RELEASE NOTES (8.45) – 06.27.2025

Texas Health and Human Service Commission (HHSC) Clinical Management for Behavioral Health Services (CMBHS) Release Information Date: 06/27/2025		
Page or Function	**Description of Change and/or User Instructions**	**Business Entity/User Type Impacted**
IRP	**Primary Role:** RME Leadership, RME Data Administrator, Recovery Manager (RM), RM Supervisor, HCBS-AMH Oversight, HCBS-AMH System Support. As an RM, it should be able to successfully log into the Individual Recovery Plan (IRP) screen. 1. Verify the New field added under the **General** Tab called "Current Enrollment Status" display the actual status to the right of the field. a. Should have the field **Current Enrollment Status,** and the status should be displayed on the right column. **2**. **Latest Clinical eligibility form**: User should be able to cross verify the latest enrollment status by, a. Searching with a client number in the CMBHS Client number field. b. Once selected, click Client Workspace button at the right of the screen. c. For Document Type – choose HCBS Clinical Eligibility check under Enrollment Status. - Status should reflect from the **latest clinical eligibility form.** **3**. Email field length: a. System should accept email up to **100-character** length in the IRP **Contact and Signatures** tab. **4**. Contacts and Signatures - Enhancements. On the signatures page, a. I should see the third check box as mandatory field. b. On the same third check box the language should read: By signing below, I attest that I have been presented with options for services and providers. I hereby give my consent to the HCBS-AMH services and the providers outlined in my Individual Recovery Plan. c. On the signature page, right below the Individual, system should display a text box labeled as "**Preferred Name**" that allows 100 characters.	**All**

Once the Preferred Name is entered in the initial IRP and saved in closed complete. then, for follow-up IRP it should populate from initial IRP and should be changeable in the follow-up IRP if necessary.

5. Types pf Services.

a. On the IRP screen at the **Services** tab, field "Type of Service" the user should be able to select the options **Flex Fund** multiple times from the drop-down list within the same created IRP.

b. On the IRP screen at the **Services** tab, field "Type of Service" the user should be able to select the options **Adaptive Aid** multiple times from the drop-down list within the same created IRP.

c. On the IRP screen at the **Services** tab, field "Type of Service" the user should be able to select the option **Transition Assistance Service (TAS)** multiple times from the drop-down list within the same created IRP.

Types of Services - Changes.

Adaptive Aids:

- User can request Adaptive Aid multiple times and funds can be requested for each AA request.
- Users should be able to request up to $10,000 as the maximum occurrence per year.

  Year calculated as 365 days from the first AA date and 366 days if that includes a leap year.
- Always the calculation of the year should trigger at the first adaptive aid date that was added to the IRP. The reset happens after a year based on the first adaptive aid date. Please see the attached diagram for examples.
- Error message: If the amount exceeds $10,000 in a single AA request or if the total of sum of AA requests within that year exceeds $10,000, then display this warning message: **"Warning! You have reached the maximum units/amount allowed for this service. Your request will be reviewed by HHSC."**
- System should not stop the user from requesting AA service even if the amount exceeds over $10,000.00. Only a warning message is needed for any amount, and they should still be able to request and routed to the HHSC for review.
- Do not allow the user to copy over any AA connected to funds when creating a new AA. It should be blank.

Transition Assistance:

1.1 System Enhancements:

- System should allow the IRP users to select Transition Assistance services to be selected multiple times.

	• Remove the precondition or dependency of selecting the residential service when adding transition assistance. Please Note: Transition Assistance - R-64 confirms that transition assistance is dependent on selection of residential services (#2). Remove this precondition of selecting the residential service. • System should ensure/confirm that participants can still select transition assistance when they do not select a residential service. • System should check for all IRPs where transition assistance is selected and should route to HHSC for review and approval. • After the dependencies of residential services for TA services has been removed, make standard need for TA $1000 and for high need it should be $2500 regardless of any residential service selected as per Appendix 1- Services- Unit of Measure, Standard Need, High Need, Maximum Occurrence- under transition assistance for reference. There is no duration for TA services. This is a lifetime cap. • System should not stop the user from requesting TA service even if the amount exceeds over $1000.00 for standard need and $2500.00 for high need. Only a warning message is needed for any amount, and they should still be able to request and be routed to the HHSC for review. • Remove any duration cap for TA services. • Warning message TA services for high needs**: "Warning! You have reached the maximum units/amount allowed for this service. Your request will be reviewed by HHSC."** **The IRP screen changes.** Business Reason: It is not possible for providers to separate each request for flex funds and adaptive aid service for different categories (such as room and board, medication, and enhanced supervision). This makes it difficult to accurately track general revenue funds in the system. **a. Currently the flex fund, adaptive aid and Transition Assistance Service (TAS) can only be selected once per created IRP.** Provide option for **Flex Fund**, **Adaptive Aid** and **Transition Assistance Service (TAS)** to reappear in the drop-down list **within the same created IRP** so that users can choose those three categories to create multiple line items. Flex Funds:	

	• System should allow the IRP users to select Flex Funds to be selected multiple times. • System should not stop the user from requesting Flex Fund service for any requested amount. Only a warning message is needed, and they should still be able to request and be routed to the HHSC for review. **6**. Removal of the annual IRP. a. From the General Tab of IRP screen, for the field **Plan of Care** there should not be an option to choose in the drop-down list for **Annual**. b. All BRs tied to annual IRP is removed.	
	Update IRP – Progress Notes: **Authorized amount remaining to be a built-in function** (New feature). Subtract the new amount from the grand total. "Authorized Amount" field should be renamed to **Remaining Authorized Amount.** Authorized amount pulls from the most current IRP, grand total authorized amount should be the total of all the services type combined. Example. if TAs then all combined TA amount, If FFs then all combined FF amount and if AA then all combined AA amount. For more clarity, authorized amount is what was approved by the IRP that covers that date of services. Remaining amount is what is authorized amount minus the number of unites been used up to that date of service minus the amount of units from that progress note. ***NOTE:*** The system should take all closed progress notes for each service between the previous IRP and the following IRP, sum the used amount from each of those progress notes and keep track of the total. The system should compare to the total request amount of units on that IRP. Once the sum total is reached, an error message to tell the provider that they have reached the total amount of units on the IRP.	**All**
GPRA Reminder Messages	**Updated GPRA Reminder Message Logic as described below:** **Initial (Treatment)** **Trigger**: Service Begin is created in "Closed Complete" for an eligible Opioid Service and no existing Initial Assessment in Closed Complete after the Service Begin created date. **Frequency**: Overnight after trigger for 6 days for the initial reminder message and then 7 days each for the remaining. **Initial tied to Open Case (Recovery)**	**All**

	Trigger: Date on 'Open Case' document saved in Closed Complete for an eligible Opioid Service and no existing Initial Assessment in Closed Complete after the Case Open date. **Frequency**: Overnight after 53 days from 'Open Case Date' for 6 days for the first reminder and 1 week for each remaining reminder message. **Initial tied to RSS Enrollment (Recovery)** **Trigger**: Date of RSS Enrollment Form document saved in Closed Complete for an eligible Opioid Service and no existing Initial Assessment in Closed Complete after the Case Open date. **Frequency**: Overnight after trigger for 6 days for the initial reminder message and then 7 days each for the remaining. **Follow-up (Treatment and Recovery)** **Trigger**: Five months after Initial GPRA Assessment is set to Closed Complete. **Frequency**: To begin overnight after trigger each month for the 3 messages with the final message being removed 5 days before the 8 month deadline. **Follow-up "Final" reminder messages (Treatment and Recovery)** **Trigger**: Five days before the eighth month past the date the Initial GPRA Assessment is set to Closed Complete. **Frequency**: To begin overnight after trigger and match the timeline within the messages (5 days before due date, 2 days before due date, and on the due date) and removed the day after the due date. **Follow-up "Past Due" (Treatment and Recovery)** **Trigger**: Due date of 8 months after the initial GPRA assessment interview date. To be removed when Follow-up assessment is set to closed complete or client re-enters services and criteria for Initial GPRA Reminder message are met. **Frequency**: Once **Discharge (Treatment and Recovery)** **Trigger**: Discharge Client is created in "Closed Complete" and there is an Initial GPRA Assessment in Closed Complete for the admission **Frequency**: Overnight after trigger for the initial message for 6 days, then 7 days for the second message titled "first reminder", and then the final message appears 15 days after trigger for up to 30 days.	

If you have problems using CMBHS please contact the
CMBHS Help Line at 1 866 806-7806
Monday - Friday 8:00 am to 4:30 pm