these comments. Title 1, Texas Administrative Code §357.484, specifies the requirements for requesting a hearing with the HHSC Appeals Division. Section 357.484(b) states, in part, that (1) the request for hearing must be received within 15 days from the date the person receives notice of adverse action and (2) if the request is not filed in accordance with §357.484, the judge may deny the request. If §371.1721 allowed more than 15 days to request appeal, this could lead to confusion or, potentially, a denial of the appeal request despite complying with the time deadline in §371.1721. Additionally, OIG and the person subject to inspection discuss the inspection findings before the end of fieldwork, which occurs before dissemination of the draft and final inspection reports.

Comment: One commenter asked whether §371.1721(f)(4)(C) means that the person or provider who does not challenge inspection findings must still file an administrative hearing appeal to include that they will either pay the overpayment or seek a payment plan agreement.

Response: Section 371.1721(f)(4)(C) applies only when the person is challenging some, but not all, of the OIG inspection findings. In that circumstance, the person's written request to OIG for appeal must specify - for those findings that are not being challenged - whether the person will pay the overpayment within 60 days or seek a payment plan agreement.

STATUTORY AUTHORITY

The new rule is adopted under 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 Government Code §531.102(a), which grants the OIG the responsibility for the prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse in the provision and delivery of all health and human services in the state, including services through any state-administered health or human services program that is wholly or partly federally funded, and which provides the OIG with the authority to obtain any information or technology necessary to enable it to meet its responsibilities; Texas Government Code §531.102(a-2), which requires the Executive Commissioner of HHSC to work in consultation with the Office of the Inspector General to adopt rules necessary to implement a power or duty of the office; Texas Government Code §531.102(x), which requires the Executive Commissioner of HHSC, in consultation with the Office of Inspector General, to adopt rules establishing criteria for determining enforcement and punitive actions with regard to a provider who has violated state law, program rules, or the provider's Medicaid provider agreement; Texas Government

Code §531.033, which requires the Executive Commissioner of HHSC to adopt rules necessary to carry out the commission's duties under Chapter 531; Texas Human Resources Code §32.021, which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas and adopt rules necessary for the proper and efficient operation of the Medicaid program; Texas Government Code §531.021(a), which provides HHSC with the authority to administer Medicaid funds; Texas Government Code §531.1131(e), which requires the Executive Commissioner of HHSC to adopt rules necessary to implement §531.1131, including rules establishing due process procedures that must be followed by managed care organizations when engaging in payment recovery efforts as provided by §531.1131; and Texas Human Resources Code §32.039, which provides authority to assess administrative penalties and damages and provides due process for persons potentially subject to damages and penalties.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 6, 2024.

TRD-202405893
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Effective date: December 26, 2024
Proposal publication date: June 14, 2024
For further information, please call: (512) 221-7320

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TITLE 4. AGRICULTURE

PART 1. TEXAS DEPARTMENT OF AGRICULTURE

CHAPTER 2. LICENSING
SUBCHAPTER A. GENERAL PROVISIONS

4 TAC §2.1

The Texas Department of Agriculture (Department) adopts amendments to Texas Administrative Code, Title 4, Chapter 2 (Licensing), Subchapter A (General Provisions), §2.1 (Application for a License), published in the June 7, 2024, issue of the *Texas Register* (49 TexReg 3981) without changes. The Department identified the need for the amendments during its rule review conducted pursuant to Texas Government Code §2001.039. The amendments to §2.1 are adopted without changes to the proposed text as published in the June 7, 2024, issue of the *Texas Register* (49 TexReg 3981) and will not be republished.

The adopted amendments change language to allow the Department to determine what constitutes an incomplete application, change references to Chapter 2 from "these rules" to "this chapter," remove unnecessary language, make grammatical corrections, make editorial changes to language to improve the rule's readability, and update the form of a legal citation to the Texas Government Code, §2005.004.

The Department did not receive any public comments concerning the proposed amendments.

The amendments are adopted under Section 12.016 of the Texas Agriculture Code, which allows the Department to adopt rules as necessary for the administration of its powers and duties under the Texas Agriculture Code.

Chapter 12 of the Texas Agriculture Code is affected by the adoption.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 9, 2024.

TRD-202405903
Susan Maldonado
General Counsel
Texas Department of Agriculture
Effective date: December 29, 2024
Proposal publication date: June 7, 2024
For further information, please call: (512) 463-6591

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TITLE 26. HEALTH AND HUMAN SERVICES

PART 1. HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 260. DEAF BLIND WITH MULTIPLE DISABILITIES (DBMD) PROGRAM AND COMMUNITY FIRST CHOICE (CFC) SERVICES

The Texas Health and Human Services Commission (HHSC) adopts amendments to §260.5, concerning Definitions; §260.7, concerning Descriptions of DBMD Program and CFC; §260.59, concerning Requirements for Home and Community-Based Settings; §260.203, concerning Qualifications of Program Provider Staff; §260.205, concerning Training; §260.341, concerning Employment Services; and §260.357, concerning Non-Billable Time and Activities.

The amendments to §260.5, §260.203 and §260.341 are adopted with changes to the proposed text as published in the August 2, 2024, issue of the *Texas Register* (49 TexReg 5686). These rules will be republished.

The amendments to §260.7, §260.59, §260.205, and §260.357 are adopted without changes to the proposed text as published in the August 2, 2024, issue of the *Texas Register* (49 TexReg 5686). These rules will not be republished.

BACKGROUND AND JUSTIFICATION

The adopted amendments are necessary to implement Texas Human Resources Code §32.0755, added by House Bill (H.B.) 4169, 88th Legislature, Regular Session, 2023. The adopted amendments implement a service similar to prevocational services, named employment readiness, in the Deaf Blind with Multiple Disabilities (DBMD) Program, one of HHSC's §1915(c) Medicaid waiver programs.

COMMENTS

The 31-day comment period ended September 3, 2024.

During this period, HHSC received comments regarding the proposed rules from five commenters, including Disability Rights Texas; Texas Association of People Supporting Employment First; Texas Council for Developmental Disabilities; The Arc of Texas; and Advo Companies.

A summary of comments relating to the rules and HHSC's responses follows.

Comment: One commenter expressed concern that the term "job-task oriented" in proposed §260.5(76) is subjective and unmeasurable and will lead to an increase in job task-oriented activities.

Response: HHSC declines to make a change in response to this comment because the term is only used in the description of employment readiness in proposed §260.341(f)(3) to establish that the service is not job-task oriented.

Comment: Several commenters recommended HHSC revise proposed §260.5(76) to change the definition of "Job-task oriented" from "focused on developing a skill related to a specific type of employment" to "focused on developing a single skill related to a specific type of employment" because its current definition is vague.

Response: HHSC declines to add "single" to the definition of "job-task oriented" in proposed §260.5(76). Adding "single" implies that focusing on developing multiple skills related to a specific type of employment is not job-task oriented, which is incorrect.

Comment: One commenter expressed concerns that the requirements in proposed §260.59(e), to ensure that an employment readiness location allows an individual to control the individual's own schedule and activities, have access to the individual's food at any time, receive visitors of the individual's choosing at any time and be physically accessible and free of hazards, are more appropriate for residential settings and irrelevant to employment readiness settings.

Response: HHSC did not make changes in response to this comment because the requirements in proposed §260.59(e) were added to comply with federal home and community-based services (HCBS) settings requirements for services provided in a group setting.

Comment: Several commenters questioned what the parameters are for the program provider's assurance in proposed §260.59(f)(2)(H). The commenters requested HHSC require program providers to provide assurance that the modifications are safe and based on evidence and best practice.

Response: HHSC declines to make changes in response to these comments. Proposed §260.59(f) already requires documentation of a specific and individualized assessed need that justifies the modification and the individual's or legally authorized representative's signature evidencing informed consent to the modification. The documentation around assessing need and justifying the modification encompasses an assurance that the modifications are safe and based on evidence of need and best practices.

Comment: One commenter expressed concern that the service provider qualification requirements in proposed §260.203(i) do not include specific employment or vocational training.

Response: HHSC declines to make changes in response to this comment because HHSC believes the qualifications in proposed §260.203(i)(3)(B) are sufficient to ensure that a service provider of employment readiness has the experience and competence to perform the job tasks needed to provide employment readiness. Employment readiness is habilitative in nature and not job-task oriented.

Comment: Several commenters expressed concerns with proposed rule §260.203(i)(2) related to qualifications of program provider staff which states parents and spouses are excluded from providing employment readiness to their minor children.

Response: The rule as proposed conforms with the Texas DBMD waiver application approved by CMS. Thus, HHSC declines to make changes in response to the comments above.

Comment: Several commenters recommended HHSC revise proposed §260.203 that requires three personal references unrelated by blood to the qualifications of program provider staff attesting to the provider's ability to maintain a safe environment and support goal-oriented skills development.

Response: HHSC declines to make changes in response to these comments. The rules as proposed currently require three personal references. Additionally, the training requirements currently in §260.205 require training on the individual's specific needs and goals. These training requirements are expected to help ensure staff are providing a safe environment and goal-oriented skills development.

Comment: Several commenters recommended HHSC revise proposed §260.341 to add a five-year lifetime limit to employment readiness that may only be extended after an individual attempts competitive integrated employment. The commenters emphasized the goal should be competitive integrated employment.

Response: HHSC declines to make a change in response to these comments because a lifetime limit is not person-centered and may limit the opportunities for competitive integrated employment for individuals who need more support beyond the proposed five years to prepare for employment. In addition, the annual review of service plans ensure services on an individual's plan are the most appropriate to meet the individual's current needs.

Comment: Several commenters expressed concern that the requirement in proposed §260.341(g), which requires employment readiness to be provided to an individual only if the individual's service planning team does not expect the individual to be competitively employed within one year after the date employment readiness begins, is unnecessarily complex. The commenters recommend that HHSC instead allow the provision of employment readiness if the service planning team determines that more than one year of employment readiness is necessary for the individual to gain competitive employment.

Response: HHSC declines to make a change in response to this comment. The requirement in proposed §260.341(g) to provide employment readiness to an individual only if the individual's service planning team does not expect the individual to be competitively employed within one year after the date employment readiness begins is consistent with the description of prevocational services in 42 CFR §440.180(c)(2)(i)(A).

Comment: Several commenters expressed concern that the requirement in proposed §260.341(h)(2) precludes an individual who is engaged in competitive employment from receiving em-

ployment readiness. The commenters suggested employment readiness may serve as a means for professional development for an individual who wants to improve their employment skills.

Response: HHSC declines to make changes in response to this comment. Employment assistance, a DBMD Program service defined in §260.5(44), can be used to gain additional employment skills. Furthermore, proposed §260.341(f)(1) describes employment readiness as assistance that prepares an individual to participate in employment.

Comment: One commenter stated vocational services do not cover group activities. The commenter also stated that vocational rehabilitation counselors may consider employment readiness as a day program service that diminishes skills necessary for competitive, integrated employment.

Response: HHSC did not make changes in response to this comment because vocational rehabilitation services are outside the scope of this project.

Comment: One commenter opposed the implementation of employment readiness, stating it is not a needed service and it is similar to day habilitation. The commenter expressed that employment assistance and supported employment are existing services that prepare an individual for paid employment in the community.

Response: HHSC declines to make changes in response to this comment because the implementation of employment readiness is necessary for compliance with Texas Human Resources Code §32.0755, added by House Bill 4169, 88th Legislature, Regular Session, 2023.

Comment: One commenter recommended HHSC invest in the development of individualized skills and socialization, employment assistance, and supported employment services to ensure every person has access to integrated, community-based activities and employment. The review of these services should cover the service rates, flexibility in the delivery of services, training, and transition support from Texas Workforce Commission - Vocational Rehabilitation Program services, transportation, long-term counseling for employment success, ongoing service provider training and development of expertise in employment issues at the state level.

Response: HHSC declines to make changes in response to these comments because it is outside the scope of this rule project.

Comment: One commenter requested that HHSC allow "enclave settings," i.e., settings that allow the exclusive employment of individuals with intellectual and developmental disabilities to complete contract work as part of their employment readiness service.

Response: HHSC declines to make changes in response to this comment because "enclave setting" is outside the scope of this project. Based on the interpretation of technical guidance from the Centers for Medicare & Medicaid Services, HHSC considers enclave settings, also known as small group employment, to be a distinct service from employment readiness, because of the differences in focus, structure, and goals.

HHSC made changes to the rules that are not in response to comments.

HHSC updated references in §260.5(21), (34), (50), (51), and (139) to rules administratively transferred from Title 40 Texas Administrative Code to Title 26 Texas Administrative Code.

HHSC updated references to the Texas Government Code citations in proposed §260.5(72) and (84) and §260.203(c) to implement H.B. 4611, 88th Legislature, Regular Session, 2023, which makes non-substantive revisions to the Texas Government Code that make the statute more accessible, understandable, and usable.

HHSC also made minor editorial changes in §260.5(76) and §260.341(f)(3) for consistency in the waiver program rules in the spelling of "job-task oriented."

HHSC replaced Individual Plan of Care, "IPC" reference with Individual Program Plan reference of "IPP" in proposed §260.341(f)(2)(C) because an individual's service outcomes are documented in the IPP, not the IPC.

HHSC revised proposed §260.341(i)(2) to require documentation in an individual's record that employment readiness is not available to the individual under a program funded under §110 of the Rehabilitation Act of 1973. This requirement aligns with current requirements to ensure services are not available through additional funding sources prior to accessing services in the waiver.

SUBCHAPTER A. DEFINITIONS, DESCRIPTION OF SERVICES, AND EXCLUDED SERVICES

26 TAC §260.5, §260.7

STATUTORY AUTHORITY

The amendments are adopted under 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; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance program in Texas and to adopt rules and standards for program administration; and Texas Human Resources Code §32.0755(f), which provides that the Executive Commissioner shall adopt rules to establish performance standards for providers providing prevocational or similar services to persons in a Medicaid waiver program.

§260.5. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

(1) Abuse--

(A) physical abuse;

(B) sexual abuse; or

(C) verbal or emotional abuse.

(2) Actively involved--Significant, ongoing, and supportive involvement with an individual by a person, as determined by the individual, based on the person's:

(A) interactions with the individual;

(B) availability to the individual for assistance or support when needed; and

(C) knowledge of, sensitivity to, and advocacy for the individual's needs, preferences, values, and beliefs.

(3) Adaptive aid--A service in the Deaf Blind with Multiple Disabilities (DBMD) Program that:

(A) enables an individual to retain or increase the ability to perform ADLs or perceive, control, or communicate with the environment in which the individual lives; and

(B) meets one of the following criteria:

(i) is an item included in the list of adaptive aids in the Deaf Blind with Multiple Disabilities Program Manual; or

(ii) is the repair or maintenance of an item on the list of adaptive aids in the Deaf Blind with Multiple Disabilities Program Manual that is not covered by a warranty.

(4) Adaptive behavior--The effectiveness with or degree to which an individual meets the standards of personal independence and social responsibility expected of the individual's age and cultural group as assessed by an adaptive behavior screening assessment.

(5) Adaptive behavior level--The categorization of an individual's functioning level based on a standardized measure of adaptive behavior. There are four adaptive behavior levels ranging from mild limitations in adaptive skills (I) through profound limitations in adaptive skills (IV).

(6) Adaptive behavior screening assessment--A standardized assessment used to determine an individual's adaptive behavior level, and conducted using the current version of one of the following assessment instruments:

(A) American Association of Intellectual and Developmental Disabilities (AAIDD) Adaptive Behavior Scales (ABS);

(B) Inventory for Client and Agency Planning (ICAP);

(C) Scales of Independent Behavior; or

(D) Vineland Adaptive Behavior Scales.

(7) ADLs--Activities of daily living. Basic personal everyday activities, including tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

(8) Agency foster home--This term has the meaning set forth in Texas Human Resources Code §42.002.

(9) Alarm call--A signal transmitted from an individual's Community First Choice (CFC) Emergency Response Services (ERS) equipment to the CFC ERS response center indicating that the individual needs immediate assistance.

(10) ALF--Assisted living facility. A facility licensed in accordance with Texas Health and Safety Code Chapter 247.

(11) Alleged perpetrator--A person alleged to have committed an act of abuse, neglect, or exploitation of an individual.

(12) Audiology--A DBMD Program service that provides assessment and treatment by a licensed audiologist and includes training and consultation with an individual's family members or other support providers.

(13) 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.

(14) Behavior support plan--A comprehensive, individualized written plan based on a current functional behavior assessment that includes specific outcomes and behavioral techniques designed to teach or increase adaptive skills and decrease or eliminate target behaviors.

(15) Behavioral emergency--A situation in which an individual is acting in an aggressive, destructive, violent, or self-injurious manner that poses a risk of death or serious bodily harm to the individual or others.

(16) Behavioral support--A DBMD Program service that provides specialized interventions to assist an individual in increasing adaptive behaviors and replacing or modifying behaviors that prevent or interfere with the individual's inclusion in the community and consists of the following activities:

(A) conducting a functional behavior assessment;

(B) developing an individualized behavior support plan;

(C) training and consulting with an individual, family member, or other persons involved in the individual's care regarding the implementation of the behavior support plan;

(D) monitoring and evaluating the effectiveness of the behavior support plan;

(E) modifying, as necessary, the behavior support plan based on monitoring and evaluating the plan's effectiveness; and

(F) counseling and educating an individual, family members, or other persons involved in the individual's care about the techniques to use in assisting the individual to control challenging or socially unacceptable behaviors.

(17) 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).

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

(19) Case management--The DBMD Program service described in §260.337 of this chapter (relating to Case Management).

(20) Case manager--A service provider of case management.

(21) CDS option--Consumer directed services option. A service delivery option defined in §264.103 of this title (relating to Definitions).

(22) CFC--Community First Choice.

(23) CFC ERS--CFC emergency response services. A CFC service that provides backup systems and supports used to ensure continuity of services and supports. CFC ERS includes electronic devices and an array of available technology, personal emergency response systems, and other mobile communication devices.

(24) CFC ERS provider--The entity directly providing CFC ERS to an individual, which may be the program provider or a contractor of the program provider.

(25) CFC FMS--CFC financial management services. A CFC service provided to an individual who receives only CFC PAS/HAB through the CDS option.

(26) CFC PAS/HAB--CFC personal assistance services/habilitation. A CFC service:

(A) that consists of:

(i) personal assistance services, which 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, which 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, including:

(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.

(27) CFC support consultation--A CFC service that provides support consultation to an individual who receives only CFC PAS/HAB through the CDS option.

(28) CFC support management--A CFC service that provides training on how to select, manage, and dismiss an unlicensed service provider of CFC PAS/HAB.

(29) CFR--Code of Federal Regulations.

(30) Chemical restraint--A medication used to control an individual's behavior or to restrict the individual's freedom of movement that is not a standard treatment for the individual's medical or psychological condition.

(31) Chore services--A DBMD Program service, other than CFC PAS/HAB household chores, needed to maintain a clean, sanitary, and safe environment in an individual's home and consists of heavy household chores, such as washing floors, windows, and walls, securing loose rugs and tiles, and moving heavy items or furniture.

(32) CMS--The Centers for Medicare & Medicaid Services. CMS is the agency within the United States Department of Health and Human Services that administers the Medicare and Medicaid programs.

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

(34) Contract--A provisional contract that the Texas Health and Human Services Commission enters into in accordance with §52.39 of this title (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 §52.39(e) of this title or a standard contract that HHSC enters into in accordance with §52.41 of this title (relating to Standard Contract) that has a term of no more than five years, not including any extension agreed to in accordance with §52.41(d) of this title.

(35) Controlling person--A person who:

(A) has an ownership interest in a program provider;

(B) is an officer or director of a corporation that is a program provider;

(C) is a partner in a partnership that is a program provider;

(D) is a member or manager in a limited liability company that is a program provider;

(E) is a trustee or trust manager of a trust that is a program provider; or

(F) because of a personal, familial, or other relationship with a program provider, is in a position of actual control or authority with respect to the program provider, regardless of the person's title.

(36) Day Activity and Health Services Program--This term has the meaning set forth in Texas Human Resource Code §103.003.

(37) DBMD Program--The Deaf Blind with Multiple Disabilities Program.

(38) Deafblindness--A chronic condition in which a person:

(A) has deafness, which is a hearing impairment severe enough that most speech cannot be understood with amplification; and

(B) has legal blindness, which results from a central visual acuity of 20/200 or less in the person's better eye, with correction, or a visual field of 20 degrees or less.

(39) Denial--An action taken by HHSC that:

(A) rejects an individual's request for enrollment into the DBMD Program;

(B) disallows a DBMD Program service or a CFC service requested on an individual plan of care (IPC) that was authorized on the prior IPC; or

(C) disallows a portion of the amount or level of a DBMD Program service or a CFC service requested on an IPC that was not authorized on the prior IPC.

(40) Dental treatment--A DBMD Program service that:

(A) consists of the following:

(i) emergency dental treatments, which are procedures necessary to control bleeding, relieve pain, and eliminate acute infection; operative procedures that are required to prevent the imminent loss of teeth; and treatment of injuries to the teeth or supporting structures;

(ii) routine preventative dental treatments, which are examinations, x-rays, cleanings, sealants, oral prophylaxes, and topical fluoride applications;

(iii) therapeutic dental treatments, which include fillings, scaling, extractions, crowns, and pulp therapy for permanent and primary teeth; restoration of carious permanent and primary teeth; maintenance of space; and limited provision of removable prostheses when masticatory function is impaired, when an existing prosthesis

is unserviceable, or when aesthetic considerations interfere with employment or social development;

(iv) orthodontic dental treatments, which are procedures that include treatment of retained deciduous teeth; cross-bite therapy; facial accidents involving severe traumatic deviations; cleft palates with gross malocclusion that will benefit from early treatment; and severe, handicapping malocclusions affecting permanent dentition with a minimum score of 26 as measured on the Handicapping Labiolingual Deviation Index; and

(v) dental sedation, which is sedation necessary to perform dental treatment including non-routine anesthesia, (for example, intravenous sedation, general anesthesia, or sedative therapy prior to routine procedures) but not including administration of routine local anesthesia only; and

(B) does not include cosmetic orthodontia.

(41) Developmental disability--As defined in the Developmental Disabilities Assistance and Bill of Rights Act of 2000, Section 102(8), a severe, chronic disability of an individual five years of age or older that:

(A) is attributable to a mental or physical impairment or combination of mental and physical impairments;

(B) is manifested before the individual attains 22 years of age;

(C) is likely to continue indefinitely; and

(D) results in substantial functional limitations in three or more of the following areas of major life activity:

(i) self-care;

(ii) receptive and expressive language;

(iii) learning;

(iv) mobility;

(v) self-direction;

(vi) capacity for independent living; and

(vii) economic self-sufficiency.

(42) DFPS--Department of Family and Protective Services.

(43) Dietary services--A DBMD Program service that provides nutrition services, as defined in Texas Occupations Code §701.002.

(44) Employment assistance--A DBMD Program service that provides assistance to an individual to help the individual locate competitive employment in the community to the same degree of access as individuals not receiving DBMD Program services.

(45) Employment readiness--The DBMD Program service described in §260.341 of this chapter (relating to Employment Services).

(46) Employment readiness location--A location where employment readiness is provided.

(47) Enrollment Individual Plan of Care (IPC)--The first IPC for an individual developed before the individual's enrollment into the DBMD Program.

(48) Enrollment Individual Program Plan (IPP)--The first IPP for an individual developed before the individual's enrollment into the DBMD Program in accordance with §260.65 of this chapter (relating to Development of an Enrollment IPP).

(49) 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.

(50) FMS--Financial management services. A DBMD Program service that is defined in §264.103 of this title and provided to an individual participating in the CDS option.

(51) FMSA--Financial management services agency. An entity, as defined in §264.103 of this title, that provides FMS.

(52) 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.

(53) Functional behavior assessment--An evaluation that is used to determine the underlying function or purpose of an individual's behavior, so an effective behavior support plan can be developed.

(54) Functions as a person with deafblindness--Situation in which a person is determined:

(A) to have a progressive medical condition, manifested before 22 years of age, that will result in the person having deafblindness; or

(B) before attaining 22 years of age, to have limited hearing or vision due to protracted inadequate use of either or both of these senses.

(55) Good cause--As determined by HHSC, A reason outside the control of a CFC ERS provider that is an acceptable reason for the CFC ERS provider's failure to comply.

(56) HCSSA--Home and community support services agency. An entity required to be licensed under Texas Health and Safety Code (THSC) Chapter 142.

(57) Health-related tasks--Specific tasks related to the needs of an individual that can be delegated or assigned by a licensed healthcare professional under state law to be performed by a service provider of CFC PAS/HAB. These include:

(A) tasks delegated by a registered nurse (RN);

(B) health maintenance activities, as defined in 22 TAC §225.4 (relating to Definitions), that may not require delegation; and

(C) activities assigned to a service provider of CFC PAS/HAB by a licensed physical therapist, occupational therapist, or speech-language pathologist.

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

(59) Hospital--A public or private institution that is licensed or is exempt from licensure in accordance with THSC Chapters 13, 241, 261, or 552.

(60) 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.

(61) 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.

(62) 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.

(63) ID/RC Assessment--Intellectual Disability/Related Conditions Assessment. An HHSC form used to determine the LOC for an individual.

(64) Impairment to independent functioning--An adaptive behavior level of II, III, or IV.

(65) Individual--A person seeking to enroll or who is enrolled in the DBMD Program.

(66) Individual transportation plan--A written plan developed by an individual's service planning team and documented on the HHSC Individual Transportation Plan form. The form is used to document how transportation as a residential habilitation activity will be delivered to support an individual's desired goals and outcomes for transportation as identified in the IPP.

(67) Inpatient chemical dependency treatment facility--A facility licensed in accordance with THSC Chapter 464.

(68) In person or in-person--Within the physical presence of another person. In person or in-person does not include using videoconferencing or a telephone.

(69) Institution for mental diseases--Has the meaning set forth in 42 CFR §435.1010.

(70) Institutional services--Medicaid-funded services provided in a nursing facility or in an ICF/IID.

(71) Intellectual disability--Consistent with THSC §591.003, significantly sub-average general intellectual functioning that is concurrent with deficits in adaptive behavior and originates during the developmental period.

(72) Intervener--A service provider with specialized training and skills in deafblindness who, working with one individual at a time, serves as a facilitator to involve an individual in home and community services and activities, and who is classified as an Intervener, Intervener I, Intervener II, or Intervener III in accordance with Texas Government Code §526.0404.

(73) IPC--Individual plan of care. A written plan developed by an individual's service planning team and documented on the HHSC Individual Plan of Care form. An IPC:

(A) documents:

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

(ii) if an individual will receive CFC support management; and

(B) is authorized by HHSC.

(74) IPC period--The effective period of an enrollment IPC and a renewal IPC as follows:

(A) for an enrollment IPC, the period of time from the effective date of the enrollment IPC, as described in §260.67(a)(1)(F) of this chapter (relating to Development of a Proposed Enrollment IPC), through the last calendar day of the 11th month after the month in which enrollment occurred; and

(B) for a renewal IPC, a 12-month period of time starting on the effective date of a renewal IPC as described in §260.77(a)(1) of this chapter (relating to Renewal and Revision of an IPP and IPC).

(75) IPP--Individual program plan. A written plan that includes the information described in §260.65(b) of this chapter (relating to Development of an Enrollment IPP) and documented on an HHSC Individual Program Plan form.

(76) Job-task oriented--Focused on developing a skill related to a specific type of employment.

(77) LAR--Legally authorized representative. A person authorized by law to act on behalf of an individual with regard to a matter described in this chapter, including a parent, guardian, or managing conservator of a minor; a guardian of an adult; an agent appointed under a power of attorney; or a representative payee appointed by the Social Security Administration. An LAR, such as an agent appointed under a power of attorney or representative payee appointed by the Social Security Administration, may have limited authority to act on behalf of a person.

(78) Licensed assisted living--A DBMD Program service provided by a program provider in an ALF that is owned by the program provider.

(79) Licensed home health assisted living--A DBMD Program service provided by a program provider licensed as a HCSSA, in a residence for no more than three individuals. The residence must be owned or leased by at least one of the residents and must not be owned or leased by a program provider.

(80) Licensed vocational nursing--A DBMD Program service that provides vocational nursing, as defined in Texas Occupations Code §301.002.

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

(82) LOC--Level of care. A determination given to an individual as part of the eligibility determination process based on data submitted on the ID/RC Assessment.

(83) LVN--Licensed vocational nurse. A person licensed to provide vocational nursing in accordance with Texas Occupations Code Chapter 301.

(84) Managed care organization--This term has the meaning set forth in Texas Government Code §543A.0001.

(85) MAO Medicaid--Medical Assistance Only Medicaid. A type of Medicaid by which an individual qualifies financially for Medicaid assistance but does not receive Supplemental Security Income (SSI) benefits.

(86) Mechanical restraint--A mechanical device, material, or equipment used to control an individual's behavior by restricting the ability of the individual to freely move part or all of the individual's body. The term does not include a protective device.

(87) Medicaid--A program administered by CMS and funded jointly by the states and the federal government that pays for health care to eligible groups of low-income people.

(88) 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.

(89) Mental health facility--A facility licensed in accordance with THSC Chapter 577.

(90) MESAV--Medicaid Eligibility Service Authorization Verification. The automated system that contains information regarding an individual's Medicaid eligibility and service authorizations.

(91) 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.

(92) 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.

(93) Minor home modifications--A DBMD Program service that:

(A) makes a physical adaptation to an individual's residence that:

(i) is necessary to address the individual's specific needs; and

(ii) enables the individual to function with greater independence in the individual's residence or to control his or her environment; and

(B) meets one of the following criteria:

(i) is included on the list of minor home modifications in the Deaf Blind with Multiple Disabilities Program Manual; or

(ii) is the repair or maintenance of a minor home modification purchased through the DBMD Program that:

(I) is needed after one year has elapsed from the date the minor home modification is complete;

(II) is needed for a reason other than the minor home modification was intentionally damaged, as described in §260.329(c) of this chapter (relating to Repair or Replacement of a Minor Home Modification); and

(III) is not covered by a warranty.

(94) Natural supports--Unpaid persons, including family members, volunteers, neighbors, and friends, who assist and sustain an individual.

(95) 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.

(96) Nursing--One or more of the following DBMD Program services:

(A) licensed vocational nursing;

(B) registered nursing;

(C) specialized licensed vocational nursing; and

(D) specialized registered nursing.

(97) Nursing facility--A facility that is licensed or exempt from licensure in accordance with the THSC Chapter 242.

(98) Occupational therapy--A DBMD Program service that provides occupational therapy, as described in Texas Occupations Code §454.006.

(99) Orientation and mobility--A DBMD Program service that assists an individual to acquire independent travel skills that enable the individual to negotiate safely and efficiently between locations at home, school, work, and in the community.

(100) PAS/HAB plan--Personal Assistance Services (PAS)/Habilitation Plan. A written plan developed by an individual's service planning team and documented on the HHSC Personal Assistance Services (PAS)/Habilitation Plan form that describes the type and frequency of CFC PAS/HAB activities to be performed by a service provider.

(101) Person--A corporation, organization, government or governmental subdivision or agency, business trust, estate, trust, partnership, association, natural person, or any other legal entity that can function legally, sue or be sued, and make decisions through agents.

(102) Personal funds--The funds that belong to an individual, including earned income, social security benefits, gifts, and inheritances.

(103) Person-centered planning process--The process described in §260.57 of this chapter (relating to Person-Centered Planning Process).

(104) Personal leave day--A continuous 24-hour period, measured from midnight to midnight, when an individual who resides in a residence in which licensed assisted living or licensed home health assisted living is provided is absent from the residence for personal reasons.

(105) 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.

(106) Physical restraint--Any manual method used to control an individual's behavior, except for physical guidance or prompting of brief duration that an individual does not resist, that restricts:

(A) the free movement or normal functioning of all or a part of the individual's body; or

(B) normal access by an individual to a portion of the individual's body.

(107) Physical therapy--A DBMD program service that provides physical therapy, as defined in Texas Occupations Code §453.001.

(108) Physician--Consistent with §558.2 of this title (relating to Definitions), a person who is:

(A) licensed in Texas to practice medicine or osteopathy in accordance with Texas Occupations Code Chapter 155;

(B) licensed in Arkansas, Louisiana, New Mexico, or Oklahoma to practice medicine, who is the treating physician of an individual, and orders home health or hospice services for the individual in accordance with Texas Occupations Code §151.056(b)(4); or

(C) a commissioned or contract physician or surgeon who serves in the United States uniformed services or Public Health Service if the person is not engaged in private practice, in accordance with the Texas Occupations Code §151.052(a)(8).

(109) Program provider--A person that has a contract with HHSC to provide DBMD Program services, excluding an FMSA.

(110) Protective device--An item or device, such as a safety vest, lap belt, bed rail, safety padding, adaptation to furniture, or helmet, if:

(A) used only:

(i) to protect an individual from injury; or

(ii) for body positioning of the individual to ensure health and safety; and

(B) not used to modify or control behavior.

(111) Public emergency personnel--Personnel of a sheriff's department, police department, emergency medical service, or fire department.

(112) Reduction--An action taken by HHSC as a result of a review of a revised IPC or renewal IPC that decreases the amount or level of a service authorized by HHSC on the prior IPC.

(113) Registered nursing--A DBMD Program service that provides professional nursing, as defined in Texas Occupations Code §301.002.

(114) Related condition--As defined in 42 CFR §435.1010, 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 22 years of age;

(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.

(115) 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 Deaf Blind with Multiple Disabilities Program Manual.

(116) Renewal IPC--An IPC developed in accordance with §260.77 of this chapter.

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

(118) Respite--A DBMD Program service described in §260.353 of this chapter (relating to Respite).

(119) Responder--A person designated to respond to an alarm call activated by an individual.

(120) Restraint--Any of the following:

(A) a physical restraint;

(B) a mechanical restraint; or

(C) a chemical restraint.

(121) Restrictive intervention--An action or procedure that limits an individual's movement, access to other individuals, locations, or activities, or restricts an individual's rights, including a restraint, a protective device, and seclusion.

(122) Revised IPC--An enrollment IPC or a renewal IPC that is revised during an IPC period in accordance with §260.77 of this chapter to add a new DBMD Program service or CFC service or change the amount of an existing service.

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

(124) Seclusion--A restrictive intervention that is the involuntary placement of an individual alone in an area from which the individual is prevented from leaving.

(125) Service backup plan--A written plan developed and revised by an individual's service planning team in accordance with §260.213 of this chapter (relating to Service Backup Plans) to ensure continuity of critical program services if service delivery is interrupted.

(126) Service planning team--A team consisting of:

(A) the individual;

(B) if applicable, the individual's LAR or an actively involved person;

(C) the individual's case manager;

(D) one of the following persons who is not the case manager:

(i) the program director; or

(ii) an RN designated by the program provider;

(E) other persons whose inclusion is requested by the individual, LAR, or actively involved person, including a managed care organization service coordinator, a family member, a friend, and a teacher; and

(F) other persons selected by the program provider who are:

(i) professionally qualified by certification or licensure and have special training and experience in the diagnosis and habilitation of persons with the individual's related condition; or

(ii) directly involved in the delivery of services and supports to the individual.

(127) Service provider--A person who is an employee or contractor of a program provider who provides a DBMD Program service or a CFC service directly to an individual.

(128) 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 person, volunteer, or controlling person, unless a consensual sexual relationship with an adult individual existed before the service provider, staff person, volunteer, or controlling person became a service provider, staff person, volunteer, or controlling person.

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

(130) 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.

(131) Significant subaverage general intellectual functioning--Consistent with THSC §591.003, measured intelligence on standardized general intelligence tests of two or more standard deviations (not including standard error of measurement adjustments) below the age-group mean for the tests used.

(132) Specialized licensed vocational nursing--A DBMD Program service that provides licensed vocational nursing to an individual who has a tracheostomy or is dependent on a ventilator.

(133) Specialized registered nursing--A DBMD Program service that provides registered nursing to an individual who has a tracheostomy or is dependent on a ventilator.

(134) Speech-language pathology--A DBMD Program service that provides speech-language pathology as defined in Texas Occupations Code §401.001.

(135) SSA--Social Security Administration.

(136) SSI--Supplemental Security Income.

(137) Staff person--A full-time or part-time employee of a program provider, other than a service provider.

(138) 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.

(139) Support consultation--A DBMD Program service that is defined in §264.103 of this title and may be provided an individual who chooses to participate in the CDS option.

(140) Supported employment--A DBMD Program service that provides assistance 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.

(141) System check--A test of the CFC ERS equipment to determine if:

(A) the individual can successfully activate an alarm call; and

(B) the equipment is working properly.

(142) TAC--Texas Administrative Code. A compilation of state agency rules published by the Texas State Secretary of State in accordance with Texas Government Code Chapter 2002, Subchapter C.

(143) TAS--Transition Assistance Services. A DBMD Program service provided in accordance with Chapter 272 of this title (relating to Transition Assistance Services) to an individual who is receiving institutional services and is eligible for and enrolling into the DBMD Program.

(144) Texas Workforce Commission--The state agency established under Texas Labor Code Chapter 301.

(145) THSC--Texas Health and Safety Code. Texas statutes relating to health and safety.

(146) TMHP--Texas Medicaid & Healthcare Partnership. The Texas Medicaid program claims administrator.

(147) Transfer--The movement of an individual from a DBMD Program provider or a FMSA to a different DBMD Program provider or FMSA.

(148) Trust fund account--An account at a financial institution that contains an individual's personal funds and is under the program provider's control.

(149) 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.

(150) Videoconferencing--An interactive, two-way audio and video communication:

(A) used to conduct a meeting between two or more persons who are in different locations; and

(B) that conforms to the privacy requirements under the Health Insurance Portability and Accountability Act.

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

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Karen Ray
Chief Counsel
Health and Human Services Commission
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SUBCHAPTER B. ELIGIBILITY, ENROLLMENT, AND REVIEW
DIVISION 2. ENROLLMENT PROCESS, PERSON-CENTERED PLANNING, AND REQUIREMENTS FOR SERVICE SETTINGS

26 TAC §260.59

STATUTORY AUTHORITY

The amendment is adopted under 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; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance program in Texas and to adopt rules and standards for program administration; and Texas Human Resources Code §32.0755(f), which provides that the Executive Commissioner shall adopt rules to establish performance standards for providers providing prevocational or similar services to persons in a Medicaid waiver program.

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SUBCHAPTER D. ADDITIONAL PROGRAM PROVIDER PROVISIONS

26 TAC §260.203, §260.205

STATUTORY AUTHORITY

The amendments are adopted under 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; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance program in Texas and to adopt rules and standards for program administration; and Texas Human Resources Code §32.0755(f), which provides that the Executive Commissioner shall adopt rules to establish performance standards for providers providing prevocational or similar services to persons in a Medicaid waiver program.

§260.203. Qualifications of Program Provider Staff.

(a) A program provider must employ a program director who is responsible for the program provider's day-to-day operations. The program director must:

(1) have a minimum of one year of paid experience in community programs planning and providing direct services to individuals with deafness, blindness, or multiple disabilities and have a master's degree in a health and human services related field;

(2) have a minimum of two years of paid experience in community programs planning and providing direct services to individuals with deafness, blindness, or multiple disabilities, and have a bachelor's degree in a health and human services related field; or

(3) have been a program director for the DBMD Program provider on or before June 15, 2010.

(b) A program provider must ensure that a case manager:

(1) has:

(A) a bachelor's degree in a health and human services related field and a minimum of two years of experience in the delivery of direct services to individuals with disabilities;

(B) an associate degree in a health and human services related field and a minimum of four years of experience providing direct services to individuals with disabilities; or

(C) a high school diploma or certificate recognized by a state as the equivalent of a high school diploma and a minimum of six years of experience providing direct services to individuals with disabilities; and

(2) either:

(A) is fluent in the individual's preferred communication methods (American sign language, tactile symbols, communication boards, pictures, or gestures); or

(B) within six months after being assigned to an individual, becomes fluent in the individual's communication methods.

(c) For purposes of subsection (d) of this section and consistent with Texas Government Code §526.0404, "deafblind-related course work" means educational courses designed to improve a person's:

(1) knowledge of deafblindness and its effect on learning;

(2) knowledge of the role of intervention and ability to facilitate the intervention process;

(3) knowledge of areas of communication relevant to deafblindness, including methods, adaptations, and use of assistive technology, and ability to facilitate the development and use of communication skills for a person with deafblindness;

(4) knowledge of the effect that deafblindness has on a person's psychological, social, and emotional development and ability to facilitate the emotional well-being of a person with deafblindness;

(5) knowledge of and issues related to sensory systems and ability to facilitate the use of the senses;

(6) knowledge of motor skills, movement, orientation, and mobility strategies and ability to facilitate orientation and mobility skills;

(7) knowledge of the effect that additional disabilities have on a person with deafblindness and the ability to provide appropriate support; or

(8) professionalism and knowledge of ethical issues relevant to the role of an intervener.

(d) A program provider must ensure that:

(1) an intervener:

(A) is at least 18 years of age;

(B) is not:

(i) the spouse of the individual to whom the intervener is assigned; or

(ii) if the individual is under 18 years of age, a parent of the individual to whom the intervener is assigned;

(C) holds a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma;

(D) has at least two years of experience working with individuals with developmental disabilities; and

(E) has the ability to proficiently communicate in the functional language of the individual to whom the intervener is assigned;

(2) an intervener I:

(A) meets the requirements for an intervener described in paragraph (1) of this subsection;

(B) has at least six months of experience working with persons who have deafblindness or function as persons with deafblindness;

(C) completed at least eight semester credit hours in deafblind-related course work at a college or university accredited by:

(i) a state agency recognized by the United States Department of Education; or

(ii) a non-governmental entity recognized by the United States Department of Education; and

(D) has completed a practicum that is at least one semester credit hour in deafblind-related course work at a college or university accredited by:

(i) a state agency recognized by the United States Department of Education; or

(ii) a non-governmental entity recognized by the United States Department of Education;

(3) an intervener II:

(A) meets the requirements for an intervener I described in paragraph (2) of this subsection;

(B) has at least nine months of experience working with persons who have deafblindness or function as persons with deafblindness; and

(C) has completed at least an additional 10 semester credit hours in deafblind-related course work at a college or university accredited by:

(i) a state agency recognized by the United States Department of Education; or

(ii) a non-governmental entity recognized by the United States Department of Education; and:

(4) an intervener III:

(A) meets the requirements for an intervener II described in paragraph (3)(A) of this subsection;

(B) has at least one year of experience working with persons with deafblindness or function as persons with deafblindness; and

(C) holds an associate degree or bachelor's degree in a course of study with a focus on deafblind-related course work from a college or university accredited by:

(i) a state agency recognized by the United States Department of Education; or

(ii) a non-governmental entity recognized by the United States Department of Education.

(e) A program provider must ensure that a service provider who interacts directly with an individual is able to communicate with the individual.

(f) A program provider must ensure that a service provider of a therapy described in §260.355(a) of this chapter (relating to Therapies) is licensed by the State of Texas as described in §260.355(b) of this chapter.

(g) A program provider must ensure that a service provider of employment assistance or a service provider of supported employment:

(1) is at least 18 years of age;

(2) is not:

(A) the spouse of the individual; or

(B) a parent of the individual if the individual is under 18 years of age; and

(3) has:

(A) a bachelor's degree in rehabilitation, business, marketing, or a related human services field with six months of paid or unpaid experience providing services to people with disabilities;

(B) an associate degree in rehabilitation, business, marketing, or a related human services field with one year of paid or unpaid experience providing services to people with disabilities; or

(C) a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma, with two years of paid or unpaid experience providing services to people with disabilities.

(h) Documentation of the experience required by subsection (g) of this section must include:

(1) for paid experience, a written statement from a person who paid for the service or supervised the provision of the service; and

(2) for unpaid experience, a written statement from a person who has personal knowledge of the experience.

(i) A program provider must ensure that a service provider of employment readiness:

(1) be at least 18 years of age;

(2) is not:

(A) the parent of the individual if the individual is under 18 years of age; or

(B) the spouse of the individual; and

(3) has:

(A) a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma; and

(B) documentation of a proficiency evaluation of experience and competence to perform the job tasks that includes:

(i) a written competency-based assessment of the ability to document service delivery and observations of individuals receiving services; and

(ii) at least three written personal references from persons not related by blood that indicate the ability to provide a safe, healthy environment for the individuals receiving services.

(j) A program provider must ensure that dental treatment is provided by a person licensed to practice dentistry or dental hygiene in accordance with Texas Occupations Code Chapter 256.

(k) A program provider must ensure that a service provider not required to meet the other education or experience requirements described in this section:

(1) is 18 years of age or older;

(2) has:

(A) a high school diploma;

(B) a certificate recognized by a state as the equivalent of a high school diploma; or

(C) the following:

(i) documentation of a proficiency evaluation of experience and competence to perform job tasks including an ability to provide the required services needed by the individual as demonstrated through a written competency-based assessment; and

(ii) at least three personal references from persons not related by blood that evidence the person's ability to provide a safe and healthy environment for the individual; and

(3) except for a service provider of chore services, either:

(A) is fluent in the communication method preferred by the individual to whom the service provider is assigned, including American sign language, tactile symbols, communication boards, pictures, and gestures; or

(B) has the ability to become fluent in the communication methods used by an individual within three months after being assigned to the individual.

(l) A program provider must ensure that:

(1) a vehicle in which a service provider transports an individual has a valid Vehicle Identification Certificate of Inspection, in accordance with state law; and

(2) a service provider who transports an individual in a vehicle has:

(A) a current Texas driver's license; and

(B) vehicle liability insurance, in accordance with state law.

(m) A service provider:

(1) must not be a parent of the individual to whom the service provider is providing any service, if the individual is under 18 years of age;

(2) must not be the spouse of the individual to whom the service provider is providing any service;

(3) must not be a relative or guardian of the individual to whom the service provider is providing an adaptive aid; and

(4) must not be a relative or guardian of the individual to whom the service provider is providing any of the following services, if the individual is 18 years of age or older:

(A) assisted living;

(B) case management;

(C) behavioral support;

(D) dental treatment;

(E) dietary services;

(F) FMS, if the individual is participating in the CDS option;

(G) occupational therapy;

(H) orientation and mobility;

(I) physical therapy;

(J) speech and language pathology;

(K) audiology; and

(L) support consultation, if the individual is participating in the CDS option.

(n) A service provider of CFC PAS/HAB must:

(1) have:

(A) a high school diploma;

(B) a certificate recognized by a state as the equivalent of a high school diploma; or

(C) both of the following:

(i) a successfully completed written competency-based assessment demonstrating the service provider's ability to perform CFC PAS/HAB tasks, including an ability to perform CFC PAS/HAB tasks required for the individual to whom the service provider will provide CFC PAS/HAB; and

(ii) at least three written personal references from persons not related by blood that evidence the service provider's ability to provide a safe and healthy environment for the individual; and

(2) meet any other qualifications requested by the individual or LAR based on the individual's needs and preferences.

(o) The program provider must maintain documentation in a service provider's employment, contract, or personal service agreement file that the service provider meets the requirements of this section.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Karen Ray
Chief Counsel
Health and Human Services Commission
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SUBCHAPTER F. SERVICE DESCRIPTIONS AND REQUIREMENTS
DIVISION 3. REQUIREMENTS FOR OTHER DBMD PROGRAM SERVICES

26 TAC §260.341

STATUTORY AUTHORITY

The amendment is adopted under 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; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance program in Texas and to adopt rules and standards for program administration; and Texas Human Resources Code §32.0755(f), which provides that the Executive Commissioner shall adopt rules to establish performance standards for providers providing prevocational or similar services to persons in a Medicaid waiver program.

§260.341. Employment Services.

(a) A program provider must ensure that a service provider of employment assistance or a service provider of supported employment meets the qualifications described in §260.203(g) of this chapter (relating to Qualifications of Program Provider Staff).

(b) Before including employment assistance on an individual's IPC, a program provider must 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.).

(c) A program provider must ensure that employment assistance:

(1) consists of a service provider performing the following activities:

(A) identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions;

(B) locating prospective employers offering employment compatible with an individual's identified preferences, skills, and requirements;

(C) contacting a prospective employer on behalf of an individual and negotiating the individual's employment;

(D) transporting the individual to help the individual locate competitive employment in the community; and

(E) participating in service planning team meetings;

(2) is provided in accordance with the individual's IPC and with Appendix C of the DBMD waiver application approved by CMS and available on the HHSC website;

(3) is not provided to an individual with the individual present at the same time that one of the following services is provided:

(A) day habilitation;

(B) transportation provided as a residential habilitation activity;

(C) supported employment;

(D) respite; or

(E) CFC PAS/HAB; and

(4) does not include using Medicaid funds paid by HHSC to a program provider for incentive payments, subsidies, or unrelated vocational training expenses, such as:

(A) paying an employer:

(i) to encourage the employer to hire an individual; or

(ii) for supervision, training, support, or adaptations for an individual that the employer typically makes available to other workers without disabilities filling similar positions in the business; or

(B) paying the individual:

(i) as an incentive to participate in employment assistance activities; or

(ii) for expenses associated with the start-up costs or operating expenses of an individual's business.

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

(e) A program provider must ensure that supported employment:

(1) consists of a service provider performing the following activities:

(A) making employment adaptations, supervising, and providing training related to an individual's assessed needs;

(B) transporting the individual to support the individual to be self-employed, work from home, or perform in a work setting; and

(C) participating in service planning team meetings;

(2) is provided in accordance with the individual's IPC and with Appendix C of the DBMD waiver application approved by CMS and available on the HHSC website;

(3) is not provided to an individual with the individual present at the same time that one of the following services are provided:

(A) day habilitation;

(B) transportation provided as a residential habilitation activity;

(C) employment assistance;

(D) respite; or

(E) CFC PAS/HAB; and

(4) does not include:

(A) sheltered work or other similar types of vocational services furnished in specialized facilities; or

(B) using Medicaid funds paid by HHSC to a program provider for incentive payments, subsidies, or unrelated vocational training expenses, such as:

(i) paying an employer:

(I) to encourage the employer to hire an individual; or

(II) to supervise, train, support, or make adaptations for an individual that the employer typically makes available to other workers without disabilities filling similar positions in the business; or

(ii) paying the individual:

(I) as an incentive to participate in supported employment activities; or

(II) for expenses associated with the start-up costs or operating expenses of an individual's business.

(f) Employment readiness:

(1) is assistance that prepares an individual to participate in employment;

(2) provides the following person-centered activities:

(A) teaching generalized habilitative skills necessary to prepare an individual to participate in employment;

(B) training in the use of adaptive equipment necessary to obtain and retain employment skills; and

(C) achieving generalized vocational goals consistent with the outcomes identified in an individual's IPP;

(3) is not job-task oriented;

(4) includes activities for which an individual is compensated in accordance with applicable laws and regulations;

(5) provides personal assistance for an individual who cannot manage personal care needs during employment readiness activities; and

(6) includes:

(A) transportation between an individual's place of residence and an employment readiness location;

(B) transportation from one employment readiness location to another employment readiness location; and

(C) securing transportation as described in paragraph (6)(A) or (6)(B) of this subsection.

(g) A program provider may provide employment readiness to an individual only if the individual's service planning team does not expect the individual to be competitively employed within one year after the date employment readiness begins.

(h) A program provider may not provide employment readiness to an individual who is:

(1) receiving supported employment; or

(2) engaged in competitive employment.

(i) Before employment readiness is included on an individual's enrollment IPC, renewal IPC, or revised IPC, a program provider must ensure:

(1) an HHS Employment First Discovery Tool is completed in accordance with §284.105 of this title (relating to Uniform Process) and supports the provision of employment readiness to the individual; and

(2) documentation is maintained in the individual's record that employment readiness is not available to the individual under a program funded under §110 of the Rehabilitation Act of 1973 or a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.).

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 4, 2024.

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Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: January 1, 2025
Proposal publication date: August 2, 2024
For further information, please call: (512) 438-2910

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DIVISION 4. NON-BILLABLE TIME AND ACTIVITIES

26 TAC §260.357

STATUTORY AUTHORITY

The amendment is adopted under 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; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance program in Texas and to adopt rules and standards for program administration; and Texas Human Resources Code §32.0755(f), which provides that the Executive Commissioner shall adopt rules to establish performance standards for providers providing prevocational or similar services to persons in a Medicaid waiver program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 4, 2024.

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Karen Ray
Chief Counsel
Health and Human Services Commission
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For further information, please call: (512) 438-2910

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CHAPTER 262. TEXAS HOME LIVING (TxHmL) PROGRAM AND COMMUNITY FIRST CHOICE (CFC)

The Texas Health and Human Services Commission (HHSC) adopts amendments to §262.3, concerning Definitions; §262.5, concerning Description of TxHmL Program Services; §262.103, Process for Enrollment of Applicants; §262.202, concerning Requirements for Home and Community-Based Settings; §262.301, concerning IPC Requirements; §262.304, concerning Service Limits; §262.401, concerning Program Provider Reimbursement; and §262.701, concerning LIDDA Requirements for Providing Service Coordination in the TxHmL Program.

The amendments to §262.3, §262.5, §262.103, §262.401, and §262.701 are adopted with changes to the proposed text as published in the August 2, 2024, issue of the *Texas Register* (49 TexReg 5704). These rules will be republished.

The amendments to §262.202, §262.301, and §262.304 are adopted without changes to the proposed text as published in the August 2, 2024, issue of the *Texas Register* (49 TexReg 5704). These rules will not be republished.

BACKGROUND AND JUSTIFICATION

The adopted amendments are necessary to implement Texas Human Resources Code §32.0755, added by House Bill (H.B.) 4169, 88th Legislature, Regular Session, 2023. The adopted amendments implement a service similar to prevocational services, named employment readiness, in the Texas Home Living (TxHmL) Program, one of HHSC's §1915(c) Medicaid waiver programs.

COMMENTS

The 31-day comment period ended September 3, 2024.

During this period, HHSC received comments regarding the proposed rules from six commenters, including Disability Rights Texas; Texas Association of People Supporting Employment First; Texas Council for Developmental Disabilities; The Arc of Texas; Texana Center; and Advo Companies.

A summary of comments relating to the rules and HHSC's responses follows.

Comment: One commenter expressed concern about the term "group setting" because it perpetuates beliefs that individuals with intellectual and developmental disabilities (IDD) are not members of the community and are not capable of work. The commenter further expressed that the term does not align with the Centers for Medicare & Medicaid Services' (CMS) intent to integrate individuals in the community.

Response: HHSC declines to make a change in response to the comment. The term "group setting," as defined in proposed Section 262.3(25), is used only in proposed §262.202(d) that outlines the home and community-based services (HCBS) settings requirements for settings where more than one individual receives employment readiness, supported employment, and individualized skills and socialization. This ensures that such settings are compliant with the federal requirements in HCBS settings requirements. Furthermore, HHSC does not agree that the term perpetuates beliefs that individuals with IDD are not members of the community capable of work.

Comment: One commenter expressed concern that the term "job-task oriented" in proposed §262.3(48) is subjective and unmeasurable and will lead to an increase in job task-oriented activities.

Response: HHSC declines to make a change in response to this comment because the term is only used in the description of employment readiness in proposed §262.5(a)(21) to establish that the service is not job-task oriented.

Comment: Several commenters recommended HHSC revise proposed §262.3(48) to change the definition of "job-task oriented" from "focused on developing a skill related to a specific type of employment" to "focused on developing a single skill related to a specific type of employment" because its current definition is vague.

Response: HHSC declines to add "single" to the definition of "job-task oriented" in proposed §262.3(48). Adding "single" implies that focusing on developing multiple skills related to a specific type of employment is not job-task oriented, which is incorrect.

Comment: One commenter expressed concern about proposed §262.103(o)(2)(A)(ii) that adds employment readiness to the array of TxHmL Program services that may require the individual's initial individual plan of care (IPC) to include a sufficient amount of registered nursing units for the program provider's registered nurse to perform a comprehensive nursing assessment. The commenter indicated this requirement reinforces the Medical Model view of disability which perpetuates the view that a person with IDD needs treatment and is not capable of completing job tasks.

Response: HHSC declines to make a change in response this comment. The requirements in proposed §262.103(o)(2)(A)(ii) ensure a person in the TxHmL Program who receives certain TxHmL services has a sufficient amount of registered nursing services for an RN to perform a comprehensive nursing assessment to ensure the individual's health, safety, and welfare in the provision of the service.

Comment: One commenter expressed concerns that the requirements in proposed §262.202(d), to ensure that a group setting allows an individual to control the individual's own schedule and activities, have access to the individual's food at any time, receive visitors of the individual's choosing at any time and be physically accessible and free of hazards, are irrelevant to employment readiness settings and are more appropriate for residential settings.

Response: HHSC declines to make changes in response to this comment because the requirements in proposed §262.202(d) were added to comply with federal HCBS settings requirements for services provided in a group setting.

Comment: One commenter expressed that employment readiness does not reflect evidence-based practices for employment services. The commenter also expressed concern about proposed §262.301(c)(11) requiring authorization of employment readiness to be supported by an HHSC Employment First

Discovery Tool and suggested that the HHSC Employment First Discovery Tool should only be applicable in integrated settings.

Response: HHSC declines to make a change in response this comment. HHSC requires authorization of employment readiness to be supported by the HHSC Employment First Discovery Tool because the tool assesses the individual's employment goals and can assist the service planning team in identifying the most appropriate employment service to help the individual meet those goals.

Comment: Several commenters recommended HHSC revise proposed §262.304 to add a five-year lifetime limit to employment readiness that may only be extended after an individual attempts competitive integrated employment. The commenters emphasized the goal should be competitive integrated employment.

Response: HHSC declines to make a change in response to these comments because a lifetime limit is not person-centered and may limit the opportunities for competitive integrated employment for individuals who need more support beyond the proposed five years to prepare for employment. In addition, the annual review of service plans ensures services on an individual's plan are the most appropriate to meet their needs.

Comment: One commenter requested that HHSC improve individualized skills and socialization and expand it to incorporate employment assistance and supported employment rather than add the requirement in proposed §262.304(a)(5) that establishes a combined service limit for employment readiness and individualized skills and socialization rule.

Response: HHSC declines to make a change in response to this comment because it is outside the scope of this rule project. A change to the scope of individualized skills and socialization would require additional analysis and a change to the TxHmL waiver application that has been approved by CMS.

Comment: One commenter requested HHSC allow more flexibility in how employment readiness is provided by changing the weekly service limit in proposed §262.304(a)(5) from five days per calendar week to 30 hours per calendar week to allow the service to be provided six days a week in a community setting.

Response: HHSC declines to make changes in response to this comment because pursuant to Title 26 Texas Administrative Code (TAC) §566.7(k), the program provider must offer an individual opportunity for leisure time activities, vacation periods, religious observances, holidays, and days off, consistent with the individual's choice and the routines of other members of the community.

Comment: One commenter stated vocational services do not cover group activities. The commenter noted that vocational rehabilitation counselors may consider employment readiness as a day program service that diminishes skills necessary for competitive, integrated employment.

Response: HHSC declines to make changes in response to this comment because vocational rehabilitation services are outside the scope of this project.

Comment: One commenter stated employment assistance and supported employment are underutilized and using these services would eliminate the need for the requirement in proposed §262.701(v), which requires a service coordinator to update an individual's person-directed plan if a modification to a service delivered in a group setting is needed.

Response: HHSC declines to make changes in response to this comment because the implementation of employment readiness is necessary for compliance with Texas Human Resources Code §32.0755, added by H.B. 4169, 88th Legislature, Regular Session, 2023.

Comment: Several commenters questioned what the parameters are for the program provider's assurance in §262.701(v)(8). The commenters requested HHSC require program providers to provide assurance that the modifications are safe and based on evidence and best practice.

Response: HHSC declines to make changes in response to these comments. Proposed §262.701(v) already requires documentation of a specific and individualized assessed need that justifies the modification and the individual's or legally authorized representative's signature evidencing informed consent to the modification. The documentation around assessing need and justifying the modification encompasses an assurance that the modifications are safe and based on evidence of need and best practices.

Comment: One commenter opposed the implementation of employment readiness, stating it is not a needed service and it is similar to day habilitation. The commenter expressed that employment assistance and supported employment services are existing services that prepare an individual for paid employment in the community.

Response: HHSC declines to make changes in response to this comment because the implementation of employment readiness is necessary for compliance with Texas Human Resources Code §32.0755, added by H.B. 4169, 88th Legislature, Regular Session, 2023.

Comment: One commenter expressed concern that the proposed rules do not include detailed information about employment readiness including performance standards, service standards, and requirements for program providers.

Response: HHSC declines to make changes in response to this comment. Service delivery requirements that include detailed service description are in the certification standards that are outside the scope of this rule project. In addition, the TxHmL Billing Requirements which is not within the scope of this rule project will provide detailed information about the service including detailed description, billable and non-billable activities, qualified service providers, and documentation requirements.

Comment: One commenter recommended HHSC invest in the development of individualized skills and socialization, employment assistance, and supported employment services to ensure every person has access to integrated, community-based activities and employment. The review of these services should cover the service rates, flexibility in the delivery of services, training, and transition support from Texas Workforce Commission - Vocational Rehabilitation Program services, transportation, long-term counselling for employment success, ongoing service provider training, and development of expertise in employment issues at the state level.

Response: HHSC declines to make changes in response to these comments because it is outside the scope of this rule project.

Comment: Several commenters requested that HHSC add a requirement that allows individuals who are competitively employed to receive employment readiness for professional development.

Response: HHSC declines to make changes in response to this comment. Employment assistance, a TxHmL Program service described in §262.5(a)(19), can be used to gain additional employment skills. Furthermore, proposed §262.5(a)(21) describes employment readiness as assistance that prepares an individual to participate in employment.

Comment: Three commenters requested that HHSC include professional and vocational skills development experience in the service provider requirements for employment readiness.

Response: HHSC declines to make changes in response to this comment because it is outside the scope of this rule project. Service provider requirements are in the certification standards and the TxHmL Billing Requirements that are not part of this rule project.

Comment: One commenter requested that HHSC allow "enclave settings," i.e., settings that allow the exclusive employment of individuals with intellectual and developmental disabilities to complete contract work as part of their employment readiness service.

Response: HHSC declines to make changes in response to this comment because "enclave setting" is outside the scope of this project. Based on the interpretation of technical guidance from the Centers for Medicaid & Medicare Services, HHSC considers enclave settings, also known as small group employment, to be a distinct service from employment readiness, because of the differences in focus, structure, and goals.

HHSC made changes to the rules that are not in response to comments.

HHSC made a minor editorial change in §262.3(48) for consistency in the waiver program rules in the spelling of "job-task oriented."

HHSC updated references to the Texas Government Code citations in proposed §262.3(53) and (65) to implement H.B. 4611, 88th Legislature, Regular Session, 2023, which makes non-substantive revisions to the Texas Government Code that make the statute more accessible, understandable, and usable.

HHSC updated references in §263.3, §263.5, §263.104, §263.601, and §263.901 to all rules administratively transferred from Title 40 TAC to Title 26 TAC.

SUBCHAPTER A. GENERAL PROVISIONS

26 TAC §262.3, §262.5

STATUTORY AUTHORITY

The amendments are adopted under 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; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance program in Texas and to adopt rules and standards for program administration; and Texas Human Resources Code §32.0755(f), which provides that the Executive Commissioner shall adopt rules to establish performance standards for providers providing prevocational or similar services to persons in a Medicaid waiver program.

§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 §264.103 of this title (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)/habilitation (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) Group setting--A setting, other than an individual's residence, in which more than one individual or other person receives employment readiness, employment assistance, supported employment, or a similar service.

(26) FMS--Financial management services.

(27) FMSA--Financial management services agency. As defined in §264.103 of this title, an entity that provides FMS to an individual participating in the CDS option.

(28) 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.

(29) 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.

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

(31) 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.

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

(33) 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.

(34) 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.

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

(36) 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.

(37) 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.

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

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

(40) 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.

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

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

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

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

(45) 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.

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

(47) 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.

(48) Job-task oriented--Focused on developing a skill related to a specific type of employment.

(49) 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.

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

(51) 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.

(52) 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.

(53) Managed care organization--This term has the meaning set forth in Texas Government Code §543A.0001.

(54) 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.

(55) 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.

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

(57) 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.

(58) 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.

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

(60) 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.

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

(62) PDP--Person-directed plan. A plan developed with an applicant or individual and LAR using an HHSC form that:

(A) 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; and

(B) includes the setting for each service, which must be selected by the individual or LAR from setting options.

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

(64) 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.

(65) Platform--This term has the meaning set forth in Texas Government Code §521.0001.

(66) 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.

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

(68) 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.

(69) Program provider--A person, as defined in §52.3 of this title (relating to Definitions), that has a contract with HHSC to provide TxHmL Program services, excluding an FMSA.

(70) Provisional contract--A contract that HHSC enters into with a program provider in accordance with §52.39 of this title (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 §52.39(e) of this title.

(71) 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.

(72) 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.

(73) 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).

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

(75) 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.

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

(77) 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.

(78) Service coordination--A service as defined in §331.5 of this title (relating to Definitions).

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

(80) Service planning team--One of the following:

(A) for an applicant or individual other than one described in subparagraph (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 ICF/IID or has enrolled in the TxHmL Program as a diversion from admission to an institution, including a nursing facility or ICF/IID, 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 in-

volved in the delivery of services to persons with an intellectual or developmental disability.

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

(82) 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.

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

(84) 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.

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

(86) Standard contract--A contract that HHSC enters into with a program provider in accordance with §52.41 of this title (relating to Standard Contract) that has a term of no more than five years, not including any extension agreed to in accordance with §52.41(d) of this title.

(87) 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.

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

(89) Synchronous audio-visual--An interactive, two-way audio and video communication platform that:

(A) allows a service to be provided to an individual in real time; and

(B) conforms to the privacy requirements under the Health Insurance Portability and Accountability Act.

(90) 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.

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

(92) 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.

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

(94) 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.

(95) 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.

(96) 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.

(97) 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.

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

(99) 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.

(100) Videoconferencing--An interactive, two-way audio and video communication:

(A) used to conduct a meeting between two or more persons who are in different locations; and

(B) that conforms to the privacy requirements under the Health Insurance Portability and Accountability Act.

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

§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 provision 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.

(21) Employment readiness is assistance that prepares an individual to participate in employment. Employment readiness services are not job-task oriented.

(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 §264.103 of this title (relating to Definitions).

(2) Support consultation is a service defined in §264.103 of this title.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Karen Ray
Chief Counsel
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SUBCHAPTER B. ELIGIBILITY, ENROLLMENT, AND REVIEW

26 TAC §262.103

STATUTORY AUTHORITY

The amendment is adopted under 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; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance program in Texas and to adopt rules and standards for program administration; and Texas Human Resources Code §32.0755(f), which provides that the Executive Commissioner shall adopt rules to establish performance standards for providers providing prevocational or similar services to persons in a Medicaid waiver program.

§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 §301.155 of this title (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 to complete 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 Chapter 264, 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 §264.108 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 §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, employment readiness, 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 and provides the signed and dated IPC to the service coordinator 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.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER C. PERSON-CENTERED PLANNING AND SERVICE SETTINGS

26 TAC §262.202

STATUTORY AUTHORITY

The amendment is adopted under 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; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance program in Texas and to adopt rules and standards for program administration; and Texas Human Resources Code §32.0755(f), which provides that the Executive Commissioner shall adopt rules to establish performance standards for providers providing prevocational or similar services to persons in a Medicaid waiver program.

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SUBCHAPTER D. DEVELOPMENT AND REVIEW OF AN IPC

26 TAC §262.301, §262.304

STATUTORY AUTHORITY

The amendment are adopted under 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; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance program in Texas and to adopt rules and standards for program administration; and Texas Human Resources Code §32.0755(f), which provides that the Executive Commissioner shall adopt rules to establish performance standards for providers providing prevocational or similar services to persons in a Medicaid waiver program.

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SUBCHAPTER E. REIMBURSEMENT BY HHSC

26 TAC §262.401

STATUTORY AUTHORITY

The amendment is adopted under 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; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance program in Texas and to adopt rules and standards for program administration; and Texas Human Resources Code §32.0755(f), which provides that the Executive Commissioner shall adopt rules to establish performance standards for providers providing prevocational or similar services to persons in a Medicaid waiver program.

§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, employment readiness, 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 §52.121 of this title (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 did not comply with §52.109 of this title (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 did 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 did not ensure and maintain documentation in the individual's record that employment assistance was 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 did not ensure and maintain documentation in the individual's record that supported employment was not available to the individual under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.);

(J) employment readiness, if before including the employment readiness on an individual's IPC, the program provider did not ensure and maintain documentation in the individual's record that employment readiness was 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.);

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

(L) 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;

(M) 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);

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

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

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

(Q) the service was not provided; or

(R) for CFC PAS/HAB, in-home day habilitation, and in-home respite, if the service claim for the service did 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) Chapter 52, Subchapter C of this title (relating to Requirements of a Contractor); 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 approves 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.

Filed with the Office of the Secretary of State on December 4, 2024.

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Karen Ray
Chief Counsel
Health and Human Services Commission
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For further information, please call: (512) 438-2910

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SUBCHAPTER H. LIDDA REQUIREMENTS

26 TAC §262.701

STATUTORY AUTHORITY

The amendment is adopted under 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; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance program in Texas and to adopt rules and standards for program administration; and Texas Human Resources Code §32.0755(f), which provides that the Executive Commissioner shall adopt rules to establish performance standards for providers providing prevocational or similar services to persons in a Medicaid waiver program.

§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 Chapter 331 of this title (relating to LIDDA Service Coordination), except as described in paragraph (2) of this subsection.

(2) Notwithstanding §331.19(b) of this title (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) Chapter 264 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-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 readiness, 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 readiness, 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 §331.11(d) of this title (relating to LIDDA's Responsibilities).

(p) In addition to the requirements described in Chapter 331 of this title (relating to LIDDA Service Coordination), a LIDDA must:

(1) comply with:

(A) this subchapter;

(B) Chapter 264 of this title; and

(C) Chapter 301, Subchapter M of this title (relating to Abuse, Neglect, and Exploitation in Local Authorities and Community Centers); and

(2) ensure that a rights protection officer, as required by §334.113 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 §264.702 of this title (relating to Requirements Related to HHSC Investigations When an Alleged Perpetrator is a Service Provider) or §264.703 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.

(q) A service coordinator must:

(1) at least annually, in accordance with Chapter 264, 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 §264.108 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.

(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 Chapter 264, 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.

(v) If notified by a program provider that a requirement described in §262.202 (d)(1) of this chapter (relating to Requirements for Home and Community-Based Settings), needs to be modified, a service coordinator must update the individual's PDP to include the following:

(1) a description of the specific and individualized assessed need that justifies the modification;

(2) a description of the positive interventions and supports that were tried but did not work;

(3) a description of the less intrusive methods of meeting the need that were tried but did not work;

(4) a description of the condition that is directly proportionate to the specific assessed need;

(5) a description of how data will be routinely collected and reviewed to measure the ongoing effectiveness of the modification;

(6) the established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;

(7) the individual's or LAR's signature evidencing informed consent to the modification; and

(8) the program provider's assurance that the modification will cause no harm to the individual.

Filed with the Office of the Secretary of State on December 4, 2024.

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Karen Ray
Chief Counsel
Health and Human Services Commission
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For further information, please call: (512) 438-2910

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CHAPTER 263. HOME AND COMMUNITY-BASED SERVICES (HCS) PROGRAM AND COMMUNITY FIRST CHOICE (CFC)

The Texas Health and Human Services Commission (HHSC) adopts amendments to §263.3, concerning Definitions; §263.5, concerning Description of HCS Program Services; §263.104, concerning Process for Enrollment of Applicants; §263.301, concerning IPC Requirements; §263.304, concerning Service Limits; §263.501, concerning Requirements for Home and Community-Based Settings; §263.601, concerning Program Provider Reimbursement; and §263.901, concerning LIDDA Requirements for Providing Service Coordination in the HCS Program.

The amendments to §263.3, §263.5, §263.104, §263.601, and §263.901 are adopted with changes to the proposed text as published in the August 2, 2024, issue of the *Texas Register* (49 TexReg 5721). This rule will be republished.

The amendments to §263.301, §263.304, and §263.501 are adopted without changes to the proposed text as published in the August 2, 2024, issue of the *Texas Register* (49 TexReg 5721). These rules will not be republished.

BACKGROUND AND JUSTIFICATION

The adopted amendments are necessary to implement Texas Human Resources Code §32.0755, added by House Bill (H.B.) 4169, 88th Legislature, Regular Session, 2023. The adopted amendments implement a service similar to prevocational services, named employment readiness, in the Home and Community-based Services (HCS) Program, one of HHSC's §1915(c) Medicaid waiver programs.

COMMENTS

The 31-day comment period ended September 3, 2024.

During this period, HHSC received comments regarding the proposed rules from six commenters, including Disability Rights Texas; Texas Association of People Supporting Employment First; Texas Council for Developmental Disabilities; The Arc of Texas; Texana Center; and Advo Companies.

A summary of comments relating to the rules and HHSC's responses follows.

COMMENT: One commenter expressed concern about the term "group setting" because it perpetuates beliefs that individuals with intellectual and developmental disabilities (IDD) are not members of the community and are not capable of work. The commenter further expressed that the term does not align with Centers for Medicare and Medicaid Services' (CMS) intent to integrate individuals in the community.

RESPONSE: HHSC declines to make a change in response to the comment. The term "group setting," as defined in proposed Section 263.3(36), is used only in proposed §263.501 that outlines the home and community-based services (HCBS) settings requirements for settings where more than one individual receives employment readiness, supported employment, and individualized skills and socialization. This ensures such a setting is compliant with the federal requirements in HCBS settings. Furthermore, HHSC does not agree that the term perpetuates the belief that individuals with IDD are not members of the community capable of work.

COMMENT: One commenter expressed concern that the term "job-task oriented" in proposed §263.3(56) is subjective and unmeasurable and will lead to an increase in job task-oriented activities.

RESPONSE: HHSC declines to make a change in response to this comment because the term is only used in the description of employment readiness in proposed §263.5(a)(26) to establish that the service is not job-task oriented.

COMMENT: Several commenters recommended HHSC revise proposed §263.3(56) to change the definition of "Job-task oriented" from "focused on developing a skill related to a specific type of employment" to "focused on developing a single skill related to a specific type of employment" because its current definition is vague.

RESPONSE: HHSC declines to add "single" to the definition of "job-task oriented" in proposed §263.3(56). Adding "single" implies that focusing on developing multiple skills related to a specific type of employment is not job-task oriented, which is incorrect.

COMMENT: One commenter expressed concerns about proposed §263.104(k)(9) that adds employment readiness to the array of HCS Program services that may require the individual's initial individual plan of care (IPC) to include a sufficient amount of registered nursing units for the program provider's registered nurse to perform a comprehensive nursing assessment.

The commenter also expressed concerns about proposed §263.104(k)(10)(A)(ii) that adds employment readiness to the list of HCS Program services that require a service coordinator to inform the applicant or legally authorized representative that if enough registered nursing units for a comprehensive nursing assessment are not included in the initial IPC, that the applicant may not be able to receive the service. The commenter stated these requirements reinforce the Medical Model view of disability that perpetuates the view that a person with IDD needs treatment and is not capable of completing job tasks.

RESPONSE: HHSC declines to make a change in response to this comment. The requirements in proposed §263.104(k)(9) and (10)(A)(ii) ensure an individual who receives certain HCS Program services has a sufficient amount of registered nursing services for a registered nurse to perform a comprehensive nursing assessment to ensure the individual's health, safety, and welfare in the provision of the service.

COMMENT: One commenter expressed concern that employment readiness does not reflect evidence-based practices for employment services. The commenter also expressed concern that proposed §263.301(c)(15) requires authorization of employment readiness to be supported by an HHSC Employment First Discovery Tool and suggested that the HHSC Employment First Discovery Tool should only be applicable in integrated settings.

RESPONSE: HHSC declines to make a change in response this comment. HHSC requires authorization of employment readiness to be supported by the HHSC Employment First Discovery Tool because the tool assesses the individual's employment goals and can assist the service planning team in identifying the most appropriate employment service to help the individual meet those goals.

COMMENT: Several commenters recommended HHSC revise proposed §263.304 to add a five-year lifetime limit to employment readiness that may only be extended after an individual attempts competitive integrated employment. The commenters emphasized the goal should be competitive integrated employment.

RESPONSE: HHSC declines to make a change in response to these comments because a lifetime limit is not person-centered and may limit opportunities for competitive integrated employment for individuals who need more support beyond the proposed five years to prepare for employment. In addition, the annual review of service plans ensures services on an individual's plan are the most appropriate to meet the individual's current needs.

COMMENT: One commenter requested HHSC allow more flexibility in how employment readiness is provided by changing the weekly service limit in proposed §263.304(a)(7) from five days per calendar week to 30 hours per calendar week to allow the service to be provided six days a week in a community setting.

RESPONSE: HHSC declines to make changes in response to this comment because pursuant to Title 26 Texas Administrative Code (TAC) §565.5(b)(42), an individual must have the right to "have opportunities for leisure time activities, vacation periods, religious observances, holidays, and days off, consistent with the individual's choice and routines of other members of the community."

COMMENT: One commenter requested that HHSC improve individualized skills and socialization and expand it to incorporate employment assistance and supported employment rather than add the requirement in proposed §263.304(a)(7) that establishes a combined service limit for employment readiness and individualized skills and socialization.

RESPONSE: HHSC declines to make a change in response to this comment because it is outside the scope of this rule project. A change to the scope of individualized skills and socialization would require additional analysis and a change to the HCS waiver application with CMS approval.

COMMENT: One commenter expressed concerns that the requirements in proposed §263.501(d)(1) and (2), to ensure that a group setting allows an individual to control the individual's own schedule and activities, have access to the individual's food at any time, receive visitors of the individual's choosing at any time and be physically accessible and free of hazards, are more appropriate for residential settings and irrelevant to employment readiness settings.

RESPONSE: HHSC declines to make changes in response to this comment because the requirements in proposed §263.501(d)(1) and (2) were added to comply with federal HCBS settings requirements for services provided in a group setting.

COMMENT: One commenter stated vocational services do not cover group activities. The commenter also stated that vocational rehabilitation counselors may consider employment readiness as a day program service that diminishes skills necessary for competitive, integrated employment.

RESPONSE: HHSC declines to make changes in response to this comment because vocational rehabilitation services are outside the scope of this project.

COMMENT: One commenter stated that employment assistance and supported employment are underutilized and using these services would eliminate the need for the requirement in proposed §263.901(e)(21), which requires a service coordinator to update an individual's person-directed plan if a modification to a service delivered in a group setting is needed.

RESPONSE: HHSC declines to make changes in response to this comment because the implementation of employment readiness is necessary for compliance with Texas Human Resources Code §32.0755, added by H.B. 4169, 88th Legislature, Regular Session, 2023.

COMMENT: One commenter opposed the implementation of employment readiness, stating it is not a needed service and it is similar to day habilitation. The commenter expressed that employment assistance and supported employment services are existing services that prepare an individual for paid employment in the community.

RESPONSE: HHSC declines to make changes in response to this comment because the implementation of employment readiness is necessary for compliance with Texas Human Resources Code §32.0755, added by H.B. 4169, 88th Legislature, Regular Session, 2023.

COMMENT: One commenter recommended HHSC invest in the development of individualized skills and socialization, employment assistance, and supported employment services to ensure every person has access to integrated, community-based activities and employment. The review of these services should cover the service rates, flexibility in the delivery of services, training, and transition support from Texas Workforce Commission - Vocational Rehabilitation Program services, transportation, long-term counselling for employment success, ongoing service

provider training and development of expertise in employment issues at the state level.

RESPONSE: HHSC did not make changes in response to these comments because it is outside the scope of this rule project.

COMMENT: One commenter expressed concern that the proposed rules do not include detailed information about employment readiness including performance standards, service standards, and requirements for program providers.

RESPONSE: HHSC declines to make changes in response to this comment. Service delivery requirements that include detailed service description are in the certification standards that are outside the scope of this rule project. In addition, the HCS Billing Requirements, which are not within the scope of this project, will provide detailed information about the service including detailed description, billable and non-billable activities, qualified service providers, and documentation requirements.

COMMENT: Several commenters requested that HHSC add a requirement that allows individuals who are competitively employed to receive employment readiness for professional development.

RESPONSE: HHSC declines to make changes in response to this comment. Employment assistance, an HCS Program service described in §263.5(a)(24), can be used to gain additional employment skills. Furthermore, proposed §263.5(a)(26) describes employment readiness as assistance that prepares an individual to participate in employment.

COMMENT: Three commenters requested that HHSC include professional and vocational skills development experience in the service provider requirements for employment readiness.

RESPONSE: HHSC declines to make changes in response to this comment because it is outside the scope of this rule project. Service provider requirements are in the certification standards and the HCS Billing Requirements, which are not part of this project.

COMMENT: One commenter requested that HHSC allow "enclave settings," i.e., settings that allow the exclusive employment of individuals with intellectual and developmental disabilities to complete contract work as part of their employment readiness service.

RESPONSE: HHSC declines to make changes in response to this comment because "enclave setting" is outside the scope of this project. Based on the interpretation of technical guidance from CMS, HHSC considers enclave settings, also known as small group employment, to be a distinct service from employment readiness, because of the differences in focus, structure, and goals.

HHSC made changes to the rules that are not in response to comments.

HHSC made a minor editorial change in proposed §263.3(56) for consistency in the waiver program rules in the spelling of "job-task oriented."

HHSC updated references to the Texas Government Code citations in proposed §263.3(61) and (75) to implement H.B. 4611, 88th Legislature, Regular Session, 2023, which makes non-substantive revisions to the Texas Government Code that make the statute more accessible, understandable, and usable.

HHSC updated references in §263.3, §263.5, §263.104, §263.601, and §263.901 to all rules administratively transferred from Title 40 TAC to Title 26 TAC.

SUBCHAPTER A. GENERAL PROVISIONS

26 TAC §263.3, §263.5

STATUTORY AUTHORITY

The amendments are adopted under 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; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance program in Texas and to adopt rules and standards for program administration; and Texas Human Resources Code §32.0755(f), which provides that the Executive Commissioner shall adopt rules to establish performance standards for providers providing prevocational or similar services to persons in a Medicaid waiver program.

§263.3. Definitions.

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

(1) Abuse--

(A) physical abuse;

(B) sexual abuse; or

(C) verbal or emotional abuse.

(2) Actively involved--Significant, ongoing, and supportive involvement with an applicant or individual by a person, as determined by the applicant's or individual's service planning team or program provider, based on the person's:

(A) interactions with the applicant or individual;

(B) availability to the applicant or individual for assistance or support when needed; and

(C) knowledge of, sensitivity to, and advocacy for the applicant's or individual's needs, preferences, values, and beliefs.

(3) ADLs--Activities of daily living. Basic personal everyday activities, including tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

(4) Agency foster home--This term has the meaning set forth in Texas Human Resources Code §42.002.

(5) ALF--Assisted living facility. A facility licensed in accordance with Texas Health and Safety Code Chapter 247, Assisted Living Facilities.

(6) Applicant--A Texas resident seeking services in the Home and Community-Based Services Program.

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

(8) Auxiliary aid--A service or device that enables an individual with impaired sensory, manual, or speaking skills to participate in the person-centered planning process. An auxiliary aid includes interpreter services, transcription services, and a text telephone.

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

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

(11) CDS option--Consumer directed services option. A service delivery option as defined in §264.103 of this title (relating to Definitions).

(12) CFC--Community First Choice.

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

(14) CFC FMS--The term used for financial management services on the individual plan of care (IPC) of an applicant or individual if the applicant will receive or the individual receives only CFC personal assistance services (PAS)/habilitation (HAB) through the CDS option.

(15) CFC support consultation--The term used for support consultation on the IPC of an applicant or individual if the applicant will receive or the individual receives only CFC PAS/HAB through the CDS option.

(16) CMS--Centers for Medicare & Medicaid Services. The federal agency within the United States Department of Health and Human Services that administers the Medicare and Medicaid programs.

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

(18) Comprehensive nursing assessment--A comprehensive physical and behavioral assessment of an individual, including the individual's health history, current health status, and current health needs, that is completed by a registered nurse (RN).

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

(20) CRCG--Community resource coordination group. A local interagency group, composed of public and private agencies, that develops service plans for individuals whose needs can be met only through interagency coordination and cooperation. The group's role and responsibilities are described in the Memorandum of Understanding on Coordinated Services to Persons Needing Services from More Than One Agency, available on the Texas Health and Human Services Commission (HHSC) website.

(21) Delegated nursing task--A nursing task delegated by an RN to an unlicensed person in accordance with:

(A) 22 TAC Chapter 224 (relating to Delegation of Nursing Tasks by Registered Professional Nurses to Unlicensed Personnel for Clients with Acute Conditions or in Acute Care Environments); and

(B) 22 TAC Chapter 225 (relating to RN Delegation to Unlicensed Personnel and Tasks Not Requiring Delegation in Independent Living Environments for Clients with Stable and Predictable Conditions).

(22) Designated Representative--This term has the meaning set forth in §264.103 of this title.

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

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

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

(26) Emergency--An unexpected situation in which the absence of an immediate response could reasonably be expected to result in a risk to the health and safety of an individual or another person.

(27) Emergency situation--An unexpected situation involving an individual's health, safety, or welfare, of which a person of ordinary prudence would determine that the legally authorized representative (LAR) should be informed, such as an individual:

(A) needing emergency medical care;

(B) being removed from the individual's residence by law enforcement;

(C) leaving the individual's residence without notifying a staff member or service provider and not being located; and

(D) being moved from the individual's residence to protect the individual (for example, because of a hurricane, fire, or flood).

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

(29) Exploitation--The illegal or improper act or process of using, or attempting to use, an individual or the resources of an individual for monetary or personal benefit, profit, or gain.

(30) Family-based alternative--A family setting in which the family provider or providers are specially trained to provide support and in-home care for children with disabilities or children who are medically fragile.

(31) FMS--Financial management services.

(32) FMSA--Financial management services agency. As defined in §264.103 of this title, an entity that provides financial management services to an individual participating in the CDS option.

(33) Former military member--A person who served in the United States Army, Navy, Air Force, Marine Corps, Coast Guard, or Space Force:

(A) who declared and maintained Texas as the person's state of legal residence in the manner provided by the applicable military branch while on active duty; and

(B) who was killed in action or died while in service, or whose active duty otherwise ended.

(34) Four-person residence--A residence:

(A) that a program provider leases or owns;

(B) in which at least one person but no more than four persons receive:

(i) residential support;

(ii) supervised living;

(iii) a non-HCS Program service similar to residential support or supervised living (for example, services funded by DFPS or by a person's own resources); or

(iv) respite;

(C) that, if it is the residence of four persons, at least one of those persons receives residential support;

(D) that is not the residence of any persons other than a service provider, the service provider's spouse or person with whom the service provider has a spousal relationship, or a person described in subparagraph (B) of this paragraph; and

(E) that is not a setting described in §263.501(b) of this chapter (relating to Requirements for Home and Community-Based Service Settings).

(35) GRO--General residential operation. This term has the meaning set forth in Texas Human Resources Code §42.002.

(36) Group setting--A setting, other than an individual's residence, in which more than one individual or other person receives employment readiness, employment assistance, supported employment, or a similar service.

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

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

(39) 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.

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

(41) 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.

(42) 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.

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

(44) 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.

(45) 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.

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

(47) Implementation plan--A written document developed by a program provider for an individual, for each HCS Program service, except supported home living, and for each CFC service, except CFC support management, on the individual's IPC to be provided by the program provider. An implementation plan includes:

(A) a list of outcomes identified in the person-directed plan that will be addressed using HCS Program services and CFC services;

(B) specific objectives to address the outcomes required by subparagraph (A) of this paragraph that are:

(i) observable, measurable, and outcome-oriented; and

(ii) derived from assessments of the individual's strengths, personal goals, and needs;

(C) a target date for completion of each objective;

(D) the number of units of HCS Program services and CFC services needed to complete each objective;

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

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

(48) 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.

(49) Individual--A person enrolled in the HCS Program.

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

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

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

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

(A) states:

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

(ii) the services and supports to be provided to the individual through resources other than HCS Program services or CFC services, including natural supports, medical services, and educational services; and

(iii) if an individual will receive CFC support management; and

(B) is authorized by HHSC.

(54) IPC cost--Estimated annual cost of HCS Program services included on an IPC.

(55) 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.

(56) Job-task oriented--Focused on developing a skill related to a specific type of employment.

(57) LAR--Legally authorized representative. A person authorized by law to act on behalf of another person with regard to a matter described in this chapter, including a parent, guardian, or managing conservator of a minor; a guardian of an adult; an agent appointed under a power of attorney; or a representative payee appointed by the Social Security Administration. An LAR, such as an agent appointed under a power of attorney or representative payee appointed by the Social Security Administration, may have limited authority to act on behalf of a person.

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

(59) 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.

(60) LON--Level of need. An assignment given by HHSC to an individual upon which reimbursement for host home/companion care, supervised living, residential support, in-home day habilitation, and day habilitation is based.

(61) Managed care organization--This term has the meaning set forth in Texas Government Code §543A.0001.

(62) 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.

(63) 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.

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

(65) 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.

(66) 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.

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

(68) 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.

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

(70) PDP--Person-directed plan. A plan developed with an applicant or individual and LAR using an HHSC form that:

(A) 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; and

(B) includes the setting for each service, which must be selected by the individual or LAR from setting options.

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

(72) Permanency planner--A person who:

(A) develops a permanency plan using the HHSC Permanency Planning Instrument for Children Under 22 Years of Age form; and

(B) performs other permanency planning activities for an applicant or individual under 22 years of age.

(73) Permanency planning--A philosophy and planning process that focuses on the outcome of family support for an applicant or individual under 22 years of age by facilitating a permanent living arrangement in which the primary feature is an enduring and nurturing parental relationship.

(74) 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.

(75) Platform--This term has the meaning set forth in Texas Government Code §521.0001.

(76) 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.

(77) Pre-enrollment minor home modifications assessment--An assessment performed by a licensed professional as required by the HCS Program Billing Requirements to determine the need for pre-enrollment minor home modifications.

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

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

(A) audiology;

(B) occupational therapy;

(C) physical therapy;

(D) speech and language pathology;

(E) behavioral support;

(F) cognitive rehabilitation therapy;

(G) dietary services; and

(H) social work.

(80) Program provider--A person, as defined in §52.3 of this title(relating to Definitions), that has a contract with HHSC to provide HCS Program services, excluding an FMSA.

(81) Provisional contract--A contract that HHSC enters into with a program provider in accordance with §52.39 of this title (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 §52.39(e) of this title.

(82) 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.

(83) Relative--A person related to another person within the fourth degree of consanguinity or within the second degree of affinity. A more detailed explanation of this term is included in the HCS Program Billing Requirements.

(84) Renewal IPC--An IPC developed for an individual in accordance with §263.302(a) of this chapter (relating to Renewal and Revision of an IPC).

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

(86) Revised IPC--An initial IPC or a renewal IPC that is revised during an IPC year in accordance with §263.302(b) or (d) of this chapter to add a new HCS Program service or CFC service or change the amount of an existing service.

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

(88) Service backup plan--A plan that ensures continuity of critical program services if service delivery is interrupted.

(89) Service coordination--A service as defined in §331.5 of this title (relating to Definitions).

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

(91) Service planning team--One of the following:

(A) for an applicant or individual other than one described in subparagraph (B) or (C) of this paragraph, a planning team consisting of:

(i) an applicant or individual and LAR;

(ii) service coordinator; and

(iii) other persons chosen by the applicant or individual or LAR, for example, a staff member of the program provider, a family member, a friend, a teacher, or if applicable, the permanency planner;

(B) for an applicant 21 years of age or older who is residing in a nursing facility and enrolling in the HCS Program, a planning team consisting of:

(i) the applicant and LAR;

(ii) the service coordinator;

(iii) if the applicant is at least 21 years of age but younger than 22 years of age, the permanency planner;

(iv) a staff member of the program provider;

(v) providers of specialized services;

(vi) a nursing facility staff person who is familiar with the applicant's needs;

(vii) other persons chosen by the applicant or LAR, for example, a family member, a friend, or a teacher; and

(viii) at the discretion of the LIDDA and with the approval of the individual or LAR, other persons who are directly involved in the delivery of services to persons with an intellectual or developmental disability; or

(C) for an individual 21 years of age or older who has enrolled in the HCS Program from a nursing facility or ICF/IID or has enrolled in the HCS Program as a diversion from admission to an institution, including a nursing facility or ICF/IID, for 365 calendar days after enrollment, a planning team consisting of:

(i) the individual and LAR;

(ii) the service coordinator;

(iii) if the individual is at least 21 years of age but younger than 22 years of age and resides in a three-person residence or four-person residence, the permanency planner;

(iv) a staff member of the program provider;

(v) other persons chosen by the individual or LAR, for example, a family member, a friend, or a teacher; and

(vi) 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.

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

(93) 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.

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

(95) 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.

(96) Specialized services--This term has the meaning set forth in §303.102 of this title (relating to Definitions).

(97) Staff member--An employee or contractor of an HCS program provider.

(98) Standard contract--A contract that HHSC enters into with a program provider in accordance with §52.41 of this title (relating to Standard Contract) that has a term of no more than five years, not including any extension agreed to in accordance with §52.41(d) of this title.

(99) 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.

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

(101) Supported Decision-Making Agreement--This term has the meaning set forth in Texas Estates Code §1357.002(4).

(102) Synchronous audio-visual--An interactive, two-way audio and video communication platform that:

(A) allows a service to be provided to an individual in real time; and

(B) conforms to the privacy requirements under the Health Insurance Portability and Accountability Act.

(103) 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.

(104) TANF--Temporary Assistance for Needy Families.

(105) TAS--Transition assistance services.

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

(107) Temporary admission--A stay in a facility listed in §263.705(a) of this chapter (relating to Suspension of HCS Program Services and CFC Services) for 270 calendar days or less or, if an extension is granted in accordance with §263.705(h) of this chapter, a stay in such a facility for more than 270 calendar days.

(108) Three-person residence--A residence:

(A) that a program provider leases or owns;

(B) in which at least one person but no more than three persons receive:

(i) residential support;

(ii) supervised living;

(iii) a non-HCS Program service similar to residential support or supervised living (for example, services funded by DFPS or by a person's own resources); or

(iv) respite;

(C) that is not the residence of any person other than a service provider, the service provider's spouse or person with whom the service provider has a spousal relationship, or a person described in subparagraph (B) of this paragraph; and

(D) that is not a setting described in §263.501(b) of this chapter.

(109) THSC--Texas Health and Safety Code. Texas statutes relating to health and safety.

(110) Transfer IPC--An IPC that is developed in accordance with §263.701 of this chapter (relating to Process for Individual to Transfer to a Different Program Provider or FMSA) and §263.702 of this chapter (relating to Process for Individual to Receive a Service Through the CDS Option that the Individual is Receiving from a Program Provider) when an individual transfers to another program provider or chooses a different service delivery option.

(111) Transition plan--A written plan developed in accordance with §303.701 of this title (relating to Transition Planning for a Designated Resident) for an applicant residing in a nursing facility who is enrolling in the HCS Program.

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

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

(114) 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.

(115) Videoconferencing--An interactive, two-way audio and video communication:

(A) used to conduct a meeting between two or more persons who are in different locations; and

(B) that conforms to the privacy requirements under the Health Insurance Portability and Accountability Act.

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

§263.5. Description of HCS Program Services.

(a) HCS Program services are described in this section and in Appendix C of the HCS Program waiver application approved by CMS and available on the HHSC website.

(1) Adaptive aids are devices, controls, or items that are necessary to address specific needs identified in an individual's service plan. Adaptive aids enable an individual to maintain or increase the ability to perform ADLs or the ability to perceive, control, or communicate with the environment in which the individual lives.

(2) Audiology is the provision of audiology as defined in the Texas Occupations Code Chapter 401.

(3) Speech and language pathology is the provision of speech-language pathology as defined in the Texas Occupations Code Chapter 401.

(4) Occupational therapy is the provision of occupational therapy as described in the Texas Occupations Code Chapter 454.

(5) Physical therapy is the provision of physical therapy as defined in the Texas Occupations Code Chapter 453.

(6) Dietary services are the provision of nutrition services as defined in the Texas Occupations Code Chapter 701.

(7) Behavioral support is the provision of specialized interventions that:

(A) assist an individual to increase adaptive behaviors to replace or modify maladaptive or socially unacceptable behaviors that prevent or interfere with the individual's inclusion in home and family life or community life; and

(B) improve an individual's quality of life.

(8) Social work is the provision of social work as defined in Texas Occupations Code Chapter 505.

(9) Cognitive rehabilitation therapy is assistance to an individual in learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry in order to enable the individual to compensate for the lost cognitive functions, including reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems.

(10) Day habilitation is assistance with acquiring, retaining, or improving self-help, socialization, and adaptive skills provided in a location other than the residence of an individual. Day habilitation does not include in-home day habilitation.

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

(12) Dental treatment is:

(A) emergency dental treatment;

(B) preventive dental treatment;

(C) therapeutic dental treatment; and

(D) orthodontic dental treatment, excluding cosmetic orthodontia.

(13) Minor home modifications are physical adaptations to an individual's home to address specific needs identified by an individual's service planning team and include pre-enrollment minor home modifications which are modifications completed before an applicant is discharged from a nursing facility, an ICF/IID, or a GRO and before the effective date of the applicant's enrollment in the HCS Program.

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

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

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

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

(18) Supported home living is transportation of an individual with a residential type of "own/family home."

(19) Host home/companion care is residential assistance provided in a residence that is owned or leased by the service provider of host home/companion care or the individual and is not owned or leased by the program provider. The service provider of host home/companion care must live in the same residence as the individual receiving the service.

(20) Supervised living is residential assistance provided in a three-person residence or four-person residence in which service providers are present in the residence and are able to respond to the needs of individuals during normal sleeping hours.

(21) Residential support is residential assistance provided in a three-person residence or four-person residence in which service providers are present and awake in the residence whenever an individual is present in the residence.

(22) Respite is temporary relief for an unpaid caregiver in a location other than the individual's home for an individual who has a residential type of "own/family home."

(23) In-home respite is temporary relief for an unpaid caregiver in the individual's home for an individual who has a residential type of "own/family home."

(24) Employment assistance is assistance to help an individual locate paid employment in the community.

(25) Supported employment is assistance, in order to sustain competitive employment, to an individual who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which individuals without disabilities are employed.

(26) Employment readiness is assistance that prepares an individual to participate in employment. Employment readiness services are not job-task oriented.

(27) TAS is assistance to an applicant in setting up a household in the community before being discharged from a nursing facility, an ICF/IID, or a GRO and before enrolling in the HCS Program and consists of:

(A) for an applicant whose initial IPC does not include residential support, supervised living, or host home/companion care:

(i) paying security deposits required to lease a home, including an apartment, or to establish utility services for a home;

(ii) purchasing essential furnishings for a home, including a table, a bed, chairs, window blinds, eating utensils, and food preparation items;

(iii) paying for expenses required to move personal items, including furniture and clothing, into a home;

(iv) paying for services to ensure the health and safety of the applicant in a home, including pest eradication, allergen control, or a one-time cleaning before occupancy; and

(v) purchasing essential supplies for a home, including toilet paper, towels, and bed linens; and

(B) for an applicant whose initial IPC includes residential support, supervised living, or host home/companion care:

(i) purchasing bedroom furniture;

(ii) purchasing personal linens for the bedroom and bathroom; and

(iii) paying for allergen control.

(b) The services described in this subsection are for an individual who is receiving at least one HCS Program service through the CDS option.

(1) FMS is a service defined in §264.103 of this title (relating to Definitions).

(2) Support consultation is a service defined in §264.103 of this title.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Karen Ray
Chief Counsel
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SUBCHAPTER B. ELIGIBILITY, ENROLLMENT, AND REVIEW

26 TAC §263.104

The amendment is adopted under 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; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance program in Texas and to adopt rules and standards for program administration; and Texas Human Resources Code §32.0755(f), which provides that the Executive Commissioner shall adopt rules to establish performance standards for providers providing prevocational or similar services to persons in a Medicaid waiver program.

§263.104. Process for Enrollment of Applicants.

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

(1) whose interest list date, assigned in accordance with §263.103 of this subchapter (relating to HCS Interest List), is earliest on the statewide interest list for the HCS Program maintained by HHSC; or

(2) who is a member of a target group identified in the HCS Program waiver application approved by CMS.

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

(c) A LIDDA must offer enrollment in the HCS Program to an applicant described in subsection (a)(2) of this section in accordance with HHSC's procedures.

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

(1) a statement that:

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

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

(2) the HHSC Deadline Notification form, which is available on the HHSC website.

(e) If an applicant or LAR responds to an offer of enrollment in the HCS Program, a LIDDA must:

(1) provide the applicant, LAR, and, if the LAR is not a family member, at least one family member if possible, both an oral and written explanation of the services and supports for which the applicant may be eligible, including the ICF/IID Program, both state supported living centers and community-based facilities, waiver programs authorized under §1915(c) of the Social Security Act, and other community-based services and supports, using the HHSC Explanation of Services and Supports document, which is available on the HHSC website;

(2) provide the applicant and LAR both an oral and a written explanation of all HCS Program services and CFC services using the HHSC Understanding Program Eligibility and Services form, which is available on the HHSC website; and

(3) give the applicant or LAR the HHSC Waiver Program Verification of Freedom of Choice form, which is available on the HHSC website, to document the applicant's choice between the HCS Program or the ICF/IID Program.

(f) A LIDDA must withdraw an offer of enrollment in the HCS Program made to an applicant or LAR if:

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

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

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

(4) the applicant or LAR does not complete the necessary activities to finalize the enrollment process and HHSC has approved the withdrawal of the offer; or

(5) the applicant has moved out of the State of Texas.

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

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

(i) If a LIDDA terminates an applicant's services in accordance with subsection (h) of this section, the LIDDA must notify the applicant or LAR of the termination, in writing, by certified United States mail and provide an opportunity for a review in accordance with §301.155 of this title (relating to Notification and Appeals Process).

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

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

(2) The LIDDA must complete an ID/RC Assessment in accordance with §263.105 of this subchapter (relating to LOC Determination) and §263.106 of this subchapter (relating to LON Assignment).

(A) The LIDDA must:

(i) do one of the following:

(I) conduct a DID in accordance with §304.401 of this title (relating to Conducting a Determination of Intellectual Disability) except that the following activities must be conducted in person:

(-a-) a standardized measure of the individual's intellectual functioning using an appropriate test based on the characteristics of the individual; and

(-b-) a standardized measure of the individual's adaptive abilities and deficits reported as the individual's adaptive behavior level; or

(II) review and endorse a DID report in accordance with §304.403 of this title (relating to Review and Endorsement of a Determination of Intellectual Disability Report); and

(ii) determine whether the applicant has been diagnosed by a licensed physician as having a related condition.

(B) The LIDDA must:

(i) conduct an ICAP assessment in person; and

(ii) recommend an LON assignment to HHSC in accordance with §263.106 of this subchapter.

(C) The LIDDA must enter the information from the completed ID/RC Assessment and electronically submit the information to HHSC for approval in accordance with §263.105(a) of this subchapter and §263.106(a) of this subchapter and, if applicable, submit supporting documentation as required by §263.107(c) of this subchapter (relating to HHSC Review of LON).

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

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

(A) develop a PDP;

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

(C) develop an initial IPC in accordance with §263.301(c) of this chapter (relating to IPC Requirements).

(5) The CFC PAS/HAB Assessment form required by paragraph (4)(B) of this subsection must be completed in person with the individual unless the following conditions are met in which case the form may be completed by videoconferencing or telephone:

(A) the service coordinator gives the individual the opportunity to complete the form in person in lieu of completing it by videoconferencing or telephone and the individual agrees to the form being completed by videoconferencing or telephone; and

(B) the individual receives appropriate in-person support during the completion of the form by videoconferencing or telephone.

(6) A service coordinator must discuss the CDS option with the applicant or LAR in accordance with §263.401(a) and (b) of this chapter (relating to CDS Option).

(k) A service coordinator must:

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

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

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

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

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

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

(B) anticipates needing TAS;

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

(A) complete, with the applicant or LAR and the selected program provider, the HHSC Transition Assistance Services

(TAS) Assessment and Authorization form, which is available on the HHSC website, in accordance with the form's instructions, which includes:

(i) identifying the TAS the applicant needs; and

(ii) estimating the monetary amount for each transition assistance service identified, which must be within the service limit described in §263.304(a)(6) of this chapter (relating to Service Limits);

(B) submit the completed form to HHSC to determine if TAS is authorized;

(C) send the form authorized by HHSC to the selected program provider; and

(D) include the TAS and the monetary amount authorized by HHSC on the applicant's initial IPC;

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

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

(B) has not met the maximum service limit for minor home modifications as described in §263.304(a)(3)(A) of this chapter; and

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

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

(A) complete, with the applicant or LAR and selected program provider, the HHSC Home and Community-based Services (HCS) Program Pre-enrollment MHM Authorization Request form, which is available on the HHSC website, in accordance with the form's instructions, which includes:

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

(ii) identifying the pre-enrollment minor home modifications assessments conducted by the program provider; and

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

(I) the pre-enrollment minor home modifications identified on the form, which must be within the service limit described in §263.304(a)(3)(A) of this chapter; and

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

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

(C) send the form authorized by HHSC to the selected program provider; and

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

(9) if an applicant or LAR chooses a program provider to deliver supported home living, nursing, host home/companion care, residential support, supervised living, respite, employment assistance, supported employment, employment readiness, in-home day habilitation, day habilitation, or CFC PAS/HAB, ensure that the initial IPC includes a sufficient number of RN nursing units for the program provider's RN to perform a comprehensive nursing assessment unless:

(A) nursing services are not on the IPC and the applicant or LAR and selected program provider have determined that no nursing tasks will be performed by an unlicensed service provider as documented on the HHSC Nursing Task Screening Tool form; or

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

(10) if an applicant or LAR refuses to include on the initial IPC a sufficient number of RN nursing units for the program provider's RN to perform a comprehensive nursing assessment as required by paragraph (9) of this subsection:

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

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

(ii) if the applicant needs host home/companion care, residential support, supervised living, supported home living, respite, employment assistance, supported employment, employment readiness, in-home day habilitation, day habilitation, or CFC PAS/HAB from the program provider, will result in the individual not receiving that service unless:

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

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

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

(11) ensure that the applicant or LAR signs and dates the initial IPC and provides the signed and dated IPC to the service coordinator in person, electronically, by fax, or by United States mail;

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

(13) sign and date the initial IPC, which indicates that the service coordinator agrees that the requirements described in §263.301(c) of this chapter have been met;

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

(A) of the eligibility requirements for HCS Program services as described in §263.101(a) of this subchapter (relating to Eligibility Criteria for HCS Program Services and CFC Services);

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

(i) of the eligibility requirements for CFC services as described in §263.101(c) of this subchapter to applicants who do not receive MAO Medicaid; and

(ii) of the eligibility requirements for CFC services as described in §263.101(d) of this subchapter to applicants who receive MAO Medicaid;

(C) that HCS Program services may be terminated if:

(i) the individual no longer meets the eligibility criteria described in §263.101(a) of this subchapter; or

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

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

(i) the individual no longer meets the eligibility criteria described in §263.101(c) or (d) of this subchapter; or

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

(l) A LIDDA must conduct permanency planning in accordance with §263.902(a) - (f) of this chapter (relating to Permanency Planning).

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

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

(2) keep the original initial IPC in the individual's record;

(3) ensure the information from the initial IPC entered in the HHSC data system and electronically submitted to HHSC contains information identical to the information on the initial IPC; and

(4) submit other required enrollment information to HHSC.

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

(o) Before the applicant's service begin date, the LIDDA must provide to the selected program provider and FMSA, if applicable:

(1) copies of all enrollment documentation and associated supporting documentation, including relevant assessment results and recommendations;

(2) the completed ID/RC Assessment;

(3) the initial IPC;

(4) the applicant's PDP; and

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

(p) Except for the provision of TAS, pre-enrollment minor home modifications, and a pre-enrollment minor home modifications assessment, the selected program provider must not initiate services until notified of HHSC's approval of the applicant's enrollment.

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

(1) an implementation plan for:

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

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

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

(r) A LIDDA must retain in an applicant's record:

(1) the HHSC Waiver Program Verification of Freedom of Choice form;

(2) the HHSC Documentation of Provider Choice form, if applicable;

(3) the HHSC Deadline Notification form; and

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

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Karen Ray
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SUBCHAPTER D. DEVELOPMENT AND REVIEW OF AN IPC

26 TAC §263.301, §263.304

The amendments are adopted under 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; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance program in Texas and to adopt rules and standards for program administration; and Texas Human Resources Code §32.0755(f), which provides that the Executive Commissioner shall adopt rules to establish performance standards for providers providing prevocational or similar services to persons in a Medicaid waiver program.

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SUBCHAPTER F. REQUIREMENTS FOR SERVICE SETTINGS AND PROGRAM PROVIDER OWNED OR CONTROLLED RESIDENTIAL SETTINGS

26 TAC §263.501

The amendment is adopted under 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; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance program in Texas and to adopt rules and standards for program administration; and Texas Human Resources Code §32.0755(f), which provides that the Executive Commissioner shall adopt rules to establish performance standards for providers providing prevocational or similar services to persons in a Medicaid waiver program.

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SUBCHAPTER G. REIMBURSEMENT BY HHSC

26 TAC §263.601

The amendment is adopted under 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; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance program in Texas and to adopt rules and standards for program administration; and Texas Human Resources Code §32.0755(f), which provides that the Executive Commissioner shall adopt rules to establish performance standards for providers providing prevocational or similar services to persons in a Medicaid waiver program.

§263.601. Program Provider Reimbursement.

The following requirements apply to program provider reimbursement.

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

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

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

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

(D) HHSC pays:

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

(ii) if requested, a TAS service fee in accordance with the HCS Program Billing Requirements.

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

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

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

(2) To be paid for the provision of a service, a program provider must submit a service claim that meets the requirements in §52.121 of this title (relating to Claims Payment) and the HCS Program Billing Requirements or the CFC Billing Requirements for HCS and TxHmL Program Providers.

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

(A) in-home day habilitation;

(B) day habilitation;

(C) supported home living;

(D) in-home respite;

(E) respite;

(F) employment assistance;

(G) supported employment;

(H) employment readiness;

(I) professional therapies;

(J) nursing; and

(K) CFC PAS/HAB.

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

(5) HHSC does not pay a program provider for:

(A) a service or recoups any payments made to the program provider for a service if:

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

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

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

(II) the service was provided during a period of time for which there was not a signed and dated ID/RC Assessment for the individual;

(III) the service was provided during a period of time for which the individual did not have an LOC determination;

(IV) the service was not provided in accordance with a signed, dated, and authorized IPC meeting the requirements set forth in §263.301(c) of this chapter (relating to IPC Requirements);

(V) the service was not provided in accordance with the individual's PDP or implementation plan;

(VI) the service was provided before the individual's enrollment date into the HCS Program; or

(VII) the service was not included on the signed, dated, and authorized IPC of the individual in effect at the time the service was provided, except as permitted by §263.302(d) of this chapter (relating to Renewal and Revision of an IPC);

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

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

(v) the program provider did not comply with §52.109 of this title (relating to Records);

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

(vii) the claim for the service did not meet the requirements in §52.121 of this title (relating to Claims Payment) or the HCS Program Billing Requirements or the CFC Billing Requirements for HCS and TxHmL Program Providers;

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

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

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

(xi) the service was paid at an incorrect LON because the information entered in the HHSC data system from a completed ID/RC Assessment was not identical to the information on the completed ID/RC Assessment; or

(xii) the service was not provided;

(B) supervised living or residential support, if the program provider provided the supervised living or residential support service in a residence in which four individuals or other persons receiving similar services live without HHSC's approval as described in rules governing the HCS Program;

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

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

(E) employment readiness, if before including the employment readiness on an individual's IPC, the program provider did not ensure and maintain documentation in the individual's record that employment readiness was 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.);

(F) host home/companion care, residential support, or supervised living, if the host home/companion care, residential support, or supervised living was provided on the day of the individual's suspension or termination of HCS Program services;

(G) TAS, if the TAS, was not provided in accordance with a Transition Assistance Services (TAS) Assessment and Authorization form authorized by HHSC;

(H) pre-enrollment minor home modifications and a pre-enrollment minor home modifications assessment, if the pre-enrollment minor home modifications and a pre-enrollment minor home modifications assessment, was not provided in accordance with a Home and Community-based Services (HCS) Program Pre-enrollment MHM Authorization Request form authorized by HHSC;

(I) a CFC service, if the CFC service, was provided to an individual receiving host home/companion care, supervised living, or residential support;

(J) supported home living, if the supported home living, was not provided in accordance with a transportation plan and

§263.5(a)(18) of this chapter (relating to Description of HCS Program Services); or

(K) CFC PAS/HAB, in-home day habilitation provided to an individual with a residential type of "own/family home," or in-home respite, if the CFC PAS/HAB, in-home day habilitation, or in-home respite, did not match the EVV visit transaction as required by 1 TAC §354.4009(a)(4) (relating to Requirements for Claims Submission and Approval).

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

(7) Except as provided in paragraph (8) of this section, if HHSC approves an LOC requested in accordance with §263.105(b)(3) of this chapter (relating to LOC Determination), HHSC pays a program provider for services provided to an individual for a period of not more than 180 calendar days after the individual's previous ID/RC Assessment expires.

(8) If HHSC determines that a program provider submitted an ID/RC Assessment more than 180 calendar days after the expiration date of the previous ID/RC Assessment, because of circumstances beyond the program provider's control, HHSC may pay the program provider for a period of more than 180 calendar days after the date the individual's previous ID/RC Assessment expired.

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

(A) this chapter;

(B) the HCS Program Billing Requirements;

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

(D) Chapter 52, Subchapter C of this title (relating to Requirements of a Contractor); and

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

(10) HHSC conducts provider fiscal compliance reviews in accordance with the Provider Fiscal Compliance Review Protocol set forth in the HCS Program Billing Requirements and the CFC Billing Requirements for HCS and TxHmL Program Providers. As a result of a provider fiscal compliance review, HHSC may:

(A) recoup payments from a program provider; and

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

(11) A corrective action plan required by HHSC in accordance with paragraph (10)(B) of this section must:

(A) include:

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

(ii) the corrective action to be taken;

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

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

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

(C) be approved by HHSC before implementation.

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

(13) If HHSC requires a program provider to develop and submit a corrective action plan in accordance with paragraph (10)(B) of this section and the program provider requests an administrative hearing for the recoupment in accordance with §263.802 of this chapter (relating to Program Provider's Right to Administrative Hearing), the program provider is not required to develop or submit a corrective action plan while a hearing decision is pending. HHSC notifies the program provider if the requirement to submit a corrective action plan or the content of such a plan changes based on the outcome of the hearing.

(14) If a program provider does not submit a corrective action plan or complete a required corrective action within the time frames described in paragraph (11) of this section, HHSC may impose a vendor hold on payments due to the program provider until the program provider takes the corrective action.

(15) If a program provider does not submit a corrective action plan or complete a required corrective action within 30 calendar days after the date a vendor hold is imposed in accordance with paragraph (14) of this section, HHSC may terminate the contract.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Karen Ray
Chief Counsel
Health and Human Services Commission
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For further information, please call: (512) 438-2910

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SUBCHAPTER J. LIDDA REQUIREMENTS

26 TAC §263.901

The amendment is adopted under 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; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance program in Texas and to adopt rules and standards for program administration; and Texas Human Resources Code §32.0755(f), which provides that the Executive Commissioner shall adopt rules to establish performance standards for providers providing prevocational or similar services to persons in a Medicaid waiver program.

§263.901. LIDDA Requirements for Providing Service Coordination in the HCS Program.

(a) In addition to the requirements described in Chapter 331 of this title (relating to LIDDA Service Coordination), a LIDDA must:

(1) comply with:

(A) this chapter;

(B) Chapter 264 of this title (relating to Consumer Directed Services Option); and

(C) Chapter 301, Subchapter M of this title (relating to Abuse, Neglect, and Exploitation in Local Authorities and Community Centers); and

(2) ensure that a rights protection officer required by §334.113 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 §264.702 of this title (relating to Requirements Related to HHSC Investigations When an Alleged Perpetrator is a Service Provider) or §264.703 of this title (relating to Requirements Related to HHSC Investigations When an Alleged Perpetrator is a Staff Person or a Controlling Person of an FMSA), gives a copy of the report to the individual's service coordinator.

(b) A LIDDA must 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 Chapter 331 of this title except as described in paragraph (2) of this subsection.

(2) Notwithstanding §331.19(b)(2)(B) of this title (relating to Staff Person Training), a service coordinator must complete a comprehensive non-introductory person-centered service planning training developed or approved by HHSC within six months after the service coordinator's date of hire, unless an extension of the six month timeframe is granted by HHSC.

(3) A service coordinator must receive training about the following within the first 90 calendar days after beginning service coordination duties:

(A) rules governing the HCS Program and CFC; and

(B) Chapter 264 of this title.

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

(d) If, as a result of monitoring, the service coordinator identifies a concern with the implementation of the PDP, the LIDDA must ensure that the concern is communicated to the program provider and attempts are made to resolve the concern. The LIDDA may refer an unresolved concern to HHSC by calling the HHSC IDD Ombudsman toll-free telephone number at 1-800-252-8154.

(e) A service coordinator must:

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

(2) provide an individual, LAR, or family member with the booklet, *Your Rights In the Home and Community-based Services (HCS) Program,* available on the HHSC website, and the HHSC HCS Rights Addendum form, and an oral explanation of the rights in the booklet and the form:

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

(B) upon revision of the booklet or the form;

(C) upon request; and

(D) if one of the following occurs:

(i) the individual becomes 18 years of age;

(ii) a guardian is appointed for the individual; or

(iii) a guardianship for the individual ends;

(3) document the provision of the information required by paragraph (2) of this subsection, and ensure that the documentation is signed by:

(A) the individual or LAR; and

(B) the service coordinator;

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

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

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

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

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

(A) a copy of the IPC;

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

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

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

(E) any other pertinent information related to the individual;

(6) initiate, coordinate, and facilitate the person-centered planning process to meet the goals and outcomes identified by an individual and LAR in the individual's PDP, including scheduling service planning team meetings;

(7) to meet the needs of an individual as those needs are identified, develop for the individual a full range of services and resources using:

(A) providers for services other than HCS Program services and CFC services; and

(B) advocates or other actively involved persons;

(8) ensure that the PDP for an applicant or individual:

(A) is developed, reviewed, and updated in accordance with:

(i) §263.104(j)(4)(A) of this chapter (relating to Process for Enrollment of Applicants);

(ii) §263.302 of this chapter (relating to Renewal and Revision of an IPC); and

(iii) §331.11 of this title (relating to LIDDA's Responsibilities); and

(B) document, for each HCS Program service, other than supervised living and residential support, and for each CFC service, whether the service is critical to the individual's health and safety as determined by the service planning team;

(9) ensure that the updated finalized PDP is signed by the individual or LAR;

(10) participate in the development, renewal, and revision of an individual's IPC in accordance with §263.104 and §263.302 of this chapter;

(11) ensure the service planning team participates in the renewal and revision of the IPC for an individual in accordance with §263.302 of this chapter and ensure the service planning team completes other responsibilities and activities as described in this chapter;

(12) notify the service planning team if the service coordinator receives notification from the program provider that:

(A) an individual's behavior requires the implementation of a behavior support plan; or

(B) based on an annual review by the program provider, an individual's behavior support plan needs to continue;

(13) if a change to an individual's PDP is needed, other than as required by §263.302 of this chapter:

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

(B) update the PDP as necessary; and

(C) within 10 calendar days after the PDP is updated, send a copy of the updated PDP to the program provider, the individual or LAR and, if applicable, the FMSA;

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

(15) monitor the provision of HCS Program services, CFC services, and non-HCS Program and non-CFC services to an individual;

(16) document whether an individual or LAR perceives that the individual is progressing toward desired outcomes identified on the individual's PDP;

(17) together with the program provider, ensure the coordination and compatibility of HCS Program services and CFC services with non-HCS Program and non-CFC services, including, in coordination with the program provider, assisting an individual in obtaining a neurobehavioral or neuropsychological assessment and plan of care from one of the following professionals:

(A) a psychologist licensed in accordance with Texas Occupations Code Chapter 501;

(B) a speech-language pathologist licensed in accordance with Texas Occupations Code Chapter 401; or

(C) an occupational therapist licensed in accordance with Texas Occupations Code Chapter 454;

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

(19) if individual does not have a guardian:

(A) ensure that the service planning team determines whether the individual would benefit from having a guardian or a less restrictive alternative to a guardian;

(B) if the service planning team determines that the individual would benefit from having a less restrictive alternative to a guardian such as a supported decision making agreement, take appropriate actions to implement such an alternative; and

(C) if the service planning team determines that the individual would benefit from having a guardian, make a referral to the appropriate court if:

(i) the individual would not benefit from a less restrictive alternative to a guardian; or

(ii) the individual would benefit from having a less restrictive alternative to a guardian but implementing such an alternative is not feasible;

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

(21) if notified by the program provider that a requirement described in §263.501(d)(1) of this chapter (relating to Requirements for Home and Community-Based Settings), §263.502(b)(1) - (7) of this chapter (relating to Requirements for Program Provider Owned or Controlled Residential Settings) or §263.503(c)(15) of this chapter (relating to Residential Agreements) needs to be modified, update the individual's PDP to include the following:

(A) a description of the specific and individualized assessed need that justifies the modification;

(B) a description of the positive interventions and supports that were tried but did not work;

(C) a description of the less intrusive methods of meeting the need that were tried but did not work;

(D) a description of the condition that is directly proportionate to the specific assessed need;

(E) a description of how data will be routinely collected and reviewed to measure the ongoing effectiveness of the modification;

(F) the established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;

(G) the individual's or LAR's signature evidencing informed consent to the modification; and

(H) the program provider's assurance that the modification will cause no harm to the individual;

(22) if notified by the program provider that an individual or LAR has refused a comprehensive nursing assessment and that the program provider has determined it cannot ensure the individual's health, safety, and welfare in the provision of host home/companion care, residential support, supervised living, supported home living, respite, employment assistance, supported employment, employment readiness, in-home day habilitation, day habilitation, or CFC PAS/HAB:

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

(i) nursing services; or

(ii) host home/companion care, residential support, supervised living, supported home living, respite, employment assistance, supported employment, employment readiness, in-home day habilitation, day habilitation, or CFC PAS/HAB, if the individual needs

one of those services and the program provider has determined that it cannot ensure the health and safety of the individual in the provision of the service; and

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

(23) if the service coordinator determines that HCS Program services or CFC services provided for an individual should be terminated, including for a reason described in §263.104(k)(14)(C) or (D) of this chapter:

(A) document a description of:

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

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

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

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

(24) if an individual requests termination of all HCS Program services or all CFC services, within ten calendar days after the individual's request:

(A) inform the individual or LAR of:

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

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

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

(B) submit documentation to HHSC that:

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

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

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

(26) at the time of assignment and as changes occur, ensure that an individual and LAR and program provider are informed of the name of the individual's service coordinator and how to contact the service coordinator;

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

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

(29) unless contraindications are documented with justification by the service planning team, ensure that an individual who is 18 years or older has opportunities to participate in day activities of the individual's or LAR's choice that promote achievement of PDP outcomes;

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

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

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

(33) if the program provider notifies the service coordinator that the program provider is unable to locate the parent or LAR to assist the LIDDA in conducting permanency planning or if notified by the LIDDA that the LIDDA is unable to locate the parent or LAR in accordance with §263.902(g)(9) of this subchapter (relating to Permanency Planning):

(A) make reasonable attempts to locate the parent or LAR by contacting a person identified by the parent or LAR in the contact information described in paragraph (35)(A) and (B) of this subsection; and

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

(34) if the service coordinator determines that a parent's or LAR's contact information described in paragraph (35)(A) of this subsection is no longer current:

(A) make reasonable attempts to locate the parent or LAR by contacting a person identified by the parent or LAR in the contact information described in paragraph (35)(B) of this subsection; and

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

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

(A) the parent's or LAR's:

(i) name;

(ii) address;

(iii) telephone number;

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

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

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

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

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

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

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

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

(36) within three business days after an individual under 22 years of age begins receiving supervised living or residential support:

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

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

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

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

(i) the individual's full name;

(ii) the individual's sex;

(iii) the individual's ethnicity;

(iv) the individual's birth date;

(v) the individual's social security number;

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

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

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

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

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

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

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

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

(iii) routine service planning team meetings; and

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

(B) ensure that reasonable accommodations include:

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

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

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

(iv) providing a language interpreter, if appropriate;

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

(D) before an individual who is under 18 years of age, or who is at least 18 years of age and under 22 years of age and has an LAR, moves to another residence operated by the program provider, attempt to obtain consent for the move from the LAR unless the move is made because of a serious risk to the health or safety of the individual or another person; and

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

(38) in accordance with Chapter 303, Subchapter G of this title (relating to Transition Planning) conduct:

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

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

(39) do the following to inform applicants and individuals about responsibilities related to EVV:

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

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

(ii) sign the HHSC Electronic Visit Verification Responsibilities and Additional Information form to attest to explaining the information and to providing a copy to the individual or LAR;

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

(iv) perform the activities described in clause (i) - (iii) of this subparagraph before the individual's enrollment; and

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

(B) for an individual who will receive a service that requires the use of EVV from the program provider or who is transferring to another program provider or LIDDA and will receive a service that requires the use of EVV from the program provider or through the CDS option:

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

(ii) sign the HHSC Electronic Visit Verification Responsibilities and Additional Information form to attest to explaining the information and to providing a copy to the individual or LAR;

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

(iv) perform the activities described in clause (i)-(iii) of this subparagraph on or before the effective date of the IPC that includes the EVV required service or the effective date of the transfer to another program provider or LIDDA; and

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

(C) for an individual who will receive a service that requires the use of EVV through the CDS option or who will transfer to another FMSA and is receiving a service requiring the use of EVV:

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

(ii) sign the HHSC Electronic Visit Verification Responsibilities and Additional Information form to attest to explaining the information and to providing a copy to the individual or LAR;

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

(iv) perform the activities described in clause (i)-(iii) of this subparagraph before the individual receiving the EVV required service through the CDS option or on or before the effective date of the transfer to another FMSA; and

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

(40) have contact with an individual in-person, by videoconferencing, or telephone to provide service coordination during a month in which it is anticipated that the individual will not receive an HCS Program service unless:

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

(B) the service coordinator had an in-person contact with the individual that month to comply with §331.11(d) of this title (relating to LIDDA's Responsibilities);

(41) within one business day after the meeting to revise an IPC described in §263.503(k) of this chapter (relating to Residential Agreements), submit the following documentation to HHSC if the individual or LAR wants to keep residential support, supervised living, or host home/companion care on the individual's IPC:

(A) a completed HHSC Notification of Service Coordinator Disagreement form;

(B) a copy of the written notice of proposed eviction described in §263.503(h)(3) of this chapter;

(C) a copy of the written notice to vacate described in §263.503(j)(3) of this chapter;

(D) progress notes from any meetings related to the eviction; and

(E) a copy of the individual's PDP; and

(42) within one business day after receiving the notice from a program provider described in §263.503(m) of this chapter, notify HHSC that the individual is no longer delinquent in room or board payments.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 4, 2024.

TRD-202405885
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: January 1, 2025
Proposal publication date: August 2, 2024
For further information, please call: (512) 438-2910

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TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 3. LIFE, ACCIDENT, AND HEALTH INSURANCE AND ANNUITIES

SUBCHAPTER RR. VALUATION MANUAL

28 TAC §3.9901

The commissioner of the Texas Department of Insurance (TDI) adopts amended 28 TAC §3.9901, concerning the adoption of a valuation manual for reserving and related requirements. The amendment is adopted without changes to the proposed text published in the September 27, 2024, issue of the *Texas Register* (49 TexReg 7836) and will not be republished.

REASONED JUSTIFICATION. An amendment is necessary to comply with Insurance Code §425.073, which requires the commissioner to adopt a valuation manual that is substantially similar to the valuation manual adopted by the National Association of Insurance Commissioners (NAIC).

Under Insurance Code §425.073, the commissioner must adopt the valuation manual, and any changes to it, by rule.

Under Insurance Code §425.073(c), when the NAIC adopts changes to the valuation manual, TDI must adopt substantially similar changes. This subsection also requires the commissioner to determine that the NAIC's changes were approved by an affirmative vote representing at least three-fourths of

the voting NAIC members, but not less than a majority of the total membership. In addition, the NAIC members voting in favor of amending the valuation manual must represent jurisdictions totaling greater than 75% of the direct written premiums as reported in the most recently available life, accident, and health/fraternal annual statements and health annual statements.

TDI originally adopted the valuation manual in §3.9901 on December 29, 2016. On August 15, 2024, the NAIC voted to adopt changes to the valuation manual. Fifty jurisdictions, representing jurisdictions totaling 97.81% of the relevant direct written premiums, voted in favor of adopting the amendments to the valuation manual. The vote adopting changes to the NAIC valuation manual meets the requirements of Insurance Code §425.073(c).

In addition to clarifying existing provisions, the 2025 valuation manual includes changes that:

- require qualified actuaries for principle-based reserving to meet the American Academy of Actuaries' Specific Qualification Standard with respect to their opining areas;

- for credit disability, remove the 12% increase to claim incidence rates for credit disability, based on more recent experience;

- authorize the valuation rate for non-jumbo contracts (contracts of less than $250 million) to be determined daily rather than quarterly;

- allow for the valuation rate for funding agreements to be determined monthly rather than annually;

- add explicit requirements for international mortality to principle-based reserving for life products; and

- allow for variable annuity principle-based reserving prescribed assumption updates, as ongoing maintenance.

The NAIC's adopted changes to the valuation manual can be viewed at https://content.naic.org/sites/default/files/pbr_data_valuation_manual_future_edition_redline.pdf.

Section 3.9901. The amendment to §3.9901 strikes the date on which the NAIC adopted its previous valuation manual and inserts the date on which the NAIC adopted its current valuation manual, adopting by reference the new valuation manual dated August 15, 2024. An additional change lowercases the word "commissioner," for consistency with current agency style preferences.

This adoption order includes provisions related to NAIC rules, regulations, directives, or standards, and, under Insurance Code §36.004, TDI must consider whether authority exists to enforce or adopt it. In addition, under Insurance Code §36.007, an agreement that infringes on the authority of this state to regulate the business of insurance in this state has no effect unless the agreement is approved by the Texas Legislature. TDI has determined that neither Insurance Code §36.004 nor §36.007 prohibit the proposed rule because §425.073 requires the commissioner to adopt a manual that is substantially similar to the NAIC manual.

SUMMARY OF COMMENTS. TDI provided an opportunity for public comment on the rule proposal for a period that ended on October 28, 2024. TDI did not receive any comments on the proposed amendment.

STATUTORY AUTHORITY. The commissioner adopts amendments to §3.9901 under Insurance Code §425.073 and §36.001. Insurance Code §425.073 requires the commissioner to adopt changes to the valuation manual that are substantially similar to the changes to the valuation manual adopted by the NAIC, and it provides that after a valuation manual has been adopted by the commissioner by rule, any changes to the valuation manual must be adopted by rule.

Insurance Code §36.001 provides that the commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 3, 2024.

TRD-202405807
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: December 23, 2024
Proposal publication date: September 27, 2024
For further information, please call: (512) 676-6555

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TITLE 40. SOCIAL SERVICES AND ASSISTANCE

PART 19. DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

CHAPTER 700. CHILD PROTECTIVE SERVICES

The Department of Family and Protective Services (DFPS) adopts amendments to section rules in Title 40, Texas Administrative Code (TAC), Part 19, Chapter 700 Subchapters B, C, H, J, M, Q, and W and adopts new Subchapter E.

The Department of Family and Protective Services (DFPS) adopts new §§700.115, 700.501 - 700.510, 700.512, and 700.513 and amendments to §§700.211, 700.328, 700.332, 700.334, 700.844, 700.1039 and 700.1733 in Chapter 700 concerning Child Protective Services. DFPS adopts §§700.514 - 700.528, and 700.511 without changes to the proposed text published in the October 11, 2024, issue of the *Texas Register* (49 TexReg 8349). The edits to these rules do not change the nature or the scope of the rule nor does it create any new duties or power or affect new persons or entities, other than those already given notice. Rather the change more directly reflects what is already permitted under the rule but is corrected as it was an error in text. Accordingly, the rules will not be republished.

BACKGROUND AND JUSTIFICATION

The newly amended rules aim to implement the provisions of the General Appropriations Act, Senate Bill 1 Regular Session 2021 (Article II, Special Provisions Related to All Health and Human Services Agencies, Section 26). The Department of Family and Protective Services (DFPS) with the assistance of HHSC, developed an alternative reimbursement methodology proposal for

the 87th Legislature for foster care and Community-based Care (CBC) rates.

The purpose of the adopted rule amendments is to implement the alternative reimbursement methodology, which will transform the foster care system to better align and support the success of CBC by establishing clearly defined foster care models/service packages with new corresponding foster care rates.

COMMENTS

The 30-day comment period ended November 11, 2024. During this period, DFPS received comments from Texas Alliance of Child and Family Services. A summary of the comments and DFPS's response follows:

Comment: Texas Alliance of Child and Family Services commented that throughout Chapter 700, Subchapter E, Division 2, the operation and direct care staff language regarding credentials was unclear. The language as written made it seem that an individual staff would have to be credentialed. Another concern was that throughout communications with DFPS regarding the implementation of T3C, DFPS has indicated that the add-on service in proposed rule §700.511 would be the CPA's expense, while the rule are proposed stated that "a portion of the funding" would be from CPAs.

Response: DFPS updated Chapter 700, Subchapter E, Division 2, to remove language regarding direct care staff having to be credentialed. In proposed rule §700.511, DFPS also removed reference to "portions of funding" so that it more accurately reflects that all of the funding is intended to reimburse Child Placing Agencies. Both edits reflect wording errors.

SUBCHAPTER A. ADMINISTRATION
DIVISION 1. INTAKE, INVESTIGATION AND ASSESSMENT

40 TAC §700.115

STATUTORY AUTHORITY

The adopted amended rule implements the General Appropriations Act, Senate Bill 1, Regular Session 2021 (Article II, Special Provisions Related to All Health and Human Services Agencies, Section 26).

The modification is adopted under Human Resources Code (HRC) §40.027, which provides that the Department of Family and Protective Services commissioner shall oversee the development of rules relating to the matters within the department's jurisdiction and notwithstanding any other law, shall adopt rules for the operation and provision of services by the department.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 2, 2024.

TRD-202405790
Quyona Gregg
Senior Policy Attorney
Department of Family and Protective Services
Effective date: December 22, 2024
Proposal publication date: October 11, 2024
For further information, please call: (512) 929-6633

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SUBCHAPTER B. CONFIDENTIALITY AND RELEASE OF RECORDS
DIVISION 1. INTAKE, INVESTIGATION AND ASSESSMENT

40 TAC §700.211

The adopted amended rule implements the General Appropriations Act, Senate Bill 1, Regular Session 2021 (Article II, Special Provisions Related to All Health and Human Services Agencies, Section 26).

The modification is adopted under Human Resources Code (HRC) §40.027, which provides that the Department of Family and Protective Services commissioner shall oversee the development of rules relating to the matters within the department's jurisdiction and notwithstanding any other law, shall adopt rules for the operation and provision of services by the department.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Quyona Gregg
Senior Policy Attorney
Department of Family and Protective Services
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For further information, please call: (512) 929-6633

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SUBCHAPTER C. ELIGIBILITY FOR CHILD PROTECTIVE SERVICES

40 TAC §§700.328, 700.332, 700.334

The adopted amended rules implement the General Appropriations Act, Senate Bill 1, Regular Session 2021 (Article II, Special Provisions Related to All Health and Human Services Agencies, Section 26).

The modification is adopted under Human Resources Code (HRC) §40.027, which provides that the Department of Family and Protective Services commissioner shall oversee the development of rules relating to the matters within the department's jurisdiction and notwithstanding any other law, shall adopt rules for the operation and provision of services by the department.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Quyona Gregg
Senior Policy Attorney
Department of Family and Protective Services
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For further information, please call: (512) 929-6633

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SUBCHAPTER E. TEXAS CHILD-CENTERED CARE SYSTEM SERVICE PACKAGES
DIVISION 1. BASIC FOSTER FAMILY HOME SUPPORT SERVICE PACKAGES

40 TAC §§700.501 - 700.512

The adopted new rules implement the General Appropriations Act, Senate Bill 1, Regular Session 2021 (Article II, Special Provisions Related to All Health and Human Services Agencies, Section 26).

The modification is adopted under Human Resources Code (HRC) §40.027, which provides that the Department of Family and Protective Services commissioner shall oversee the development of rules relating to the matters within the department's jurisdiction and notwithstanding any other law, shall adopt rules for the operation and provision of services by the department.

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Quyona Gregg
Senior Policy Attorney
Department of Family and Protective Services
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For further information, please call: (512) 929-6633

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DIVISION 2. GENERAL RESIDENITIAL OPERATION TIER I AND TIER II SUPPORT SERVICE PACKAGES

40 TAC §§700.513 - 700.528

The adopted new rules implement the General Appropriations Act, Senate Bill 1, Regular Session 2021 (Article II, Special Provisions Related to All Health and Human Services Agencies, Section 26).

The modification is adopted under Human Resources Code (HRC) §40.027, which provides that the Department of Family and Protective Services commissioner shall oversee the development of rules relating to the matters within the department's jurisdiction and notwithstanding any other law, shall adopt rules for the operation and provision of services by the department.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Quyona Gregg
Senior Policy Attorney
Department of Family and Protective Services
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For further information, please call: (512) 929-6633

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SUBCHAPTER H. ADOPTION ASSISTANCE PROGRAM
DIVISION 3. APPLLICATION PROCESS, AGREEMENTS AND BENEFITS

40 TAC §700.844

The adopted amended rule implements the General Appropriations Act, Senate Bill 1, Regular Session 2021 (Article II, Special Provisions Related to All Health and Human Services Agencies, Section 26).

The modification is adopted under Human Resources Code (HRC) §40.027, which provides that the Department of Family and Protective Services commissioner shall oversee the development of rules relating to the matters within the department's jurisdiction and notwithstanding any other law, shall adopt rules for the operation and provision of services by the department.

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Quyona Gregg
Senior Policy Attorney
Department of Family and Protective Services
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For further information, please call: (512) 929-6633

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SUBCHAPTER J. ASSISTANCE PROGRAMS FOR RELATIVES AND OTHER CAREGIVERS
DIVISION 2. PERMANENCY CARE ASSISTANCE PROGRAM

40 TAC §700.1039

The amended rule implements the General Appropriations Act, Senate Bill 1, Regular Session 2021 (Article II, Special Provisions Related to All Health and Human Services Agencies, Section 26).

The modification is adopted under Human Resources Code (HRC) §40.027, which provides that the Department of Family and Protective Services commissioner shall oversee the development of rules relating to the matters within the department's jurisdiction and notwithstanding any other law, shall adopt rules for the operation and provision of services by the department.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Quyona Gregg
Senior Policy Attorney
Department of Family and Protective Services
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For further information, please call: (512) 929-6633

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SUBCHAPTER Q. PURCHASED PROTECTIVE SERVCES

DIVISION 2. POST-PERMANENCY SERVICES

40 TAC §700.1733

The adopted amendment implements the General Appropriations Act, Senate Bill 1, Regular Session 2021 (Article II, Special Provisions Related to All Health and Human Services Agencies, Section 26).

The modification is adopted under Human Resources Code (HRC) §40.027, which provides that the Department of Family and Protective Services commissioner shall oversee the development of rules relating to the matters within the department's jurisdiction and notwithstanding any other law, shall adopt rules for the operation and provision of services by the department.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Quyona Gregg
Senior Policy Attorney
Department of Family and Protective Services
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For further information, please call: (512) 929-6633

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