Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Texas** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Community Living Assistance and Support Services (CLASS)

C. Waiver Number:TX.0221
Original Base Waiver Number: TX.0221.

D. Amendment Number:TX.0221.R05.01

E. Proposed Effective Date: *(mm/dd/yy)*
08/31/16
Approved Effective Date: 08/31/16
Approved Effective Date of Waiver being Amended: 09/01/14

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
1. Appendix B and J- Increase the number of individuals that can be enrolled in the waiver at any point in time and the maximum number of unduplicated individuals that can be served based on legislative appropriations.

2. Appendix C-1/C-3 Prescribed Drugs (Extended State Plan Service) and Appendix J - Prescribed Drugs (Extended State Plan Service) - The waiver is being changed to clarify eligibility for prescription drugs through the CLASS waiver program. As a result of the transition from the fee-for-service delivery method to the managed care delivery method, effective September 1, 2014, individuals in the waiver who are enrolled in managed care for their acute care services receive unlimited prescription medications through managed care and therefore do not qualify for prescriptions through the waiver. Dual eligible individuals are excluded from enrollment into managed care and, thus, are still eligible for prescription medications through the waiver if they exhaust non-CLASS waiver resources first (such as the Medicare Prescription Drug Plan and the Texas Medicaid State Plan resources). The acute versus waiver dollars for prescriptions will be revised to better reflect the source of funding for prescription costs.

3. Appendix B- Make a technical correction to Medicaid eligibility groups identified in the Code of Federal Regulations (CFR) and Texas statutory citations. The citations will change from Transitional Medical Assistance §1902(e)(1)(A), §1925, 42 CFR 435.112 (any age) and Spousal Support Transitional §1902(a)(10)(A)(i)(I), 42 CFR 435.115(f) (any age) to Transitional Medical Assistance §1902(e)(1) and Spousal Support Transitional 1931(c)(1), 42 CFR 435.115(f) (any age).

These changes do not affect eligibility.

4. Appendix J- As a result of the implementation of community first choice (CFC), the costs associated with CFC are being transferred from waiver costs (Factor D) to acute care costs (Factor D').

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ **Waiver Application**	
☐ **Appendix A – Waiver Administration and Operation**	
☑ **Appendix B – Participant Access and Eligibility**	B-3, B-4
☑ **Appendix C – Participant Services**	C-1/C-3
☐ **Appendix D – Participant Centered Service Planning and Delivery**	
☐ **Appendix E – Participant Direction of Services**	
☐ **Appendix F – Participant Rights**	
☐ **Appendix G – Participant Safeguards**	
☐ **Appendix H**	
☐ **Appendix I – Financial Accountability**	
☑ **Appendix J – Cost-Neutrality Demonstration**	J-1, J-2

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☑ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☑ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☑ **Increase/decrease number of participants**
- ☑ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☐ **Other**

Specify:

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Texas** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Community Living Assistance and Support Services (CLASS)

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: TX.0221
Waiver Number:TX.0221.R05.01
Draft ID: TX.033.05.01

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 09/01/14
Approved Effective Date of Waiver being Amended: 09/01/14

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☑ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities
Select one:

◉ **Not applicable**

○ **Applicable**
Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Community Living Assistance and Support Services (CLASS) waiver, first authorized September 1, 1991, provides community-based services and supports to eligible individuals as an alternative to an intermediate care facility for individuals with intellectual disabilities. CLASS waiver services are intended to, as a whole, enhance the individual's integration into the community, maintain or improve the individual's independent functioning, and prevent the individual's admission to an institution. Services and supports are intended to enhance an individual's quality of life, functional independence, health and welfare, and to supplement, rather than replace, existing informal or formal supports and resources.

The Department of Aging and Disability Services (DADS) is the designated operating agency that administers the CLASS waiver. However, the Health and Human Service Commission (HHSC), the single State Medicaid agency, supervises DADS' administration of the waiver. HHSC exercises administrative discretion in the administration and supervision of the waiver and reviews all policies, rules, and regulations related to the waiver.

HHSC directly performs financial eligibility determinations for prospective enrollees, develops the reimbursement rate methodology and sets reimbursement rates, and conducts Medicaid Fair Hearings in accordance with Title 42 of the Code of Federal Regulations, Part 431, Subpart E, and as described in Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A (relating to Medicaid Fair Hearings).

HHSC delegates to DADS the routine functions necessary for the operation of the waiver. These functions include managing waiver enrollment against approved limits; monitoring waiver expenditures against approved levels; conducting level of care evaluation activities and authorizing levels of care. Additionally, DADS authorizes the service plan and conducts utilization management. DADS enrolls providers and executes the Medicaid provider agreements; conducts training and technical assistance concerning waiver requirements; and performs quality management functions.

CLASS services are provided using contracted providers. The case management agency only provides case management services, such as, coordinating the development of the individual's service plan; informing the individual of the service delivery options (consumer directed services option and provider managed services option) and assisting the individual in accessing non-waiver services. If the individual chooses the consumer directed services option, a financial management services agency provides financial management services and may provide support consultation. A direct services agency, licensed as a home and community support services agency, provides all other services except transition assistance services, which are provided by contracted transition assistance services providers. When notified of their release from the CLASS interest list, applicants choose a case management agency and direct services agency to complete their enrollment. DADS

does not provide CLASS waiver services to individuals who are inpatients of a hospital, nursing facility, assisted living facility, or intermediate care facility. CLASS waiver services are available statewide.

The direct services agency completes assessments to establish a level of care for CLASS waiver services. DADS reviews that information to authorize the level of care. After all requirements for eligibility are met, and at least annually thereafter, the service planning team, which includes the individual and legally authorized representative, develops a person-centered service plan that addresses the individual's needs. The process emphasizes the provision of supports and services necessary to maintain successful integration in the community. The service plan describes the waiver services to be furnished, their frequency, and the type of provider who will furnish each. The service plan also includes the justification for those services based on needs identified by the individual or legally authorized representative and supported by assessments. Providers deliver all waiver services according to the service plan. An individual must continue to meet financial and level of care requirements to remain eligible for CLASS waiver services.

When the service plan is developed, the individual receiving services may choose to self-direct residential habilitation, support consultation, nursing, physical therapy, occupational therapy, speech and language pathology, supported employment, employment assistance, respite services, and cognitive rehabilitation therapy through the consumer directed services option. All other services are provided by the direct services agency chosen by the individual. An individual choosing the provider-managed service delivery option selects a direct services agency for all services included in the service plan, except case management and transition assistance services. Case management services are provided to all individuals receiving services in CLASS.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
HHSC distributed the CLASS Amendment 1 Tribal Notification to the tribal representatives on June 24, 2016, in compliance with the 60-day federal and state requirements. The Tribal Notification provided contact information to request copies of the amendment, provide comments, and request information from the State via email, mail, or telephone. The State provides copies free of charge. The State did not receive any comments from the tribal representatives.

The Public Notice of Intent (PNI) for CLASS Amendment 1 was published in the Texas Register (http://www.sos.state.tx.us/texreg/pdf/backview/0410/index.shtml) on June 24, 2016, allowing a 30-day comment period in compliance with federal and state requirements. The Texas Register is published weekly and is the journal of state agency rulemaking for Texas. In addition to activities related to rules, the Texas Register publishes various public notices including attorney general opinions, gubernatorial appointments, state agency requests for proposals and other documents, and it is used regularly by stakeholders. HHSC publishes all Medicaid waiver submissions in the Texas Register in addition to many other notices. The publication is available online and in hard copy at the Texas State Library and Archives Commission, the State Law Library, the Legislative Reference Library located in the State Capitol building, and the University of North Texas libraries. All of these sites are located in Austin, except for the University of North Texas, which is located in Denton. Printed copies of the Texas Register are also available through paid subscription; subscribers include cities, counties, and public libraries throughout the state. The PNI provided contact information to request copies of the amendment, provide comments, and request information from the State via email, mail, or telephone. The State provides copies free of charge.

The public comment period expired on July 24, 2016. The State received two requests for a copy of the amendment; however, no public comments were received.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Montalbano

First Name:

Kathi

Title:

Manager of Program Policy Support

Agency:

Texas Health and Human Services Commission

Address:

4900 North Lamar Blvd.

Address 2:

Mail Code H-620

City:

Austin

State:

Texas

Zip:

78751

Phone:

(512) 730-7409 **Ext:** ☐ **TTY**

Fax:

(512) 730-7472

E-mail:

kathi.montalbano@hhsc.state.tx.us

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Chancellor

First Name:

Jennifer

Title:

Manager of Long Term Services and Support Unit

Agency:

Texas Department of Aging and Disability Services

Address:

P.O. Box 149030

Address 2:

Mail Code W-521

City:

Austin

State:

Texas

Zip:

78714-9030

Phone:

(512) 438-3385 **Ext:** ☐ **TTY**

Fax:

(512) 438-5135

E-mail:

jennifer.chancellor@dads.state.tx.us

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

Jacqueline Pernell

State Medicaid Director or Designee

Submission Date:

Apr 25, 2017

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

Snyder

First Name:

Jami

Title:

State Medicaid Director

Agency:

Texas Health and Human Services Commission

Address:

4900 North Lamar Blvd

Address 2:

Mail Code H-620

City:

Austin

State:

Texas

Zip:

78751

Phone:

(512) 707-6096 **Ext:** ☐ **TTY**

Fax:

(512) 730-7472

E-mail:

jami.snyder@hhsc.state.tx.us

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☑ **Eliminating a service.**

- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

The service adult day health is removed from this waiver application because the service was never implemented. Individuals in the waiver program requiring adult day health services may access the same services through the Medicaid State Plan service of Day Activity and Health Services.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301 (c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The State assures the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

CLASS Settings Transition Plan

Rule Overview
The Centers for Medicare & Medicaid Services (CMS) issued a final rule for home and community-based settings, effective March 17, 2014. Under 42 CFR §441.301, states must meet new requirements for home and community-based services and supports. The new rule defines requirements for the person-centered planning process; person-centered service plan; review of the person-centered service plan; qualities for home and community-based settings; assurances of compliance with the requirements; and transition plans to achieve compliance with the requirements. The rule also identifies settings that are not home and community-based.

Each state that operates a waiver under 1915(c) or a State Plan Amendment (SPA) under 1915(i) of the Social Security Act that was in effect on or before March 17, 2014, is required to file a Statewide Transition Plan, hereinafter referred to as the Statewide Settings Transition Plan. The Statewide Settings Transition Plan must be filed within 120 days of the first waiver renewal or amendment that is submitted to CMS after the effective date of the rule (March 17, 2014), but not later than March 17, 2015. The Statewide Settings Transition Plan must either provide assurances of compliance with 42 CFR §441.301 or set forth the actions that the State will take to bring each 1915(c) Home and Community-Based Service (HCBS) waiver and 1915(i) State Plan Amendment into compliance, and detail how the State will continue to operate all 1915(c) HCBS waivers and 1915(i) SPAs in accordance with the new requirements.
CLASS Waiver

The Community Living Assistance and Support Services (CLASS) waiver is operated by the Texas Department of Aging

and Disability Services and provides home and community-based services and supports to an eligible individual as an alternative to an intermediate care facility for individuals with intellectual disabilities. CLASS program services are intended, as a whole, to enhance the individual's integration into the community, maintain or improve the individual's independent functioning, and prevent the individual's admission into an institution. The waiver serves individuals with related conditions living in their own home or their family's home. The waiver allows individuals to receive services in a licensed foster home; however, only two individuals are currently receiving services in that type of setting.

A comprehensive list of settings in which CLASS Waiver services are as follows:
• waiver individual's own home or family home;
• residence of the Support Family Services (SFS) provider or Continued Family Services (CFS) provider, which are foster homes verified by Department of Family and Protective Services (DFPS) licensed Child Placing Agency or licensed directly through DFPS;
• non-residential community/public settings (including shopping areas, schools, offices and settings where the waiver participant is employed);
• or day habilitation settings where prevocational services may be provided;
• private residence of the in-home respite care provider, if that provider is the friend or relative of the waiver individual;
• day or overnight camp open to the public and accredited by the American Camping Association (for the provision of out-of-home respite);
• adult foster care home licensed by DADS (for the provision of out-of-home respite);
• licensed nursing facility (for the provision of out of home respite);
• assisted living facility (for the provision of out of home respite);
• intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) (for the provision of out-of-home respite); and
• residence of another person receiving a Medicaid waiver service (for the provision of out-of-home respite).
The State presumes that settings consisting of the individual's own home, family home, or a public place, including camps open to the public, are compliant. Out-of-home respite provided in an ICF/IID, nursing facility, or assisted living facility is allowed under existing federal regulations as it is time limited. All other settings in the CLASS waiver will be assessed for compliance with the HCBS final rule as part of the assessment process described below and referenced as "CLASS waiver settings."

CLASS Settings Transition Plan

The CLASS Settings Transition Plan is composed of the following three main components: (1) Assessment Process, (2) Remedial Strategy, and (3) Public Input. The Settings Transition Plan includes a timeframe and milestones for State actions, such as the various assessment and remedial actions.

Assessment Process:
The Assessment process may involve a (1) systemic (internal) review, (2) site specific assessments, (3) provider assessments and (4) identification of any settings presumed not to be home and community-based.

Systemic review: The State first determines its current level of compliance with the settings requirements. The State assesses the extent to which its rules, regulations, standards, policies, licensing requirements, and other provider requirements ensure settings comport with the HCBS settings requirements. In addition, the State assesses and describes the State's oversight process to ensure continuous compliance. The State may also assess individual settings/types of settings to further document compliance. Upon conducting the compliance assessment, if the State determines that existing standards meet the federal settings requirements and the State's oversight process is adequate to ensure ongoing compliance, the State will describe the process that it used for conducting the compliance assessment and the outcomes of that assessment. However, if the State determines that its standards may not meet the federal settings requirements, the State will include the following in its Settings Transition Plan: (1) remedial action(s) to come into compliance, such as proposing new state regulations or revising existing ones, revising provider requirements, or conducting statewide provider training on the new state standards; (2) a timeframe for completing these actions; and (3) an estimate of the number of settings that likely do not meet the federal settings requirements.

Site specific assessments: States may conduct specific site evaluations through standard processes, such as licensing reviews, provider qualifications reviews, or support coordination visit reports. States may also choose to engage individuals receiving services and representatives of consumer advocacy entities in the assessment process. Evaluations may be conducted by entities such as state personnel, case managers that are not associated with the operating agency, licensing entities, managed care organizations, individuals receiving services, and/or representatives of consumer advocacy entities such as long-term care ombudsman programs and/or protections and advocacy systems. States may perform on-site

assessments of a statistically significant sample of settings.

Provider assessments: The State may administer surveys of providers and include a validity check against self-evaluations.

Settings presumed not to be home and community-based: Where the State bases its assessment on state standards, the State will provide its best estimate of the number of settings that (1) fully align with the federal requirements, (2) do not comply with the federal requirements and will require modifications, (3) cannot meet the federal requirements and require removal from the program and/or relocation of the individuals, and (4) are presumptively non-home and community-based but for which the State will provide evidence to show that those settings do not have the characteristics of an institution and do have the qualities of home and community-based settings.

State Activity

ASSESSMENT OF CLASS WAIVER SETTINGS

First Phase of Assessment [March 2014-September 2014] (System/Internal Review):

In the first phase of the assessment process, Texas conducted a systemic/internal review of current waiver program rules and policies identifying areas that were in compliance with the new regulation, non-compliant, or silent. In addition, the State reviewed oversight processes to determine if revisions were needed to ensure ongoing compliance with the new HCBS rules.

The results of the systemic/internal review of rules and policies yielded an assessment document for the 1915(c) waivers operated by the Texas Department of Aging & Disability Services (DADS) that outlined areas of compliance and non-compliance across all of the DADS waiver programs, including the CLASS waiver. The document indicated whether the rules and policies were compliant, partially compliant, non-compliant, or silent. DADS concluded from the first phase of the assessment process that continued assessment of settings for compliance with federal requirements was indicated. The assessment document, titled "Impact of Federal HCBS Rules on DADS 1915(c) Waiver Process," is posted on the DADS website (http://www.dads.state.tx.us/providers/HCBS/hcbs-settingsassessment.pdf) allowing ongoing input into the assessment process. The Texas Health & Human Services Commission (HHSC) website (http://www.hhsc.state.tx.us/medicaid/hcbs/index.shtml) also links to the DADS website to support access to the assessment document.

In July 2014 the State gave public notice for preliminary settings transition plans for CLASS waiver. Comments received were considered for incorporation into the assessment.

Second Phase of Assessment [September 2014-December 2015] (External Review):

Public input received during the first phase of the assessment indicated the need for an external assessment phase of the CLASS waiver settings. As a result, additional external assessment activities were identified to include the following (The State may conduct additional assessments as deemed necessary):

-The State sought public input on the waiver specific preliminary settings transition plans for all of the 1915(c) waivers through an open meeting for stakeholders and the general public on October 13, 2014. The meeting was also webcast to allow for greater participation across the state. The State accepted public testimony on waiver specific preliminary settings transition plans and additional recommendations for improving the assessment process for all of the 1915(c) waivers.
- Provider self-assessment surveys: In order to validate the results of the first assessment phase, DADS is releasing a provider self-assessment survey to a representative sample of providers. The survey will be based on the exploratory questions provided by CMS with input from external stakeholders. The provider self-assessment survey will be developed in conjunction with providers, provider associations, and advocacy organizations to ensure a comprehensive approach. Providers who are not a part of the sample can still obtain and complete a self-assessment survey on the agency websites and provide data that will be considered as the State moves forward. Based on the results of the survey and other assessment activities the assessment document will be updated and posted on the website at the end of the assessment phase.
- Participant surveys: In order to validate the provider self-assessment surveys, DADS is releasing a participant survey to a representative sample of individuals receiving services. The survey will be based on the questions asked in the provider self-assessment. Participants who are not a part of the sample can still obtain and complete a participant survey on the agency websites and provide data that will be considered as the State moves forward. Based on the results of the survey and other assessment activities, the assessment document will be updated and posted on the website at the end of the assessment phase.

- Site specific assessments: CLASS residential providers are small in number and state resources provide for onsite visits of CLASS providers offering support family services and continued family services to validate provider self-assessment results.
- Stakeholder meetings: The State is developing a plan for holding meetings around the state to allow providers, advocates, individuals receiving services, legally authorized representatives and other interested parties the opportunity to comment on all 1915(c) waiver programs and any concerns regarding compliance with the new regulations.
- National Core Indicators (NCI) Data: The State is in the process of analyzing NCI data and will consider using it in the assessment process.

Texas does not have any settings in the current 1915(c) Medicaid waivers that are presumed not to be community-based settings according to the regulations. The only possible exception may be day habilitation settings where CLASS prevocational services may be provided.

Third Phase of Assessment June 2015-May 2016

Texas will send provider self-assessment surveys to a representative sample of non-residential service providers (prevocational service providers) the state identifies based on the internal assessment, public input, and additional CMS guidance. Provider self-assessments will be verified by a representative sample of participant surveys.

Remedial Strategy:

The Remedial Strategy describes the actions the State proposes to assure initial and on-going compliance with the HCBS settings requirements, including timelines, milestones, and monitoring processes. State level remedial actions may include new requirements promulgated in statute, licensing standards or provider qualifications; revised service definitions and standards; revised training requirements or programs; or plans to relocate individuals to settings that are compliant with the regulations. Provider level remediation actions might include changes to the facility or program operation to assure that the Medicaid beneficiary has greater control over critical activities like access to meals, engagement with friends and family, choice of roommate, or access to activities of his/her choosing in the larger community, including the opportunity to seek and maintain competitive employment.

If the State determines the need to submit evidence to CMS for the application of heightened scrutiny for settings that are presumed not to be home and community-based, the Settings Transition Plan will include information that demonstrates that the setting does not have the characteristics of an institution and meets the HCBS settings requirements. The State does not anticipate encountering this situation, but should it occur the State will update the Settings Transition Plan and timeline accordingly.

If relocation of beneficiaries is required as part of the remediation strategy, the Settings Transition Plan will assure that the State provides reasonable notice and due process to those individuals; addresses the timeline for relocation; provides the number of beneficiaries impacted; and provides a description of the State's process to ensure that beneficiaries, through the person-centered planning process, are given the opportunity, information, and supports to make an informed choice of alternate setting that aligns, or will align with, the requirements and that critical services or supports are in place in advance of the individual's transition. The State does not anticipate encountering this situation, but should it occur, the State will update the Settings Transition Plan and timeline accordingly.

State Activity

REMEDIATION OF CLASS WAIVER SETTINGS

Texas has identified a number of remediation strategies to address issues of potential non-compliance for the CLASS waiver settings:

- Rule and policy revisions: State rule revisions require extensive input from stakeholders including providers, advocates, individuals receiving services, legally authorized representatives and other interested parties. Stakeholders are allowed two opportunities to review draft rule language and provide comments prior to rules becoming effective. The first opportunity is through email announcing rule drafts are available for public comment on agency websites. Based on written comments, stakeholders may be contacted by agency staff for additional dialogue regarding proposed rule language. The second opportunity for input is through the formal 30-day public comment process outlined in statute. Provider manual revisions are also shared externally and stakeholders are asked to provide comments on drafts of the policy before it becomes

effective.

- Revisions to processes used for provider oversight: All waiver programs have oversight processes administered by regulatory or contract monitoring staff. Applicable tools will be revised to reflect changes in rule and policy to ensure ongoing provider assessment will include compliance with HCBS regulations to the greatest extent possible. Written guidance concerning rights and responsibilities will be revised to ensure individuals receiving services understand their rights and know how to file a complaint with the appropriate state agency if there are restrictions being imposed on rights without adequate discussion and documentation through the person centered planning process.

- Provider education: Providers will have multiple opportunities to learn about the new regulations and understand rule and policy changes. The State will offer webinars as a main source for provider education in addition to revising new provider training curriculum. DADS offers CLASS Provider Training twice each year.

Texas does not have any settings in the CLASS waiver that are presumed not to be community-based settings according to the regulations. The only possible exception may be day habilitation settings where prevocational services may be provided. However, if the State determines the need to submit evidence to CMS for the application of heightened scrutiny for settings that are presumed not to be home and community- based, the Settings Transition Plan will be amended to rebut the presumption or provide a transition plan for the individuals.

The State does not anticipate that relocation of individuals will be required as part of the remediation strategy. However, if relocation is required, then the State will provide reasonable notice and due process to those individuals, and ensure that individuals, through the person-centered planning process, are given the opportunity, information, and supports to make an informed choice of alternate setting that aligns, or will align with, the requirements. The State will also ensure that critical services or supports are in place in advance of the individual's transition and the Settings Transition Plan will be amended if necessary to provide additional information.

Public Input and Notice:

Prior to filing with CMS, the State must seek input from the public for the proposed Statewide Settings Transition Plan, preferably from a wide range of stakeholders representing consumers, providers, advocates, families and others. The Texas Statewide Settings Transition Plan includes the CLASS waiver settings transition plan.

The public input process requires the State to provide at least a 30-day public notice and comment period regarding the Statewide Settings Transition Plan that the State intends to submit to CMS for review and consideration. The State must provide a minimum of two statements of public notice and public input procedures. The State must ensure that the Statewide Settings Transition Plan is available to the public for public comment. The State must consider and modify the Statewide Settings Transition Plan, as the State deems appropriate, to account for public comment. Upon submission of the Statewide Settings Transition Plan to CMS, the State must include evidence of compliance with the public notice requirements and a summary of the comments received during the public notice period, why comments were not adopted, and any modifications to the Statewide Settings Transition Plan based upon those comments.

The process for submitting public comment must be convenient and accessible. The Statewide Settings Transition Plan must be posted on the State's website and include a website address for comments. In addition, the State must have at least one additional option for public input, such as a public forum. The Statewide Settings Transition Plan must include a description of the public input process.

State Activity

The State intends to reach out throughout the transition to State staff, providers, advocates, and individuals receiving services and their families. Through various venues, the State plans to educate providers about their responsibilities, help individuals understand their rights under the new HCBS requirements, and solicit input.

Based on public input in all phases of the transition process, HHSC and DADS are committed to using feedback to guide remediation and assessment strategies until the transition is complete. HHSC and DADS continue to work with internal and external stakeholders through existing statutorily mandated committees, workgroups and stakeholder meetings. The State continues to refine remediation activities in response to public input where possible.

On July 11, 2014, the public had an opportunity to provide input when the CLASS preliminary settings transition plan was posted on the DADS website and in the Texas Register, with the 30-day public notice and comment period ending August

11, 2014. The State provided this public notice in the Texas Register (39 TexReg 5457) at:
http://www.sos.state.tx.us/texreg/pdf/backview/0711/0711is.pdf
and on the DADS website hyperlink which lists all notices and provider alerts:
http://www.dads.state.tx.us/providers/communications/alerts/index.cfm
The CLASS internal assessment was also posted on the DADS website in July 2014. The settings assessment document, titled "Impact of Federal HCBS Rules on DADS 1915(c) Waiver Process," may be found at:
http://www.dads.state.tx.us/providers/HCBS/hcbs-settingsassessment.pdf allowing ongoing input on the assessment process. The Texas Health & Human Services Commission (HHSC) website also links to the DADS website to support access to the assessment document.
In November 2014, the public had another opportunity to provide input when the State published the Texas Statewide Settings Transition Plan (which included the CLASS Settings Transition Plan) with the following public notice and input process:
- Tribal Notice: HHSC distributed the Texas Statewide Settings Transition Plan Tribal Notification to the tribal representatives on October 20, 2014, in compliance with the 60 day federal and state requirements. The Tribal Notification provided contact information for requesting additional information from the State via email, mail, or telephone. The State provides copies free of charge. The State did not receive any comments from the tribal representatives or requests for copies.
- The Public Notice of the Texas Statewide Settings Transition Plan was published in the Texas Register on November 7, 2014, allowing a 30 day comment period in compliance with federal and state requirements. The Texas Register is published weekly and is the journal of state agency rulemaking for Texas. In addition to activities related to rules, the Texas Register publishes various public notices including attorney general opinions, gubernatorial appointments, state agency requests for proposals and other documents, and it is used regularly by stakeholders. HHSC publishes all Medicaid waiver submissions in the Texas Register in addition to many other notices. The publication is available online and in hard copy at the Texas State Library and Archives Commission, the State Law Library, the Legislative Reference Library located in the State Capitol building, and the University of North Texas libraries. All of these sites are located in Austin, except for the University of North Texas, which is located in Denton. Printed copies of the Texas Register are also available statewide through paid subscription; subscribers include cities, counties and public libraries throughout the state. The Public Notice of the Texas Statewide Settings Transition Plan provided information about the Texas Statewide Settings Transition Plan and contact information to request copies of the amendment from the State via email, mail, or telephone. The State provides copies free of charge. The "Statewide Settings Transition Plan," which includes the CLASS Settings Transition Plan, was posted on the HHSC, and DADS websites. The websites also provided links to make comments.
http://www.hhsc.state.tx.us/medicaid/hcbs/index.shtml
http://www.dads.state.tx.us/providers/HCBS/index.cfm

Because the State has submitted a more robust Texas Statewide Settings Transition Plan (which included a CLASS Settings Transition Plan) to CMS than the CLASS Preliminary Settings Transition Plan published approximately a year ago (July 2014), the State will submit the more robust version of the CLASS waiver specific plan taken from within the Texas Statewide Settings Transition Plan with the renewal rather than the basic preliminary plan version. Note, however, that in August 2014 the State received comments regarding the CLASS Preliminary Settings Transition Plan. When the State submits the CLASS renewal to CMS, the State will also submit those early comments and responses along with any additional comments received during the June-July 2015 comment period.
DADS concluded from the first phase of the assessment process that continued assessment of settings for compliance with federal requirements was indicated. In addition, the State has implemented the following public input strategy, aimed at achieving optimum public input:

- Stakeholder education webinars: DADS conducted two webinars on September 11 and September 14, 2014, to provide all stakeholders an opportunity to learn about the new regulations prior to the October 13, 2014 open meeting held in Austin.

- Stakeholder meetings: On October 13, 2014, the State held an open stakeholder meeting in Austin providing all stakeholders the opportunity to provide input on the new regulations. The meeting was also webcast to allow for greater participation across the state. The State accepted public testimony on waiver specific preliminary settings transition plans and additional recommendations for improving the assessment process for all of the 1915(c) waivers.

- Electronic notices: The State posted the Texas Statewide Settings Transition Plan on agency websites and in the Texas Register in November 2014. The DADS assessment was also posted on the agency website. The preliminary settings transition plans for several of the waivers were posted in the Texas Register and on the agency websites.

- Feedback mechanism: Dedicated electronic mail boxes and websites for HHSC and DADS are available to provide information about the new rules and accept feedback. The websites and the option to make comments will remain active

throughout the transition and the State will take any comments received into consideration, until the State completes the transition. State websites are located at the following:
http://www.hhsc.state.tx.us/medicaid/hcbs/index.shtml
http://www.dads.state.tx.us/providers/HCBS/index.cfm
In addition to the electronic mailboxes and websites, individuals may also provide comments as well as request information (including free copies of documents) via mail or by telephone. This contact information is included in all public notices and on the website.

- Presentations at statutorily mandated committees: The State regularly provides updates to the following groups and offers them opportunities to comment on ongoing assessment and remediation activities:
-Promoting Independence Advisory Committee: comprised of individuals receiving services, advocacy organizations, and providers across target populations.

-Employment First Task Force: comprised of advocates and providers interested in employment issues.

-Texas Council on Autism and Pervasive Developmental Disorders: comprised of parents of individuals with autism and professionals.

-IDD Redesign Advisory Committee: comprised of individuals receiving services, advocacy organizations, and providers.

- Presentations at agency workgroups: The agencies also have agency-established workgroups comprised of advocates and providers whose purpose is to examine ongoing rule and policy issues. Staff will provide updates on HCBS transition activities and provide the workgroup members the opportunity to provide comments.

- Presentations at conferences: Provider associations hold annual conferences and State staff have been invited to speak at these conferences. This provides access to a large number of providers for purposes of education, coordination and input regarding changes being made to rules and policy.

For more information or to obtain free copies of the CLASS Settings Transition Plan, you may contact Dana Williamson by mail at Texas Health and Human Services Commission, P.O. Box 13247, Mail Code H-370, Austin, Texas, 78711-3247 phone (512) 462-6287, fax (512) 730-7472 or by email at TX_Medicaid_Waivers@hhsc.state.tx.us.

Timeline of Community Living Assistance and Support Services Settings Transition Plan

ASSESSMENT OF CLASS WAIVER SETTINGS

*Represents milestone activities

*Phase I: March 2014 - September 2014

1) State (HHSC and DADS) staff system/internal review of rules and policies and oversight processes governing the waivers.

2) State staff identification of areas in which policy and rules appeared to be silent or in contradiction with new HCBS rules.

3) State staff review of the internal assessment results and finalizing the internal assessment.

4) July 2014: System/internal assessment results posted on the DADS website for public input. HHSC website is linked to the DADS website.

5) Consider and modify internal assessment based upon ongoing public input (e.g., stakeholder groups.)

*Phase II: September 2014 - December 2015

1) October 2014: Recommendations from stakeholders provided at the October 13, 2014, meeting and webcast will be considered and appropriate changes made.

2) November 2014 – December 2014: Public notice and comment period for the Statewide Settings Transition Plan, which includes the CLASS settings transition plan.

*3) December 2014: Submission of Statewide Settings Transition Plan to CMS.

*4) July 2015 through December 2015: Survey representative sample of providers using a self-assessment tool based on the new HCBS requirements. Provider self-assessments will be verified by a representative sample of participant surveys.

5) *July 2015 through December 2015: Hold additional stakeholder meetings providing individuals receiving services and providers an opportunity to provide input on the internal assessment and CLASS Settings Transition Plan.

6) July 2015 through December 2015: The State will continue to refine the CLASS Settings Transition Plan and CLASS settings assessment based on public input.

7) The State will update the internal assessment, "Impact of Federal HCBS Rules on DADS 1915 (c) Waiver Programs", after completion of the entire assessment phase. The update to the internal assessment will be posted on the agency websites. If as a result of the assessment, there was a change in "Impact of Federal HCBS Rules on DADS 1915(c) Waiver Programs" assessment findings, or the State has added additional remedial action and milestones, the State will submit an amendment or modification to the Texas Statewide Settings Transition Plan, after the required public notice and comment period.

Phase III: January 2015 - May 2016

1) January 2015 – May 2016: DADS will survey a representative sample of non-residential providers, including providers of prevocational services in day habilitation settings, to ascertain whether providers are in compliance with CMS guidance.

2) July 2015 – December 2015: A representative sample of provider self-assessments will be verified by a representative sample of participant surveys.

PUBLIC INPUT

1) July 2014: Preliminary Settings Transition Plans for CLASS available for public comment through posting in the Texas Register.

2) July 2014: Preliminary Settings Transition Plan for CLASS available for public comment through posting on the DADS website.

*3) July 2014 – September 2014: Internal compliance assessment document, "Impact of Federal HCBS Rules on DADS 1915 (c) Waiver Programs", http://www.dads.state.tx.us/providers/HCBS/hcbs-settingsassessment.pdf, outlining compliance and non-compliance with settings requirements across all 1915(c) waivers operated by DADS posted for public input.

4) July 2014 continuing through the end of the transition period: Presentations to statutorily mandated committees and agency workgroups that have provider and advocate membership will continue throughout the assessment process. Stakeholders will have multiple opportunities to provide input.

5) August 2014 continuing through the end of the transition period: Presentations at provider association annual conferences.

6) September 2014 continuing through the end of the transition period: DADS HCBS website and electronic mailbox is available to collect stakeholder input and allow public comment on the State's activities toward compliance with the settings requirements.

*7) October 2014: A public stakeholder meeting provided individuals with an opportunity to contribute feedback on the assessment process, the preliminary settings transition plans posted thus far, and implementation of the settings transition plans to all of the 1915(c) waivers and the 1115 demonstration waiver.

8) November 2014 continuing through the end of the transition period: Internal assessment document outlining compliant and non-compliant settings requirements for CLASS waiver posted for public input, http://www.dads.state.tx.us/providers/HCBS/hcbs-settingsassessment.pdf.

*9) November 2014 – December 2014: The Texas Statewide Settings Transition Plan posted for public comment. Two forms of public notice were utilized: notice in the Texas Register and on the HHSC, DADS, and DSHS websites. Tribal notice was also sent out in compliance with federal and state requirements.

10) Ongoing through the end of the transition period: The State may implement additional stakeholder communications as such opportunities are identified.

11) Once the assessment phases are completed, if the assessments result in a change in the findings or added specific remedial action and milestones to a waiver, the State will incorporate the public notice and input process into the appropriate submissions to CMS.

12) The State has given approximate dates for amendments to the Texas Statewide Settings Transition Plan during the remediation phase, should amendments be necessary.

State websites are located at the following:
http://www.hhsc.state.tx.us/medicaid/hcbs/index.shtml
http://www.dads.state.tx.us/providers/HCBS/index.cfm

CLASS Remediation Activities: November 2014 – June 2018

REMEDIATION OF CLASS WAIVER SETTINGS

1) November 2014 – September 2016: Deliver educational webinars for CLASS providers about new HCBS guidelines.

2) January 2015 – May 2018: Deliver education webinars for CLASS providers on needed changes to prevocational services based on CMS guidance.

*3) January 2016 – December 2016: Amend CLASS program rules and Chapter 49 contracting rules governing Support Family Services, Continued Support Family Services, and employment services to ensure the services comply with the new HCBS guidelines. Stakeholder input is actively solicited during the rule making process.

4) April 2016 – December 2016: Revise the CLASS policy manual, including rights/responsibilities forms/publications, based on the assessment to further outline HCBS requirements.

5) June 2016 – February 2017: Develop a new contract monitoring tool for Support Family Services and Continued Family Services to incorporate HCBS setting requirements. The revised monitoring tools will be used to ensure providers are compliant with the new rules and policies aimed at compliance with the HCBS regulations.

*6) June 2016 – May 2017: Based on CMS guidance regarding prevocational services, seek additional funding in 2017 legislative session.

*7) June 2017 –June 2017: Submit CLASS amendment updating the Settings Transition Plan with appropriate changes based on public input after the required public notice.

8) June 2017 – March 2018: Revise the CLASS policy manual, including rights/responsibilities forms/publications, based on CMS guidance regarding prevocational services.

9) June 2017 – March 2018: Amend CLASS program rules and Chapter 49 contracting rules governing prevocational services based on CMS guidance to ensure the services comply with the new HCBS guidelines. Stakeholder input is actively solicited during the rule making process.

10) June 2017 – May 2018: Develop a new contract monitoring tool for prevocational services to incorporate HCBS setting requirements. The revised monitoring tools will be used to ensure providers are compliant with the new rules and policies

aimed at compliance with the HCBS regulations.

11) December 2017 – March 2018: Review and include appropriate revisions to the CLASS Settings Transition Plan.

12) April 2018 – May 2018: Public notice and public comment period for review of the revised amendment updating the CLASS Settings Transition Plan.

*13) June 2018 – June 2018: Submit amendment updating the CLASS Settings Transition Plan with appropriate changes based on public input after the required public notice.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ○ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

   ○ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

   (Complete item A-2-a).

   ◉ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:
   Department of Aging and Disability Services (DADS)

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within

the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

In 2003, the Texas Legislature authorized the consolidation of ten health and human service agencies into four agencies (including DADS) to operate under the authority and oversight of the Health and Human Services Commission (HHSC). The consolidation was implemented in 2004. In accordance with Title 42 of the Code of Federal Regulations, Section 431.10, HHSC is designated as the single State Medicaid Agency and, therefore, has administrative authority over the waiver programs. The Texas Legislature gave HHSC plenary authority to supervise and operate the Medicaid program, including monitoring and ensuring the effective use of all federal funds received by the State's health and human services agencies.

Texas Government Code, Section 531.0055 (b), states in part that HHSC shall supervise the administration and operation of the Medicaid program.

Section 531.0055 (b) also gives HHSC full authority over federal funds received by the agencies under its control by requiring HHSC to monitor and ensure the effective use of all federal funds received by a health and human services agency in accordance with Section 531.028 and the General Appropriations Act.

Further, Texas Government Code, Section 531.021 states, in part, that HHSC is the state agency designated to administer federal medical assistance funds and requires HHSC to plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program.

Through an executive directive and based on Texas Human Resources Code, Section 161.071(1), HHSC has designated DADS as the operating agency for the waiver program. With HHSC oversight, DADS performs the following functions related to the operation of the waiver:

1. Participant waiver enrollment;
2. Waiver enrollment managed against approved levels;
3. Waiver expenditures managed against approved levels;
4. Level of care evaluation;
5. Review participant service plans;
6. Prior authorization of waiver services;
7. Utilization management;
8. Qualified provider enrollment;
9. Execution of Medicaid provider agreements;
10. Development of rules, policies, procedures, and information development governing the waiver program; and
11. Quality assurance and quality improvement activities.

All of the forgoing functions are subject to HHSC's ultimate approval authority consistent with Title 42 of the Code of Federal Regulations, Section 431.10(e). Many of the functions listed above are addressed in quality measures related to waiver assurances. For example, level of care evaluation is addressed by the quality measures in Appendix B regarding the level of care assurance.

The executive directive also describes HHSC's monitoring and oversight functions. HHSC's State Medicaid Director is directly responsible for monitoring and oversight of the waiver program. HHSC's quality oversight processes provide the infrastructure for all monitoring processes, including HHSC's oversight of DADS performance of the functions listed above.

Quarterly and annual monitoring by HHSC includes reviewing comprehensive quarterly data reports from the quality measures and CMS-372 reports to determine compliance with delegated functions. These reports include remediation activities. HHSC communicates with DADS any questions or concerns with the reports provided and may require DADS to submit additional data to determine compliance with delegated functions.

The Quality Review Team process is the key formal mechanism for HHSC's monitoring of DADS' performance of delegated functions. The Quality Review Team meets quarterly and reviews the comprehensive quarterly data reports from each waiver at least annually. Improvement plans are developed as issues or trends are identified, and the Quality Review Team reviews, modifying if needed, and approves all improvement plans. All active improvement plans for all waivers are monitored at each quality review team meeting. HHSC formally communicates the results from its monitoring to CMS and the public via the evidentiary review and annual report processes.

DADS also provides monthly dashboard reports to HHSC for each of the waivers. These dashboard reports augment the quarterly and annual comprehensive report, providing additional information for the waiver programs. HHSC will analyze the dashboard reports at least quarterly to monitor compliance with waiver assurances and performance.

HHSC and DADS maintain a collaborative relationship. DADS develops initial drafts of waiver renewals, amendments, CMS-372 reports, Request for Evidentiary Information reports, state rules, policy changes, policy clarifications, rules, and operational changes. HHSC works closely with DADS in the development of the draft documents, even prior to formal submission to HHSC for review and approval. HHSC reviews and approves all waiver renewals, amendments, CMS-372 reports, Request for Evidentiary Information reports, policy changes, policy clarifications, and operational changes that are developed by DADS. If any concerns are identified during the review process, HHSC works with DADS to address the concerns and may request that DADS modify, clarify, or provide additional information in considering approval or disapproval of proposed changes. When policy changes, policy clarifications, and operational changes are approved, DADS posts the information electronically on the DADS website which is accessible to HHSC to determine if changes required for HHSC's approval were implemented appropriately.

HHSC participates in relevant stakeholder meetings to hear feedback on the waiver programs from individuals, advocates, providers, and other interested parties. This provides HHSC the opportunity to understand the background for any policy changes, policy clarifications, or operational changes resulting from these meetings and ensure stakeholder input is incorporated as appropriate.

Additionally, HHSC and DADS hold internal waiver strategic planning meetings at least quarterly, but typically monthly, to discuss current and future policy and operational issues. These meetings also serve as a forum for planning for any necessary waiver amendments and ensure effective communication between HHSC and DADS. Action items from these meetings often result in the formation of workgroups to complete in-depth analysis of complex issues. These workgroups then share their analyses with the larger group in subsequent waiver strategic planning meetings.

HHSC's active involvement in the waiver quality assurance and improvement systems ensures HHSC oversight of all areas of waiver operations.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   ○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

   ◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

   ◉ **Not applicable**

   ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

   ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

   Specify the nature of these agencies and complete items A-5 and A-6:

   ☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

   Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
   In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.
   Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid

Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency	Other State Operating Agency
Participant waiver enrollment	☑	☑
Waiver enrollment managed against approved limits	☑	☑
Waiver expenditures managed against approved levels	☑	☑
Level of care evaluation	☑	☑
Review of Participant service plans	☑	☑
Prior authorization of waiver services	☑	☑
Utilization management	☑	☑
Qualified provider enrollment	☑	☑
Execution of Medicaid provider agreements	☑	☑
Establishment of a statewide rate methodology	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☑
Quality assurance and quality improvement activities	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
A.a.1 Number and percent of CLASS rules approved by HHSC that are implemented by DADS. N: Number of CLASS rules approved by HHSC that are implemented by DADS. D: Number of rules implemented.

Data Source (Select one):
Meeting minutes
If 'Other' is selected, specify:
Medical Care Advisory Committee quarterly meeting notes

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*

Performance Measure:
A.a.2 Number and percent of required waiver quality reports submitted on time by DADS. N: Number of required waiver quality reports submitted on time by DADS. D: Number of reports required.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DADS Quality Reports; Directive from the Executive Commissioner of HHSC to DADS Concerning Operation of Home and Community Based Services 1915(c) Waivers

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach*(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.a.3 Number and percent of individuals on the CLASS interest list who are offered waiver services on a first-come, first-served basis by DADS. N: Number of individuals offered enrollment on a first-come, first- served basis from the interest list. D: Number of individuals offered enrollment from the interest list.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DADS Community Services Interest List database

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach*(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.a.4 Number and percent of individuals enrolled at or below CMS approved level. N: Number of individuals including aggregate of new enrollees from beginning of waiver year, up to- but not exceeding- CMS approved level. D: Number of unduplicated individuals approved by CMS (Factor C).

Data Source (Select one):
Other
If 'Other' is selected, specify:
DADS Quality Assurance and Improvement Data Mart; approved waiver application

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.a.5 Number and percent of service plans at or below the cost limit. N: Number of service plans at or below the cost limit. D: Number of service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DADS Service Authorization System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.a.6 Number and percent of new enrollments authorized by DADS that include a valid level of care evaluation as described in the waiver application. N: Number of new enrollments authorized by DADS that include a level of care evaluation as described in the waiver application. D: Number of newly enrolled individuals.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CLASS Database; DADS Quality Assurance and Improvement Data Mart

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.a.7 Number and percent of case records reviewed by DADS as part of contract monitoring in accordance with the HHSC/DADS Executive Directive. N: Number of case records reviewed. D: Number of case records required to be reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Health and Human Services Contract Administration Tracking System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	

		☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Biennially	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.a.8 Number and percent of paid claims for services that are prior authorized by DADS. N: Number of paid claims for services that are prior authorized by DADS. D: Number of claims paid.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DADS Quality Assurance and Improvement Data Mart

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.a.9 Number and percent of face-to-face utilization reviews conducted by DADS in accordance with the HHSC/DADS Executive Directive. N: Number of face-to-face utilization reviews conducted by DADS in accordance with the HHSC/DADS Executive Directive. D: Number of face-to-face utilization reviews required.

Data Source (Select one):

Record reviews, on-site
If 'Other' is selected, specify:
Utilization Management Review Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

A.a.10 Number and percent of providers enrolled by DADS according to enrollment procedures. N: Number of providers enrolled by DADS according to enrollment procedures. D: Number of providers enrolled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Health and Human Services Contract Administration and Tracking System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
A.a.11 Number and percent of providers enrolled by DADS that had a Medicaid provider agreement executed prior to delivering services. N: Number of providers enrolled by DADS that had a Medicaid provider agreement executed prior to delivering services. D: Number of providers enrolled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Health and Human Services Contract Administration and Tracking System

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach*(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.a.12 Number and percent of providers without actions taken by DADS based upon results of contract monitoring. N: Number of providers that did not have actions taken on their contract. D: Number of providers monitored.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Health and Human Services Contract Administration and Tracking System

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach*(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.a.13 Number and percent of providers monitored in accordance with the schedule required by policy. N: Number of providers monitored in accordance with the schedule required by policy. D: Number of providers meeting the requirements for scheduled monitoring.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Health and Human Services Contract Administration and Tracking System; Automated Survey Processing Environment

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.a.14 Number and percent of individuals/employers using the CDS option that had a Medicaid provider agreement for each employee. N: Number of employers using the CDS option that had Medicaid provider agreements for each employee. D: Total number of individuals/employers reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Health and Human Services Contract Administration and Tracking System; DADS Quality Assurance and Improvement Data Mart

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Every three years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

HHSC and DADS hold regular status and update meetings directed at evaluating current quality systems and identifying and prioritizing enhancements. HHSC has formal processes to ensure that the waiver renewal; waiver amendments; CMS-372 reports; Request for Evidentiary Information reports; policy changes, policy clarifications, and operational changes that implement change to existing waiver policy or develop new policy; and all state rules for waiver program operations are reviewed and approved by HHSC.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

HHSC and DADS hold regular status and update meetings directed at evaluating current quality systems and identifying and prioritizing enhancements. These meetings have resulted in plans to enhance data reporting by DADS to HHSC, establishing a baseline for current activities, and developing a quality management strategy that spans more than one waiver and potentially other types of long-term care services. Additionally, HHSC reviews and approves all waiver renewals, amendments, CMS-372 reports, Request for Evidentiary Information reports, state rules, policy changes, policy clarifications, and operational changes that are developed by DADS. If any concerns are identified during the review process, HHSC has formal processes to ensure that the initial waiver, renewals, subsequent amendments, CMS-372, and Request for Evidentiary Information reports, and all state rules for waiver program operations are reviewed and approved by HHSC.

HHSC employs a variety of mechanisms for resolving issues with performance of DADS. These mechanisms have varying levels of formality, and include:

Informal conversations
Day to day, the HHSC and DADS staff function in a collaborative manner to support waiver operation and administration. When HHSC has a concern about a delegated function, the appropriate DADS staff member is called to discuss the concern. In most instances, the issue is clarified or the problem resolved. DADS staff and leadership are accessible to HHSC staff and leadership to discuss and resolve issues.

Waiver Strategic Planning meetings
Waiver strategic planning meetings of HHSC and DADS staff occur at least quarterly, but typically monthly and are led by HHSC. This group evaluates changes needed to existing waivers, including those identified via legislative mandates or direction, CMS, HHSC, stakeholder meetings, other internal workgroups, and staff. Waiver activities, including renewals, amendments, reports, and at times, new applications and remediation activities, are discussed and methods and timing for formal communications with CMS about changes needing formal approval are planned.

Elevated conversations
If an issue is urgent or chronic and is not resolved through informal communication or through discussion at waiver strategic planning meetings, HHSC staff will bring the issue to the attention of HHSC management. This is the final stage of informal communication and is an attempt to resolve issues without moving to more formal actions.

Action memos
Action memos are formal communication from agency staff to the DADS Commissioner or the HHSC Executive Commissioner. Action memos are utilized as needed to ensure leadership at the highest level is informed and supports actions needed to correct problems or make improvements.

Corrective Action Plan
HHSC may require DADS to develop a written plan to correct or resolve issues with performance. The corrective action plan must provide a detailed explanation of the reasons for the cited deficiency; an assessment or diagnosis of the cause; a specific proposal to cure or resolve a deficiency, including the date by which the deficiency will be cured; and a timetable including intermediate steps leading to the cure of the deficiency. The corrective action plan must be submitted by the deadline set forth in HHSC's request for a corrective action plan. The corrective action plan is subject to approval by HHSC. Additionally, HHSC may require DADS to produce reports to demonstrate that the deficiency has been corrected and to monitor DADS for a specified period of time.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☑ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☑	**Developmental Disability**	0		☑
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

b. Additional Criteria. The State further specifies its target group(s) as follows:

An eligible individual must meet CLASS waiver eligibility criteria and participation requirements in accordance with the following sections of the Texas Administrative Code:
(1) Eligibility Criteria:Title 40 of the Texas Administrative Code, Part 1, Chapter 45, Section 45.201 (http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=40&pt=1&ch=45&rl=201) and
(2) Mandatory Participation Requirements for an Individual: Title 40 of the Texas Administrative Code, Chapter 45, Subchapter C, Section 45.302 (http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=40&pt=1&ch=45&rl=302).

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

- (●) **Not applicable. There is no maximum age limit**
- ( ) **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- ( ) **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- (●) **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

  The limit specified by the State is *(select one)*

  - (●) **A level higher than 100% of the institutional average.**

    Specify the percentage: 200

  - ( ) **Other**

    Specify:

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  The cost limit specified by the State is *(select one)*:

  - ( ) **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

- **Is adjusted each year that the waiver is in effect by applying the following formula:**

  Specify the formula:

- **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

- **The following percentage that is less than 100% of the institutional average:**

  Specify percent:

- **Other:**

  Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

The service planning team, which includes the individual and the legally authorized representative, case manager, a representative of the direct services agency, and other persons as chosen by the individual, reviews assessments and other information related to the individual's needs in order to ascertain the amount of waiver services that the individual may require. Based on this information, the service planning team develops a service plan that includes waiver services and non-waiver services which may include Medicaid State Plan services and other services and supports available to the individual. The service planning team must have a reasonable expectation that the service plan will adequately meet the needs of the individual in a community setting and that the plan ensures that the individual's health and welfare can be assured within the cost limit. The service planning team members sign the service plan prior to implementation and certify that the waiver services are appropriate to meet the needs of the individual.

The waiver is intended to serve individuals who would require institutionalization in an intermediate care facility if the waiver services and supports were not available to them. All individuals must have an individual plan of care at a cost within the cost limit. For individuals with needs that exceed the cost limit, the service planning team considers other options to ensure their needs are met. These options include examining non-waiver services and supports, possible transition to another waiver, or institutional services.

An individual whose request for enrollment into the CLASS waiver is denied or is not acted upon with reasonable promptness is entitled to a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A. DADS sends written notice of denial of eligibility to the individual or legally authorized representative notifying the individual, or legally authorized representative, of the denial of the individual's request for enrollment into the CLASS waiver and includes in the notice the individual's right to request a fair hearing and the process to follow to request a fair hearing. DADS sends a copy of the notice to the individual's direct services agency, case management agency, and if selected, financial management services agency.

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an

amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☑ **Other safeguard(s)**

Specify:

All waiver individuals must have a service plan at a cost within the cost limit. For individuals with needs that exceed the cost limit at any time during enrollment, DADS considers other options to ensure their needs are met. The process, which ensures that individuals' health and welfare needs are met within the cost limit, includes:
- examining the availability of non-waiver resources including recommendations of referrals to other services in the community,
- transitioning the individual to another waiver or to institutional services, or
- possible use of state funds to cover costs above the cost limit in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 40, Section 40.1.

During the enrollment process and at least annually the case manager informs the individual of other options and makes referrals as appropriate. If DADS proposes to terminate the individual's waiver eligibility or reduce services, DADS gives the individual or legally authorized representative the opportunity to request a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	5250
Year 2	5869
Year 3	5885
Year 4	5885
Year 5	5885

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

○ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**

◉ **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	5045
Year 2	5633
Year 3	5633
Year 4	5633
Year 5	5633

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

○ **Not applicable. The state does not reserve capacity.**

◉ **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes	
Money Follows the Person	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Money Follows the Person

Purpose *(describe):*

Texas Money Follows the Person program began in 2001. The State reserves waiver capacity for the Texas Money Follows the Person program in order to assist individuals living in a nursing facility to return to the community to receive their long-term services and supports without having to be placed on an interest list. The target population is individuals who are residents of a nursing facility and are enrolled in Medicaid.

Texas also contracts with relocation contractors who employ relocation specialists that assist in the outreach and identification of individuals interested in relocation and then assist them in the relocation process. Relocation contractor services are available throughout Texas. If an individual chooses to relocate from a nursing facility to the community, the relocation specialist coordinates the relocation with the resident, the resident's family (or guardian/legally authorized representative), the facility, and the individual's case manager. In addition, representatives from the following organizations also provide information and assistance for nursing facility residents wanting to return to a community setting:

- DADS case manager;
- Local Area Agencies on Aging;
- Local Long-Term Care Ombudsmen;
- Nursing Facility Social Workers;
- Nursing Facility Family Councils;
- Local Long-Term Services and Supports Providers;
- Community Transition Teams;
- Aging and Disability Resource Centers;
- Local Mental Health Authorities; and
- Local Intellectual and Developmental Disability Authorities.

Describe how the amount of reserved capacity was determined:

The State reserves capacity for this target group in accordance with state legislative appropriations.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	5
Year 2	5
Year 3	5
Year 4	5
Year 5	5

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

If legislative funding is not available, DADS maintains a CLASS interest list and assigns placement on the interest list chronologically based on the date of the request for CLASS services. When the individual requests placement on the interest list, DADS requests that the individual provide contact information, including a Texas mailing address, with the exception of individuals who are temporarily out of the state due to military assignments. DADS offers a vacancy to individuals on a first-come, first-served basis as funding is available and according to the chronological

date of the individual's date of registration on the CLASS interest list. If an individual seeking entrance into CLASS meets the criteria for a reserved capacity group, they bypass the interest list, as long as there are reserved waiver capacity slots available. If there are no slots remaining in the Money Follows the Person reserved capacity group, the State will request an increase in slots included in the reserved capacity group to accommodate the additional individuals.

Once an offer to apply for CLASS is made to an individual, the applicant must choose a case management agency and a direct services agency from a list of all contracted case management agencies and a direct services agencies in the catchment area in which the individual resides and notify DADS of the choices. DADS notifies the chosen providers. The case manager schedules and conducts initial face-to-face contact to begin the eligibility determination process. The direct services agency meets with the individual to conduct the level of care eligibility assessment. The individual must (1) meet Medicaid eligibility requirements; (2) meet level of care eligibility; (3) assist the direct services agency with obtaining a completed level of care from the physician; and (4) have an ongoing need for services. Once the level of care assessment is obtained from the physician, and DADS determines eligibility, the case manager schedules a meeting for the service planning team to develop the service plan and determine the date for services to begin.

If an individual is denied waiver enrollment based on diagnosis, level of care, or other functional eligibility requirements, a DADS representative notifies the individual that, if he or she chooses, his or her name will be placed on one or more other waiver program's interest list, using his or her original interest list request date for the CLASS waiver.

If the individual requests his or her name be added to another interest list, the DADS representative will contact the appropriate interest list authority and direct the interest list authority to place the individual's name on the program's interest list, using his or her original interest list request date for the CLASS waiver.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (•) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ( ) **No**
   - (•) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional State supplement recipients**

☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

○ **100% of the Federal poverty level (FPL)**
○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

☑ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
☐ **Medically needy in 209(b) States (42 CFR §435.330)**
☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
☑ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

The State had listed both the Code of Federal Regulations and the Social Security Act references for this eligibility group. This was a cleanup of duplicative federal references but this change did not remove any eligibility groups included in the waiver.

• Transitional Medical Assistance §1902(e)(1)
• Spousal Support Transitional §1931(c)(1), 42 CFR 435.115(f) (any age)
• Parents and other Caretaker Relatives 42 CFR 435.110 (any age)
• Pregnant Women 42 CFR 435.116 (any age)
• Coverage Infants and Children under age 19 42 CFR 435.118
• Former Foster Care Children §1902(a)(10)(A)(i)(IX), 42 CFR 435.150 (age 18-25)
• Independent Foster Care Adolescents §1902(a)(10)(A)(ii)(XVII), 42 CFR 435.226 (age 18-20)
• Medicaid for Breast and Cervical Cancer §1902(a)(10)(A)(ii)(XVIII) (diagnosed with Breast or Cervical Cancer and under age 65)
• Reasonable Classification Children Under 21 §1902(a)(10)(A)(ii)(I) and (IV), 42 CFR 435.222
• Adoption Assistance and Foster Care Children §1902(a)(10)(A)(i)(I), §473(b)(3), 42 CFR 435.145
• Children with Non-IV-E Adoption Assistance §1902(a)(10)(A)(ii)(VIII), 42 CFR 435.227
• Pickle Group §1939(a)(5)(E), 42 CFR 435.135 (any age)
• Disabled Adult Children §1634(c) , §1939 (age 18 and older)
• Disabled Widow(er) §1634(b), §1939, 42 CFR 435.137 (age 60-64)
• Early Aged Widow(er) §1634(d), §1939, 42 CFR 435.138 (age 50-59)
• Medicaid Buy-In for Children §1902(a)(10)(A)(ii)(XIX), §1902(cc)(1) (under age 19)

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
◉ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☑ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**
○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☑ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

○ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

◉ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

◉ **The following standard included under the State plan**

Select one:

○ **SSI standard**
○ **Optional State supplement standard**
○ **Medically needy income standard**
◉ **The special income level for institutionalized persons**

(*select one*):

◉ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the State Plan**

Specify:

○ **The following dollar amount**

Specify dollar amount: [ ] If this amount changes, this item will be revised.

○ **The following formula is used to determine the needs allowance:**

Specify:

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

○ **Not Applicable (see instructions)**
◉ **SSI standard**
○ **Optional State supplement standard**
○ **Medically needy income standard**
○ **The following dollar amount:**

Specify dollar amount: [ ] If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

○ **Not Applicable (see instructions)**
◉ **AFDC need standard**
○ **Medically needy income standard**
○ **The following dollar amount:**

Specify dollar amount: [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The State does not establish reasonable limits.**
- ○ **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- (●) **The following standard included under the State plan**

  Select one:

  - ( ) **SSI standard**
  - ( ) **Optional State supplement standard**
  - ( ) **Medically needy income standard**
  - (●) **The special income level for institutionalized persons**

    (*select one*):

    - (●) **300% of the SSI Federal Benefit Rate (FBR)**
    - ( ) **A percentage of the FBR, which is less than 300%**

      Specify the percentage: [ ]
    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount: [ ]
  - ( ) **A percentage of the Federal poverty level**

    Specify percentage: [ ]
  - ( ) **Other standard included under the State Plan**

    Specify:

    [ ]
- ( ) **The following dollar amount**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.
- ( ) **The following formula is used to determine the needs allowance:**

  Specify:

  [ ]
- ( ) **Other**

  Specify:

  [ ]

ii. Allowance for the spouse only (*select one*):

- (●) **Not Applicable**
- ( ) **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

- ○ **SSI standard**
- ○ **Optional State supplement standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised.
- ○ **The amount is determined using the following formula:**

  Specify:

iii. Allowance for the family (*select one*):

- ○ **Not Applicable (see instructions)**
- ◉ **AFDC need standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- ○ **The amount is determined using the following formula:**

  Specify:

- ○ **Other**

  Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The State does not establish reasonable limits.**

○ **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

○ **SSI standard**
○ **Optional State supplement standard**
○ **Medically needy income standard**
◉ **The special income level for institutionalized persons**
○ **A percentage of the Federal poverty level**

Specify percentage:

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised

○ **The following formula is used to determine the needs allowance:**

Specify formula:

○ **Other**

Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ( ) **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- (●) **The State does not establish reasonable limits.**
- ( ) **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The State requires (select one):

- ( ) **The provision of waiver services at least monthly**
- (●) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

Case management must be provided at least quarterly.

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ○ **Directly by the Medicaid agency**
- ◉ **By the operating agency specified in Appendix A**
- ○ **By an entity under contract with the Medicaid agency.**

  Specify the entity:

- ○ **Other**
  Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

DADS staff that review and approve all level of care evaluations submitted by the direct services agency must:
-have a bachelor's degree in a health and human services related field plus two years of experience in the delivery of services to individuals with disabilities;
-be a qualified intellectual disability professional who meets the requirements outlined in Title 42 of the Code of Federal Regulations, Section 483.430(a); or
-have an associate's degree in a health and human services related field plus four years of experience in the delivery of services to individuals with disabilities.

The direct services agency collects information for the initial evaluation during the initial visit with the applicant. Direct services agency staff collecting the information must be a registered nurse licensed by the State while the qualifying diagnosis is authorized by a physician.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The required level of care, level of care VIII, is defined in Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter E, Section 9.239. To meet level of care VIII criteria, a person must have a primary diagnosis by a licensed physician of a related condition that is included on the list of diagnostic codes for persons with related conditions that are approved by DADS and posted on its website, and must have an adaptive behavior level of II, III, or IV (i.e., moderate to extreme deficits in adaptive behavior) obtained by administering a standardized assessment of adaptive behavior.

DADS assigns the level of care based on the Intellectual Disability/Related Condition Assessment submitted by the direct services agency. The Intellectual Disability/Related Condition Assessment includes all factors that are assessed in evaluating a level of care determination: diagnostic information that includes age of onset of the qualifying conditions, names of qualifying conditions, the appropriate International Classification of Diseases, Clinical Modification codes, using the version required by CMS, the name of the adaptive behavior assessment tool, and the adaptive behavior level. The standardized assessment tools authorized by the CLASS waiver to determine adaptive behavior level are the Inventory for Client and Agency Planning, Scales of Independent Behavior-Revised, American Association on Intellectual Disabilities Adaptive Behavior Scales, and Vineland Adaptive Behavior Scales.

The CLASS waiver additionally requires an individual to exhibit deficiencies in at least three areas assessed on the Related Conditions Eligibility Screening Instrument.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- ◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**

○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Before enrollment, an applicant is visited by the registered nurse employed by the direct services agency. The registered nurse completes the following assessments which determine the individual's level of care:
- Intellectual Disability/Related Condition Assessment;
- Adaptive Behavior Level assessment (with assistance from the applicant or individual); and
- Related Conditions Eligibility Screening Instrument.

The direct services agency submits the Intellectual Disability/Related Condition Assessment to the applicant's physician. The direct services agency ensures that the physician attests by signature on the Intellectual Disability/Related Condition Assessment to the individual's primary diagnosis, date of onset, the appropriate International Classification of Diseases, Clinical Modification code, using the version required by CMS for the primary related condition. The direct services agency sends the signed and completed Intellectual Disability/Related Condition Assessment form, along with a copy of the adaptive behavior level assessment tool and the Related Conditions Screening Instrument, to DADS for level of care determination.

DADS staff authorize or deny the assignment of level of care and notify the direct services agency in writing of the decision. If the level of care is denied, DADS sends a copy of the written notice to the individual or legally authorized representative notifying the individual, or legally authorized representative, of the individual's right to a fair hearing and the process to follow to request a fair hearing. DADS sends a copy of the notice to the individual's direct services agency and case management agency. The case management agency notifies the financial management services agency if the individual receives any services through the consumer directed services option.

With the exception of a physician's signature on the Intellectual Disability/Related Condition Assessment form, the process for reevaluation of the level of care is the same as an initial evaluation.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

○ **Every three months**
○ **Every six months**
◉ **Every twelve months**
○ **Other schedule**
Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

○ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
◉ **The qualifications are different.**
Specify the qualifications:

A registered nurse licensed by the State and employed by the direct services agency completes the Intellectual Disability/Related Condition Assessment form for reevaluation. The qualifications for the initial evaluation and re-evaluation are the same except in the re-evaluation, the qualifying diagnosis is not required to be attested to by a physician for reevaluation.

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

The CLASS direct services agency is required to track each level of care expiration date. DADS requires the CLASS direct services agency to resubmit annually the level of care assessment to DADS for approval. DADS reviews each level of care assessment for accuracy. If DADS discovers errors in submission, the CLASS direct services agency is notified and instructed to correct the errors. If the direct services agency does not submit a level of care reassessment prior to the expiration of the previously approved level of care, DADS requires the direct services agency to submit the level of care reassessment as soon as possible after the expiration. DADS does not reimburse a provider for services provided during the time DADS has not approved the level of care assessment.

DADS reviews each level of care assessment and makes the level of care determination based on information submitted by the CLASS direct services agency. DADS may request more information if necessary to make the determination. Upon approval of the level of care, DADS reviews and approves the individual's renewal service plan. DADS rejects the service plan if the level of care has expired and the provider is unable to bill for services. During the period in which an individual has an expired level of care, the case management agency, direct services agency, and financial management services agency must continue to provide services to ensure continuity of care and to prevent jeopardizing the individual's health and welfare.

DADS also monitors and reviews the level of care effective periods during on-site contract monitoring visits to ensure timely resubmission to DADS.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records of evaluations and reevaluations of level of care are maintained by the case management agency and the direct services agency.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

B.a.1 Number and percent of new enrollees whose initial level of care was completed as a condition of enrollment prior to the receipt of services. N: Number of new enrollees whose initial level of care was completed as a condition of enrollment prior to receipt of services. D: Number of new enrollees.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
CLASS Database; DADS Quality Assurance and Improvement Data Mart

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
B.b.1 Number and percent of individuals whose level of care is reevaluated annually. N: Number of individuals whose level of care is reevaluated annually. D: Number of enrolled individuals minus new enrollees.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
CLASS Database; DADS Quality Assurance and Improvement Data Mart

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
B.c.1 Number and percent of individuals' initial and annual level of care determination forms that were completed as required by the State. N: Number of enrolled individuals' initial and annual level of care determination forms that were completed as required by the State. D: Number of enrolled individuals.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
CLASS Database; DADS Quality Assurance and Improvement Data Mart

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
One hundred percent of level of care submissions are reviewed by DADS through desk reviews by DADS staff who review the assessment information used to determine level of care and assure the accuracy of the level of care value for every individual in the CLASS waiver. DADS staff are required to:
-have a bachelor's degree in a health and human services related field plus two years of experience in the delivery of services to individuals with disabilities;
-be a qualified intellectual disability professional who meets the requirements outlined in Title 42 of the Code of Federal Regulations, Section 483.430(a); or
-have an associate's degree in a health and human services related field plus four years of experience in the delivery of services to individuals with disabilities

One hundred percent of direct services agencies and case management agencies are reviewed by DADS Community Services Contracts staff at least every two years. This monitoring includes a review of a sample of case records to ensure that each individual in the sample has a completed level of care documentation within the required timeframes.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DADS staff review the assessment information used to determine level of care and assure the accuracy of the level of care value for every individual in the CLASS waiver. The DADS staff responsible for reviewing the assessment information has the following qualifications:
-a bachelor's degree in a health and human services related field plus two years of experience in the delivery of services to individuals with disabilities;
-are a qualified intellectual disability professional who meets the requirements outlined in Title 42 of the Code of Federal Regulations, Section 483.430(a); or
- an associate's degree in a health and human services related field plus four years of experience in the delivery of services to individuals with disabilities

DADS returns any level of care forms that are not completed correctly to the direct services agency for revision. DADS ensures that the returned level of care forms are corrected when errors are identified or that a denial is sent for an invalid level of care.

DADS reviews 100 percent of the level of care forms for CLASS waiver enrollments through desk reviews. When errors are identified by DADS, the direct services agency nurse must make corrections and re-submit the level of care form to DADS. Enrollments are not authorized unless the level of care is approved by DADS. DADS approves, denies, or requests additional information or corrections to submitted levels of care.

DADS offers technical assistance to case management agencies and direct services agencies on a day-to-day basis through telephone calls with DADS CLASS staff and updates to the CLASS Provider Manual as needed. DADS also hosts quarterly webinars to inform case management agencies and direct services agencies of changes in the waiver, provide information about any changes in policy or operations. In addition, DADS conducts CLASS Provider Training twice each year. This training includes a review of CLASS waiver eligibility criteria, including level of care criteria, as well as a review of the level of care assessment form.

DADS Community Services Contracts conducts monitoring, which includes a review of a sample of case

records to ensure each individual in the sample has documentation of level of care. During the review, DADS Community Services Contracts considers whether the level of care forms are signed by a physician and were approved by DADS staff; and that the level of care forms and supporting documentation were submitted to DADS within the required timeframes.

Technical assistance is shared with providers throughout the monitoring reviews. The monitoring review culminates in an exit conference, during which the provider is informed of all findings and is given the opportunity to ask questions. Further technical guidance related to the findings is provided during the exit conference. If the findings necessitate further action, DADS Community Services Contracts staff may refer the provider to the Sanction Action Review Committee, which is responsible for determining what further action, if any, is needed. These actions may include, among others, requiring the provider to submit a corrective action plan. If a corrective action plan is requested from the provider, the provider is informed that they may contact DADS staff with questions or requests for clarification of what constitutes an acceptable corrective action plan. This provides further opportunity for the provider to receive technical assistance relating to the specific area of deficiency. Upon submittal, DADS reviews the corrective action plan and either approves or, if the submitted plan does not include all of the required elements, requests revisions and resubmittal.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

When an offer to apply for CLASS is made to an individual, the applicant is provided a list of all contracted CLASS case management agencies and direct services agencies in the catchment area in which the individual resides. The individual is informed at enrollment and annually thereafter, that a list of all contracted CLASS case management agencies and direct services agencies serving the catchment area where the individual resides will be provided at any time the applicant/individual requests it.

After the individual selects a case management agency, the case management agency assigns a case manager to the individual. The case manager is required to meet with the individual face-to-face within 14 days of the date that the case management agency is notified by DADS that they have been selected by the individual. During the initial meeting with an individual, the case manager informs the individual of services available through CLASS and of any alternatives available, including the choice of institutional care versus home and community-based waiver services. The freedom of choice form is the Waiver Program Verification of Freedom of Choice form. The individual or legally authorized representative signs the form during the initial meeting to indicate he or she chooses waiver services over institutional care. During the initial meeting and annually, the case manager addresses living arrangements and choice of providers as well as available third party resources.

b. **Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The forms are maintained by the case management agency.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The Executive Staff Office, Support Services Coordination Unit, assists the program areas in obtaining translations into other languages and interpreter services (face-to-face or over-the phone) through a number of third-party vendors for DADS.

DADS Communications Office, Language Services Unit provides the following: translation of written materials from English to Spanish or vice versa for state office and the regions; review and evaluation of Spanish translations that were prepared elsewhere; proofreading translated copy to ensure accuracy; translating correspondence sent by individuals to state office; providing voice talent for audio and video productions; coordinating translation and interpretation for languages other than Spanish.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. **Waiver Services Summary.** *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Case Management**		
Statutory Service	**Prevocational Services**		
Statutory Service	**Residential Habilitation**		
Statutory Service	**Respite (In-Home and Out-–of-Home)**		
Statutory Service	**Supported Employment**		

Service Type	Service		
Extended State Plan Service	Adaptive Aids		
Extended State Plan Service	Dental Treatment		
Extended State Plan Service	Dietary		
Extended State Plan Service	Nursing		
Extended State Plan Service	Occupational Therapy		
Extended State Plan Service	Physical Therapy		
Extended State Plan Service	Prescribed Drugs		
Extended State Plan Service	Speech and Language Pathology		
Supports for Participant Direction	Financial Management Services		
Supports for Participant Direction	Support Consultation		
Other Service	Auditory Integration Training/Auditory Enhancement Training		
Other Service	Behavioral Support		
Other Service	Cognitive Rehabilitation Therapy		
Other Service	Continued Family Services		
Other Service	Employment Assistance		
Other Service	Minor Home Modifications		
Other Service	Specialized Therapies		
Other Service	Support Family Services		
Other Service	Transition Assistance Services		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Case management means a service that assists an individual in the following:
- assessing the individual's needs;
- enrolling the individual into the CLASS Program;
- developing the individual's service plan;
- coordinating the provision of CLASS services;
- monitoring the effectiveness of the CLASS services and the individual's progress toward achieving the outcomes identified;
- revising the individual's service plan, as appropriate;
- accessing non-waiver services, including Medicaid State Plan services;
- resolving crisis situations in the individual's life; and
- advocating for the individual.

Case managers initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of service plans at enrollment, annually, and as needed. They lead the service planning team in development of a service plan that optimizes the opportunities for the individual to use their abilities and to integrate in community settings. They communicate with service planning team members to ensure that the service plan is being carried out appropriately. They monitor the success of the service plan by observing the individual at home and in the community. Case managers are responsible for ongoing monitoring of the provision of services included in the service plan. Case managers advocate for an individual's needs when necessary and appropriate. Case management is required for enrollment and annual service planning.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case management agency holding a CLASS Medicaid provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Case management agency holding a CLASS Medicaid provider agreement

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The case management agency must complete the Medicaid provider agreement application and all necessary documents.

The case management agency must show proof of an office in the catchment area that it serves and hire staff that meets case manager qualifications. Those qualifications include:
-have the formal educational equivalent of a bachelor's degree in a health and human services field, plus two years' experience in the delivery of human services to persons with disabilities, or
-hold a high school degree or equivalent, plus four years' experience in the coordination and delivery of human services to persons with disabilities.

The case manager must complete training within 60 days of employment and annually, thereafter:
- how to recognize the signs and symptoms of abuse, neglect, and exploitation;
- understand the reporting requirements; and
- how to report.

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as stated below.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. DADS Community Services Contracts staff responds to complaints received against any CLASS provider for failure to maintain provider qualifications. DADS levies appropriate Medicaid provider agreement actions and sanctions for failure to follow the Medicaid provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Prevocational services means services that are not job-task oriented and are provided to an individual who the service planning team does not expect to be employed (without receiving supported employment) within one year after prevocational services are to begin, to prepare the individual for employment. Prevocational services consist of:

(A) assessment of vocational skills an individual needs to develop or improve upon;

(B) individual and group instruction regarding barriers to employment;

(C) training in skills:

(i) that are not job-task oriented;

(ii) that are related to goals identified in the individual's habilitation plan;

(iii) that are essential to obtaining and retaining employment, such as the effective use of community resources, transportation, and mobility training; and

(iv) for which an individual is not compensated more than 50 percent of the federal minimum wage or industry standard, whichever is greater;

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

(E) transportation between the individual's place of residence and prevocational services work site when other forms of transportation are unavailable or inaccessible.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Prevocational services are provided under this waiver when no other financial resource is available or when other available resources have been used.

This service refers to those prevocational services not already available through a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17). Documentation is maintained in the file of each individual that this service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or Public Law 94-142. Prevocational services are provided to persons not expected to be able to join the general work force within one year (excluding supported employment programs).

This service may not be provided at the same time that respite, residential habilitation, employment assistance or supported employment services are provided.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Direct services agency holding a CLASS Medicaid provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Direct services agency holding a CLASS Medicaid provider agreement

Provider Qualifications

License *(specify):*

The agency must be licensed as a home and community support service agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

Certificate *(specify):*

Other Standard *(specify):*

Provider must be age 18 or older and have:
-a bachelor's degree in a health and human services field and two years' work experience in the delivery of services and supports to persons with related conditions or similar disabilities;
-a high school diploma, and four years' work experience in the delivery of services and supports to persons with related conditions or similar disabilities; or
-a Certificate of High School Equivalency (GED credentials), and four years' work experience in the delivery of services and supports to persons with related conditions or similar disabilities.

A service provider may be a relative of the individual, except that neither the individual's. spouse or parent of an individual who is a minor child may be a provider.

Must:
- pass criminal history and other applicable registry checks; and
- maintain a current driver's license and insurance if transporting the individual.

The provider must complete training on the following within 60 days of employment, and annually thereafter:
- an individual's rights and responsibilities;
- the complaints process;
- mandatory participation requirements;
- review of CLASS rules concerning the Rights and Responsibilities of an Individual; and
-how to recognize the signs and symptoms of abuse, neglect, and exploitation, the reporting requirements, and how to report.

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a CLASS direct services agency for failure to maintain provider qualifications. DADS levies appropriate Medicaid provider agreement actions and sanctions for failure to follow the Medicaid provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

DADS Regulatory Services licenses home and community support services agencies and is responsible for ensuring that providers meet licensing requirements. Home and community support services agencies that are not accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. Upon license renewal, DADS Regulatory Services verifies that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission on Accreditation of Healthcare Organizations and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission on Accreditation of Healthcare Organizations or Community Health Accreditation Program. If an accredited and deemed home and community support service agency is a licensed and certified home health agency, DADS Regulatory Services coordinates with the Center for Medicare and Medicaid Services prior to initiating a complaint investigation.

DADS has an internal policy to coordinate communications and operations between all involved DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Residential habilitation is provided to individuals living in their own home or family home to allow an individual to reside successfully in a community setting by training the individual to acquire, retain, and improve self-help, socialization, and daily living skills or assisting the individual with activities of daily living. Residential habilitation services consist of the following:

(A) habilitation training, which is interacting face-to-face with an individual who is awake, to train the individual in the following activities:

(i) self-care;
(ii) personal hygiene;
(iii) household tasks;
(iv) mobility;
(v) money management;

(vi) community integration;
(vii) use of adaptive equipment;
(viii) management of caregivers;
(ix) personal decision making;
(x) interpersonal communication;
(xi) reduction of challenging behaviors;
(xii) socialization and the development of relationships;
(xiii) participating in leisure and recreational activities;
(xiv) use of natural supports and typical community services available to the public;
(xv) self-administration of medication; and
(xvi) strategies to restore or compensate for reduced cognitive skills;
(B) habilitation activities of daily living, which are:
(i) interacting face-to-face with an individual who is awake to assist the individual in the following activities:
(I) self-care;
(II) personal hygiene;
(III) ambulation and mobility;
(IV) money management;
(V) community integration;
(VI) use of adaptive equipment;
(VII) self-administration of medication;
(VIII) reinforce any therapeutic goal of the individual;
(IX) provide transportation to the individual; and
(X) protect the individual's health, safety and security;
(ii) interacting face-to-face or by telephone with an individual or an involved person regarding an incident that directly affects the individual's health or safety; and
(iii) performing one of the following activities that does not involve interacting face-to-face with an individual:
(I) shopping for the individual;
(II) planning or preparing meals for the individual;
(III) housekeeping for the individual;
(IV) procuring or preparing the individual's medication; or
(V) arranging transportation for the individual; and
(C) habilitation delegated, which is tasks delegated by a registered nurse to a service provider of habilitation in accordance with Title 22 of the Texas Administrative Code, Part 11, Chapter 224 or Chapter 225.

Personal assistance may be an incidental component to habilitation for some activities of daily living for some individuals in the waiver.

Individuals in the CLASS waiver must have an ongoing demonstrated need for and be able to benefit from CLASS residential habilitation services based on the pre-enrollment needs assessment by the case manager and the service plan developed by the service planning team.

Transportation costs which are not billable, but which are incurred to provide residential habilitation, are included in the indirect portion of the rate.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Payment will not be made for routine care and supervision that would be expected to be provided by a family member or for activities or supervision for which a payment is made by a source other than Medicaid. This service does not include payment for room or board. Residential habilitation may not be provided at the same time that respite, prevocational services, employment assistance, or supported employment is provided.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**

☑ **Relative**

☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer directed services direct service provider
Agency	Direct services agency holding a CLASS Medicaid provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

All residential habilitation service providers must be age 18 or older. Any residential habilitation service provider hired on or after July 1, 2015, must also have:
- a high school diploma;
- a Certificate of High School Equivalency (GED credentials); or
- 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 at least three personal references from persons not related by blood that evidence the person's ability to provide a safe & healthy environment for the individual.

Can be a family member if:
- not the individual's spouse;
- parent of an individual who is a minor child;
- the legal guardian;
- the spouse of the legal guardian;
- the designated representative; or
- the spouse of the designated representative.

Must:
- have current training certification in cardiopulmonary resuscitation and choking prevention that includes an in-person evaluation by a qualified instructor verifying the service provider's ability to perform these actions;
- complete orientation and training as specified by the individual/employer;
- pass criminal history and other applicable registry checks; and
- maintain a current driver's license and insurance, if transporting the individual.

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer and financial management services agency

DADS

Frequency of Verification:
Individual/employer and financial management services agency prior to hiring.

DADS Community Services Contracts staff verifies provider qualifications during on-site reviews, completed every three years at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:
Direct services agency holding a CLASS Medicaid provider agreement
Provider Qualifications
License *(specify):*
The agency must be licensed as a home and community support service agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.
Certificate *(specify):*

Other Standard *(specify):*
All residential habilitation service providers must be age 18 or older. Any residential habilitation service provider hired on or after July 1, 2015, must also have:
- a high school diploma;
- a Certificate of High School Equivalency (GED credentials); or
- 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 at least three personal references from persons not related by blood that evidence the person's ability to provide a safe & healthy environment for the individual.

A service provider can be a family member if not the individual's spouse or parent of an individual who is a minor child.

Must:
- have current training certification in cardiopulmonary resuscitation and choking prevention that includes an in-person evaluation by a qualified instructor verifying the service provider's ability to perform these actions;
- complete an orientation, with the individual present, in the activities necessary to meet the needs and characteristics of the individual they will be providing services to;
- pass criminal history and other applicable registry checks; and
- maintain a current driver's license and insurance if transporting the individual.

The provider must complete training on the following:
- an individual's rights and responsibilities;
- the complaints process;
- mandatory participation requirements;
- review of CLASS rules concerning the Rights and Responsibilities of an Individual; and
- within 60 days of employment, and annually thereafter, on how to recognize the signs and symptoms of abuse, neglect, and exploitation, the reporting requirements, and how to report.

Verification of Provider Qualifications
Entity Responsible for Verification:
DADS
Frequency of Verification:

DADS verifies provider qualifications prior to awarding a Medicaid provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a CLASS direct services agency for failure to maintain provider qualifications. DADS levies appropriate Medicaid provider agreement actions and sanctions for failure to follow the Medicaid provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

DADS Regulatory Services licenses home and community support services agencies and is responsible for ensuring that providers meet licensing requirements. Home and community support services agencies that are not accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey, and at least every 36 months thereafter. Upon license renewal, DADS Regulatory Services verifies that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission on Accreditation of Healthcare Organizations and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission on Accreditation of Healthcare Organizations or Community Health Accreditation Program. If an accredited and deemed home and community support service agency is a licensed and certified home health agency, DADS Regulatory Services coordinates with the Center for Medicare and Medicaid Services prior to initiating a complaint investigation.

DADS has an internal policy to coordinate communications and operations between all involved DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite (In-Home and Out-–of-Home)

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Respite services means the temporary assistance with an individual's activities of daily living if the individual has the same residence as a person who routinely provides such assistance and support to the individual, and the person is temporarily unavailable to provide such assistance and support.

Respite is provided intermittently when the primary caregiver is temporarily unavailable to provide supports. Respite provides an individual with assistance with activities of daily living and instrumental activities of daily living, the performance of tasks delegated by a registered nurse in accordance with state law, and supervision of the individual's safety and security. Respite includes activities that facilitate the individual's inclusion in community activities, use of natural supports and typical community services available to all people, social interaction, and participation in leisure activities, and development of socially valued behaviors and daily living and functional living skills.

Respite services consist of the following:
(a) interacting face-to-face with an individual who is awake to assist the individual in the following activities:
(1) self-care;
(2) personal hygiene;
(3) ambulation and mobility;
(4) money management;
(5) community integration;
(6) use of adaptive equipment;
(7) self-administration of medication;
(8) reinforce any therapeutic goal of the individual;
(9) provide transportation to the individual; and
(10) protect the individual's health, safety, and security;
(b) interacting face-to-face or by telephone with an individual or an involved person regarding an incident that directly affects the individual's health or safety; and
(c) performing one of the following activities that does not involve interacting face-to-face with an individual:
(1) shopping for the individual;
(2) planning or preparing meals for the individual;
(3) housekeeping for the individual;
(4) procuring or preparing the individual's medication;

(5) arranging transportation for the individual; or
(6) protecting the individual's health, safety, and security while the individual is asleep.

Respite care will be provided in the following locations:
- Individual’s home or place of residence;
- Three person Adult Foster Home;
- Four person Adult Foster Home;
- Assisted living facility;
- Nursing facility;
- Intermediate care facility; and
- Camp accredited by the American Camp Association.

Transportation to and from the respite service site is not a billable service for the respite service but is included in the billable service for residential habilitation.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Respite is limited to 30 days of combined in-home respite and out-of-home respite for each service plan year.

Respite cannot be provided during the same period that residential habilitation, continued family service, or support family services are provided.

The provision of respite care precludes the provision of, or payment for, other duplicative services under the waiver.

If the person who routinely provides assistance and support, resides with the individual, and is temporarily unavailable to provide assistance and support, is a service provider of habilitation or an employee in the consumer directed services option of habilitation, DADS does not authorize respite unless:
- the service provider or employee routinely provides unpaid assistance and support with activities of daily living to the individual;
- the amount of respite does not exceed the amount of unpaid assistance and support routinely provided; and
- the service provider of respite or employee in the CDS option of respite does not have the same residence as the individual.

If the person who routinely provides assistance and support, resides with the individual, and is temporarily unavailable to provide assistance and support, is a service provider of support family services or continued family services, DADS does not authorize respite unless:
- for an individual receiving support family services, the individual does not receive respite on the same day the individual receives support family services;
- for an individual receiving continued family services, the individual does not receive respite on the same day the individual receives continued family services; and
- the service provider of respite or employee in the CDS option of respite does not have the same residence as the individual.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Foster Care Three Person Residence Providers (out-of-home respite)
Agency	Adult Foster Care Four Person Residence Providers (out-of-home respite)
Individual	Consumer directed services direct service provider

Provider Category	Provider Type Title
Agency	Direct services agency holding a CLASS Medicaid provider agreement
Agency	Assisted Living Facility (out-of-home respite)
Agency	Intermediate care facility (out-of-home respite)
Agency	Nursing Facility Provider (out-of-home respite)
Agency	Camp accredited by the American Camp Association Provider (out-of-home respite)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite (In-Home and Out-–of-Home)

Provider Category:
Agency

Provider Type:
Adult Foster Care Three Person Residence Providers (out-of-home respite)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The adult foster care respite provider must be age 18 or older.

A service provider can be family member if not the individual's spouse or parent of an individual who is a minor child and does not have the same residence as the individual.

Must:
- have current hands-on training in cardiopulmonary resuscitation and choking prevention that includes an in-person evaluation by a qualified instructor verifying the service provider's ability to perform these actions;
- complete an orientation with the individual present, in the activities necessary to meet the needs and characteristics of the individual they will be providing services to;
- pass criminal history and other applicable registry checks; and
- maintain current driver's license and insurance if transporting the individual.

Verification of Provider Qualifications

Entity Responsible for Verification:
DADS

Frequency of Verification:
DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews and is also responsible for ensuring that service providers meet staff qualifications. Each new contract is monitored within the first 12 months of the contract and at least every two years thereafter.

Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

DADS has an internal policy to coordinate communications and operations between all involved DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite (In-Home and Out-–of-Home)

Provider Category:

Agency

Provider Type:

Adult Foster Care Four Person Residence Providers (out-of-home respite)

Provider Qualifications

License *(specify):*

If serving four or more individuals, licensed by DADS as an assisted living facility under Title 40 of the Texas Administrative Code, Part 1, Chapter 92.

Certificate *(specify):*

Other Standard *(specify):*

The adult foster care respite provider must be age 18 or older.

A service provider can be family member if not the individual's spouse or parent of an individual who is a minor child and does not have the same residence as the individual.

Must:
- have current hands-on training in cardiopulmonary resuscitation and choking prevention that includes an in-person evaluation by a qualified instructor verifying the service provider's ability to perform these actions;
- complete an orientation with the individual present, in the activities necessary to meet the needs and characteristics of the individual they will be providing services to;
- pass criminal history and other applicable registry checks; and
- maintain current driver's license and insurance if transporting the individual.

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews and is also responsible for ensuring that service providers meet staff qualifications. Each new contract is monitored within the first 12 months of the contract and at least every two years thereafter.

Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

DADS Regulatory Services licenses four bed adult foster care homes as Type C Assisted Living.

DADS has an internal policy to coordinate communications and operations between all involved

DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite (In-Home and Out-–of-Home)

Provider Category:
Individual

Provider Type:
Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
All respite service providers must be age 18 or older. Any respite service provider hired on or after July 1, 2015, must also have:
- a high school diploma;
- a Certificate of High School Equivalency (GED credentials); or
- 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 at least three personal references from persons not related by blood that evidence the person's ability to provide a safe & healthy environment for the individual.

Can be a family member if:
- not the individual's spouse;
- not the parent of an individual who is a minor child;
- not the legal guardian;
- not the spouse of the legal guardian;
- not the designated representative; or
- not the spouse of the designated representative.

Must:
- have current training certification in cardiopulmonary resuscitation and choking prevention that includes an in-person evaluation by a qualified instructor verifying the service provider's ability to perform these actions;
- complete orientation and training as specified by the individual/employer;
- pass criminal history and other applicable registry checks; and
- maintain a current driver's license and insurance, if transporting the individual.

Verification of Provider Qualifications

Entity Responsible for Verification:
Individual/employer and financial management services agency

DADS

Frequency of Verification:
The financial management services agency and the individual-employer verify that each potential employee meets the required qualifications prior to being hired by the individual-employer.

DADS Community Services Contracts staff verifies provider qualifications during on-site reviews conducted every three years at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite (In-Home and Out-–of-Home)

Provider Category:
Agency
Provider Type:
Direct services agency holding a CLASS Medicaid provider agreement
Provider Qualifications

License *(specify):*
Must be licensed as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

Certificate *(specify):*

Other Standard *(specify):*
All respite service providers must be age 18 or older. Any respite service provider hired on or after July 1, 2015, must also have:
- a high school diploma;
- a Certificate of High School Equivalency (GED credentials); or
- 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 at least three personal references from persons not related by blood that evidence the person's ability to provide a safe & healthy environment for the individual.

A service provider can be a family member if not the individual's spouse or parent of an individual who is a minor child.

Must:
- have current training certification in cardiopulmonary resuscitation and choking prevention that includes an in-person evaluation by a qualified instructor verifying the service provider’s ability to perform these actions;
- complete an orientation, with the individual present, in the activities necessary to meet the needs and characteristics of the individual they will be providing services to;
- pass criminal history and other applicable registry checks; and
- maintain a current driver’s license and insurance if transporting the individual.

The provider must complete training on the following:
- an individual's rights and responsibilities;
- the complaints process;
- mandatory participation requirements;
- review of CLASS rules concerning the Rights and Responsibilities of an Individual; and
- within 60 days of employment, and annually thereafter, on how to recognize the signs and symptoms of abuse, neglect, and exploitation, the reporting requirements, and how to report.

Verification of Provider Qualifications

Entity Responsible for Verification:
DADS
Frequency of Verification:
DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews and is also responsible for ensuring that service providers meet staff qualifications. Each new contract is monitored within the first 12 months of the contract and at least every two years thereafter.

Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

DADS Regulatory Services licenses home and community support services agencies, and is responsible for ensuring that providers meet licensing requirements. Home and community support services agencies that are not accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. Upon license renewal, DADS Regulatory Services verifies that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission on Accreditation of Healthcare Organizations and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program. If an accredited and deemed home and community support service agency is a licensed and certified home health agency, DADS Regulatory Services coordinates with CMS prior to initiating a complaint investigation.

DADS has an internal policy to coordinate communications and operations between all involved DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite (In-Home and Out-–of-Home)

Provider Category:
Agency
Provider Type:
Assisted Living Facility (out-of-home respite)
Provider Qualifications
License *(specify):*
Assisted living facilities must have an assisted living license in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 92.
Certificate *(specify):*

Other Standard *(specify):*
The respite service provider must be age 18 or older and have:
- a high school diploma;
- a certificate of high school equivalency (General Educational Development credentials); or
- documentation of a proficiency evaluation of experience and competence to perform job tasks,

A service provider cannot live with the individual, cannot be the caregiver whether or not related to the individual, and cannot be the individual's spouse.

Must:
- have current hands-on training in cardiopulmonary resuscitation and choking prevention that includes an in-person evaluation by a qualified instructor verifying the service provider's ability to perform these actions;
- complete an orientation with the individual present, in the activities necessary to meet the needs and characteristics of the individual they will be providing services to;
- pass criminal history and other applicable registry checks; and
- maintain current driver's license and insurance if transporting the individual.

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews and is also responsible for ensuring that service providers meet staff qualifications. Each new contract is monitored within the first 12 months of the contract and at least every two years thereafter.

Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

DADS Regulatory Services licenses assisted living facilities according to Title 40 of the Texas Administrative Code, Part 1, Chapter 92, and is responsible for ensuring that providers meet qualifications. Assisted living facilities are surveyed before being licensed and prior to license renewal. Type A and Type B assisted living facility licenses are valid for two years and facilities are inspected every two years. The inspection includes observation of the care of a sample of residents. DADS Regulatory Services staff ensure operational and building requirements for Type A and Type B assisted living facilities are met as described in Title 40 of the Texas Administrative Code, Part 1, Chapter 92. Assisted living facilities are surveyed for compliance during the initial license application process. Assisted living facilities are inspected to ensure compliance with licensing requirements. The inspection includes observation of the care of a sample of individuals. Licenses are valid for two years. Complaint investigations involving alleged licensing violations are conducted according to the priority of the allegations.

DADS has an internal policy to coordinate communications and operations between all involved DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite (In-Home and Out-–of-Home)

Provider Category:

Agency

Provider Type:

Intermediate care facility (out-of-home respite)

Provider Qualifications

License *(specify):*

Licensed by DADS as an intermediate care facility in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 90.

Certificate *(specify):*

Other Standard *(specify):*

The intermediate care facility respite provider must employ staff who are age 18 or older.

A service provider can be a family member if not the individual's spouse or the parent of an individual who is a minor child.

Must:

- have current hands-on training in cardiopulmonary resuscitation and choking prevention that includes an in-person evaluation by a qualified instructor verifying the service provider's ability to perform these actions;
- complete an orientation with the individual present, in the activities necessary to meet the needs and characteristics of the individual they will be providing services to;
- pass criminal history and other applicable registry checks; and
- maintain current driver's license and insurance if transporting the individual.

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews and is also responsible for ensuring that service providers meet staff qualifications. Each new contract is monitored within the first 12 months of the contract and at least every two years thereafter.

Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

DADS Regulatory Services licenses intermediate care facilities according to Title 40 of the Texas Administrative Code, Part 1, Chapter 97. Licensed intermediate care facilities have an annual recertification of health and life safety code survey every 12 months and at least every 15 months. Licensed intermediate care facilities also have a licensure inspection to assess compliance with the State Standards of Participation.

DADS has an internal policy to coordinate communications and operations between all involved DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite (In-Home and Out-–of-Home)

Provider Category:

Agency

Provider Type:
Nursing Facility Provider (out-of-home respite)
Provider Qualifications

License *(specify):*
Licensed by DADS as a nursing facility under Title 40 of the Texas Administrative Code Part 1, Chapter 19.
Certificate *(specify):*

Other Standard *(specify):*
The nursing facility respite provider must employ staff who are age 18 or older.

A service provider can be a family member if not the individual's spouse or the parent of an individual who is a minor child.

Must:
- have current hands-on training in cardiopulmonary resuscitation and choking prevention that includes an in-person evaluation by a qualified instructor verifying the service provider's ability to perform these actions;
- complete an orientation with the individual present, in the activities necessary to meet the needs and characteristics of the individual they will be providing services to;
- pass criminal history and other applicable registry checks; and
- maintain current driver's license and insurance if transporting the individual.

Verification of Provider Qualifications

Entity Responsible for Verification:
DADS
Frequency of Verification:
DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews and is also responsible for ensuring that service providers meet staff qualifications. Each new contract is monitored within the first 12 months of the contract and at least every two years thereafter.

Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

DADS Regulatory Services licenses nursing facilities and is responsible for ensuring that facilities meet licensing qualifications. Nursing facilities are surveyed during their first year of operation and approximately 9-15 months after the licensure according to Title 40 of the Texas Administrative Code, Part 1, Chapter 19. Nursing facilities are inspected to ensure compliance with licensing requirements. The inspection includes observation of the care of a sample of individuals.

DADS has an internal policy to coordinate communications and operations between all involved DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite (In-Home and Out-–of-Home)

Provider Category:
Agency
Provider Type:
Camp accredited by the American Camp Association Provider (out-of-home respite)
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Accredited by the American Camp Association
Other Standard *(specify):*
Providers must meet accreditation standards of the American Camp Association.
Verification of Provider Qualifications
Entity Responsible for Verification:
DADS

American Camp Association
Frequency of Verification:
DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews and is also responsible for ensuring that service providers meet staff qualifications. Each new contract is monitored within the first 12 months of the contract and at least every two years thereafter.

Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

American Camp Association conducts an on-site visit every three years. Accreditation is approved on an annual basis by the local leadership based on continued compliance as evidenced by a signed Annual Statement of Compliance and payment of all current fees.

DADS has an internal policy to coordinate communications and operations between all involved DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Supported Employment
Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Supported employment means assistance provided, 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. Supported employment includes employment adaptations, supervision, and training related to an individual's assessed needs. Individuals receiving supported employment earn at least minimum wage (if not self-employed).

A provider of supported employment may bill for such services as: (1) transporting the individual to and from the worksite, (2) activities related to supporting the individual to be self-employed, work from home, or perform in a work setting, and (3) participating in the service planning team meetings.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
In the state of Texas, this service is not available to individuals receiving these services under a program funded under section 110 of the Rehabilitation Act of 1973. Documentation is maintained in the individual's record that the service is not available to the individual under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.).

The service does not include sheltered work or other types of vocational services in specialized facilities, or for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
(A) incentive payments made to an employer to encourage hiring the individual;
(B) payments that are passed through to the individual;
(C) payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business; or
(D) payments used to defray the expenses associated with starting up or operating a business. Supported employment is not provided to an individual with the individual present at the same time that respite, residential habilitation, prevocational services, or employment assistance is provided.

This service may not be provided to the individual with the individual present at the same time that respite, residential habilitation, prevocational services, or employment assistance is provided.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer directed services direct service provider
Agency	Direct services agency holding a CLASS Medicaid provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Individual
Provider Type:
Consumer directed services direct service provider
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The service provider must be at least 18 years of age; maintain current driver's license and insurance if transporting individual; and satisfy one of these options:

Option 1:
- have a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and
- six months of paid or unpaid experience providing services to people with disabilities.

Option 2:
- have an associate's degree in rehabilitation, business, marketing, or a related human services field; and
- one year of paid or unpaid experience providing services to people with disabilities.

Option 3:
- have a high school diploma or Certificate of High School Equivalency (GED credentials); and
- two years of paid or unpaid experience providing services to people with disabilities.

Under the consumer directed services option, the provider cannot be the participant's legal guardian or the spouse of the legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:
Individual/employer and financial management services agency

DADS
Frequency of Verification:
Individual/employer and financial management services agency prior to hiring.

DADS Community Services Contracts staff verifies provider qualifications during on-site reviews, completed every three years at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:
Direct services agency holding a CLASS Medicaid provider agreement
Provider Qualifications

License *(specify):*
Must be licensed as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.
Certificate *(specify):*

Other Standard *(specify):*
The service provider must be at least 18 years of age; maintain current driver's license and insurance if transporting individual; and satisfy one of these options:

Option 1:
- have a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and
- six months of paid or unpaid experience providing services to people with disabilities.

Option 2:
- have an associate's degree in rehabilitation, business, marketing, or a related human services field; and
- one year of paid or unpaid experience providing services to people with disabilities.

Option 3:
- have a high school diploma or Certificate of High School Equivalency (GED credentials); and
- two years of paid or unpaid experience providing services to people with disabilities.

The provider must complete orientation and training as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 45. Tasks delegated by a registered nurse must be performed in accordance with state law.

Verification of Provider Qualifications

Entity Responsible for Verification:
DADS
Frequency of Verification:
DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring

reviews. Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a CLASS direct services agency for failure to maintain provider qualifications. DADS levies appropriate Medicaid provider agreement actions and sanctions for failure to follow the Medicaid provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

DADS Regulatory Services licenses home and community support services agencies and is responsible for ensuring that providers meet licensing requirements. Home and community support services agencies that are not accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey, and at least every 36 months thereafter. Upon license renewal, DADS Regulatory Services verifies that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission on Accreditation of Healthcare Organizations and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program. If an accredited and deemed home and community support service agency is a licensed and certified home health agency, DADS Regulatory Services coordinates with CMS prior to initiating a complaint investigation.

DADS has an internal policy to coordinate communications and operations between all involved DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Adaptive Aids

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Adaptive aids are items or services that enable individuals to retain or increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live, and are included in the list of adaptive aids in the CLASS Provider Manual or are repair and maintenance of an adaptive aid on such list that is not covered by warranty.

Adaptive aids include items that assist an individual with mobility and communication and ancillary supplies and equipment necessary to the proper functioning of such items. Also included are medically necessary supplies and items needed for life support. All items must meet applicable standards of manufacture, design, and installation. Items reimbursed with waiver funds must be in addition to any medical equipment and supplies furnished under the Medicaid State Plan.

An adaptive aid is provided for a specific individual and becomes the exclusive property of that individual. Excluded are those items and supplies, which are not of direct medical or remedial benefit to the individual, and items and supplies that are available to the individual through the Medicaid State Plan, through other governmental programs, or through private insurance.
This service provides devices, controls, or appliances that are necessary to address specific needs identified by the individual's service plan.

Adaptive aids are limited to the following categories including repair and maintenance not covered by warranty:
1. Lifts;
2. Mobility Aids (including batteries and chargers)
3. Position Devices
4. Communication aids
5. Computers and Appropriate Accessories for communication needs not met by an augmentative communication device, to operate adaptive software, for assistance with money management or for environmental control purposes
6. Environmental controls
7. Adaptive equipment for activities of daily living
8. Medically necessary supplies
9. Specialized Training and Instructions
10. Modification/Additions to Primary Transportation Vehicles
11. Temporary lease/rental of durable medical equipment to allow for repair, purchase, or replacement of an essential support system or while non-CLASS resources reviews the necessity of an adaptive aid for an individual. Lease/rental shall not exceed 90 days.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Any item or service not listed in the CLASS Provider Manual is not billable as an adaptive aid.

Adaptive aids are provided under this waiver when no other financial resource is available or when other available resources have been exhausted. The case manager must obtain proof of non-coverage by Medicaid

and, if applicable, proof of non-coverage by Medicare.

The individual's service planning team must authorize all adaptive aids. Items costing more than $500 must be authorized by the service planning team based upon written evaluations and recommendations by the individual's physician, a licensed occupational or physical therapist, a psychologist or behavior analyst, a licensed nurse, a licensed dietitian, or a licensed audiologist or speech/language pathologist qualified to assess the individual's need for the specific adaptive aid. The written evaluation and recommendation must document the necessity and appropriateness of the adaptive aid to meet the specific needs of the individual.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Direct Services Agency holding CLASS Medicaid provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Adaptive Aids

Provider Category:
Agency
Provider Type:
Direct Services Agency holding CLASS Medicaid provider agreement
Provider Qualifications

License *(specify):*
The agency must be licensed as a home and community support service agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

Certificate *(specify):*

Other Standard *(specify):*
Adaptive aids must be provided by contractors/suppliers capable of providing adaptive aids meeting applicable standards of manufacture, design, and installation.

Verification of Provider Qualifications

Entity Responsible for Verification:
DADS
Frequency of Verification:
DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews and is also responsible for ensuring that service providers meet staff qualifications. Each new contract is monitored within the first 12 months of the contract and at least every two years thereafter.

Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a

provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

DADS Regulatory Services licenses home and community support services agencies, and is responsible for ensuring that providers meet licensing requirements. Home and community support services agencies that are not accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. Upon license renewal, DADS Regulatory Services verifies that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission on Accreditation of Healthcare Organizations and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program. If an accredited and deemed home and community support service agency is a licensed and certified home health agency, DADS Regulatory Services coordinates with CMS prior to initiating a complaint investigation.

DADS has an internal policy to coordinate communications and operations between all involved DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Dental Treatment

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Dental treatment means a service that consists of the following:
- Emergency dental treatment- 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;
- Routing preventive dental treatment- Examinations, X-rays, cleanings, sealants, oral prophylaxes, and topical fluoride applications;
- Therapeutic dental treatment- Treatment that includes fillings, scaling, extractions, crowns, 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;
- Orthodontic dental treatment- 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 Labio-lingual Deviation Index; and
-Dental sedation- 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.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Dental treatment does not include cosmetic orthodontia.

Dental treatment is provided under this waiver when no other financial resource for such treatment is available or when other available resources have been exhausted. This waiver service is only provided to individuals age 21 and over. All medically necessary dental treatment services for children under the age of 21 are covered in the state plan pursuant to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Direct Services Agency holding CLASS Medicaid provider agreement

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Dental Treatment

Provider Category:

Agency

Provider Type:

Direct Services Agency holding CLASS Medicaid provider agreement

Provider Qualifications

License *(specify):*

The agency must be licensed as a home and community support service agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

The service provider must be licensed as a dentist under Title 3 of the Texas Occupations Code, Subtitle D, Chapter 251.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews and is also responsible for ensuring that service providers meet staff qualifications. Each new contract is monitored within the first 12 months of the contract and at least every two years thereafter.

Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

DADS Regulatory Services licenses home and community support services agencies, and is responsible for ensuring that providers meet licensing requirements. Home and community support services agencies that are not accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. Upon license renewal, DADS Regulatory Services verifies that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission on Accreditation of Healthcare Organizations and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program. If an accredited and deemed home and community support service agency

is a licensed and certified home health agency, DADS Regulatory Services coordinates with CMS prior to initiating a complaint investigation.

DADS has an internal policy to coordinate communications and operations between all involved DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Dietary

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Dietary services is the provision of nutrition services as defined in Title 3 of the Texas Occupations Code, Chapter 701 and includes:

- assessing the nutritional needs of an individual or group and determining constraints and resources in the

practice;
- establishing priorities and goals that meet nutritional needs and are consistent with constraints and available resources;
- providing nutrition counseling in health and disease;
- developing, implementing, and managing nutritional care systems; and
- evaluating, changing, and maintaining appropriate quality standards in food and nutritional care services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Dietary services are provided through the waiver when no other financial resources are available or when other available resources have been exhausted. Individuals who are under 21 years of age must access benefits through the Texas Health Steps--Comprehensive Care Program before dietary services may be provided through the waiver. Funding of copayments for therapeutic services is limited to those therapeutic services available in the CLASS program.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Direct Services Agency holding CLASS Medicaid provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Dietary

Provider Category:
Agency
Provider Type:
Direct Services Agency holding CLASS Medicaid provider agreement
Provider Qualifications

License *(specify):*
The agency must be licensed as a home and community support service agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

The dietician must be licensed under Title 3 of the Texas Occupations Code, Subtitle M, Chapter 701.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DADS
Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews and is also responsible for ensuring that service providers meet staff qualifications. Each new contract is monitored within the first 12 months of the contract and at least every two years thereafter.

Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

DADS Regulatory Services licenses home and community support services agencies, and is responsible for ensuring that providers meet licensing requirements. Home and community support services agencies that are not accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. Upon license renewal, DADS Regulatory Services verifies that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission on Accreditation of Healthcare Organizations and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program. If an accredited and deemed home and community support service agency is a licensed and certified home health agency, DADS Regulatory Services coordinates with CMS prior to initiating a complaint investigation.

DADS has an internal policy to coordinate communications and operations between all involved DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Nursing

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
The nursing service provides treatment and monitoring of medical conditions prescribed by a physician/medical practitioner and/or required by standards of professional practice or state law to be performed by licensed nursing personnel.

Nursing services include: licensed vocational nursing, registered nursing, specialized licensed vocational nursing, and specialized registered nursing.

Nursing services are those services listed in the plan of care that are within the scope of the Texas Nurse Practice Act and are provided by a registered nurse, or licensed vocational nurse under the supervision of a registered nurse, licensed to practice in the State.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
All medically necessary Nursing Services for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit, except for nursing tasks that are required for the provision of waiver services. Nursing is provided under this waiver when no other financial resource is available or when other available resources have been used.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Direct Services Agency holding CLASS Medicaid provider agreement
Individual	Consumer directed services direct service provider

Service Type: Extended State Plan Service
Service Name: Nursing

Provider Category:

Agency

Provider Type:

Direct Services Agency holding CLASS Medicaid provider agreement

Provider Qualifications

License *(specify):*

The agency must be licensed as a home and community support service agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

The nurse must be licensed as a Registered Nurse or Licensed Vocational Nurse under Title 3 of the Texas Occupations Code, Subtitle E, Chapter 301.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews and is also responsible for ensuring that service providers meet staff qualifications. Each new contract is monitored within the first 12 months of the contract and at least every two years thereafter.

Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

DADS Regulatory Services licenses home and community support services agencies, and is responsible for ensuring that providers meet licensing requirements. Home and community support services agencies that are not accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. Upon license renewal, DADS Regulatory Services verifies that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission on Accreditation of Healthcare Organizations and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program. If an accredited and deemed home and community support service agency

is a licensed and certified home health agency, DADS Regulatory Services coordinates with CMS prior to initiating a complaint investigation.

DADS has an internal policy to coordinate communications and operations between all involved DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Nursing

Provider Category:
Individual

Provider Type:
Consumer directed services direct service provider

Provider Qualifications

License *(specify):*
The nurse must be licensed as a Registered Nurse or Licensed Vocational Nurse under Title 3 of the Texas Occupations Code, Subtitle E, Chapter 301.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Individual/employer and financial management services agency

DADS

Frequency of Verification:
Individual/employer and financial management services agency prior to hiring.

DADS Community Services Contracts staff verifies provider qualifications during on-site reviews every three years at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Extended State Plan Service

Service Title:
Occupational Therapy

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
The practice of occupational therapy means:
- The evaluation or treatment of a person whose ability to perform the tasks of living is threatened or impaired by developmental deficits, the aging process, environmental deprivation, sensory impairment, physical injury or illness, or psychological or social dysfunction;
- The use of therapeutic goal-directed activities to: (1) evaluate, prevent, or correct physical or emotional dysfunction; or (2) maximize function in a person's life; or
- The application of therapeutic goal-directed activities in treating patients on an individual basis, in groups, or through social systems, by means of direct or monitored treatment or consultation.

Occupational therapy services include: screening and assessment; development of therapeutic treatment plans; providing direct therapeutic intervention; recommending adaptive aids; training and assisting with adaptive aids and augmentative communication devices; consulting with other providers and family members; and participating on the service planning team, when appropriate.

The practice of occupational therapy does not include diagnosis or psychological services of the type typically performed by a licensed psychologist.

The scope of occupational therapy services offered in this waiver exceeds the Medicaid State Plan occupational therapy benefit. Through the waiver, occupational therapy services are provided to maintain the individual's optimum condition.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Occupational therapy is provided under this waiver when no other financial resource is available or when other available resources have been used. This waiver service is provided to individuals age 21 and over only. All medically necessary occupational therapy services for children under the age of 21 are covered in the state plan pursuant to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Funding of copayments for therapeutic services is limited to those therapeutic services available in the CLASS waiver.

Service Delivery Method *(check each that applies)*:

☑ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer directed services direct service provider
Agency	Direct Services Agency holding CLASS Medicaid provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

The service provider must be an occupational therapist or occupational therapy assistant licensed in accordance with Title 3 of the Texas Occupations Code, Subtitle H, Chapter 454.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer and financial management services agency

DADS

Frequency of Verification:

Individual/employer and financial management services agency prior to hiring.

DADS Community Services Contracts staff verifies provider qualifications during on-site reviews every three years at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Direct Services Agency holding CLASS Medicaid provider agreement

Provider Qualifications

License *(specify):*

The agency must be licensed as a home and community support service agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

The service provider must be an occupational therapist or occupational therapy assistant licensed in accordance with Title 3 of the Texas Occupations Code, Subtitle H, Chapter 454.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews and is also responsible for ensuring that service providers meet staff qualifications. Each new contract is monitored within the first 12 months of the contract and at least every two years thereafter.

Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

DADS Regulatory Services licenses home and community support services agencies, and is responsible for ensuring that providers meet licensing requirements. Home and community support services agencies that are not accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. Upon license renewal, DADS Regulatory Services verifies that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission on Accreditation of Healthcare Organizations and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program. If an accredited and deemed home and community support service agency is a licensed and certified home health agency, DADS Regulatory Services coordinates with CMS prior to initiating a complaint investigation.

DADS has an internal policy to coordinate communications and operations between all involved DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Physical therapy means a form of health care that prevents, identifies, corrects, or alleviates acute prolonged movement dysfunction or pain of anatomic or physiologic origin.

Physical therapy includes the evaluation, examination, and utilization of exercises, rehabilitative procedures, massage, manipulations, and physical agents. Physical agents include mechanical devices, heat, cold, air, light, water, electricity, and sound used in the aid of diagnosis or treatment.

Physical therapy services include: screening and assessment; developing therapeutic treatment plans; providing direct therapeutic intervention; recommending adaptive aids; training and assisting with adaptive aids; consulting with other providers and family members; and participating on the service planning team, when appropriate.

The scope of physical therapy services offered in this waiver exceeds the state plan physical therapy

benefit. State Plan physical therapy services are provided only to treat for acute conditions or to treat exacerbation of chronic condition lasting less than 180 days. Services provided through the waiver cover ongoing chronic conditions even after rehabilitation has reached a plateau (e.g. range of motion). Through the waiver, physical therapy services will be provided to maintain the individual's optimum condition.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Physical therapy is provided under this waiver when no other financial resource is available or when other available resources have been used. This waiver service is provided to individuals age 21 and over only. All medically necessary physical therapy services for children under the age of 21 are covered in the state plan pursuant to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Funding of copayments for therapeutic services is limited to those therapeutic services available in the CLASS program.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Direct Services Agency holding CLASS Medicaid provider agreement
Individual	Consumer directed services direct service provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:

Agency

Provider Type:

Direct Services Agency holding CLASS Medicaid provider agreement

Provider Qualifications

License *(specify):*

The agency must be licensed as a home and community support service agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

The service provider must be a physical therapist or physical therapist assistant licensed in accordance with Title 3 of the Texas Occupations Code, Chapter 453.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews and is also responsible for ensuring that service providers meet staff qualifications. Each new contract is monitored within the first 12 months of the contract and at least every two years thereafter.

Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

DADS Regulatory Services licenses home and community support services agencies, and is responsible for ensuring that providers meet licensing requirements. Home and community support services agencies that are not accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. Upon license renewal, DADS Regulatory Services verifies that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission on Accreditation of Healthcare Organizations and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program. If an accredited and deemed home and community support service agency is a licensed and certified home health agency, DADS Regulatory Services coordinates with CMS prior to initiating a complaint investigation.

DADS has an internal policy to coordinate communications and operations between all involved DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

The service provider must be a physical therapist or physical therapist assistant licensed in accordance with Title 3 of the Texas Occupations Code, Chapter 453.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Individual/employer and financial management services agency

DADS
Frequency of Verification:
Individual/employer and financial management services agency prior to hiring

DADS Community Services Contracts staff verifies provider qualifications during on-site reviews every three years at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:
Prescribed Drugs

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Provides unlimited prescription medications to individuals enrolled in the waiver who are eligible for both Medicaid and Medicare (dually eligible). An individual who is dually eligible must obtain prescribed medications through the Medicare Part D Prescription Drug Plan or, through the Texas Medicaid State Plan (for certain medications excluded from Medicare), before medications are furnished under the waiver.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Individuals in the waiver who are enrolled in managed care for their acute care services receive unlimited prescription medications through their managed care and therefore do not qualify for prescriptions under the waiver. Dual eligible individuals are excluded from enrollment into managed care and are still eligible for prescription medications under the waiver if they meet the requirements in the above service definition.

This waiver service is provided to individuals age 21 and over only. All medically necessary prescribed drugs services for children under the age of 21 are covered in the state plan pursuant to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Pharmacies holding a Medicaid provider agreement- Vendor Drug with HHSC

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Prescribed Drugs

Provider Category:
Agency
Provider Type:
Pharmacies holding a Medicaid provider agreement- Vendor Drug with HHSC
Provider Qualifications
License *(specify):*
The pharmacy must be licensed by the Texas State Board of Pharmacy under Title 22 of the Texas Administrative Code, Part 15, Chapter 291.
Certificate *(specify):*
Other Standard *(specify):*
Must hold Vendor Drug Medicaid provider agreement with HHSC.
Verification of Provider Qualifications
Entity Responsible for Verification:
Texas State Board of Pharmacy
Frequency of Verification:
Biennially

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Speech and Language Pathology

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Speech and language pathology means the application of nonmedical principles, methods, and procedures for measurement, testing, evaluation, prediction, counseling, habilitation, rehabilitation, or instruction related to the development and disorders of communication, including speech, voice, language, oral pharyngeal function, or cognitive processes, for the purpose of evaluating, preventing, or modifying or offering to evaluate, prevent, or modify those disorders and conditions in an individual or a group.

Speech and language pathology includes: screening and assessment; developing therapeutic treatment plans; providing direct therapeutic intervention; recommending augmentative communication devices; training and assisting with augmentative communication devices; consulting with other providers and family members; and participating on the service planning team as appropriate.

The scope of speech and language pathology offered in this waiver exceeds the Medicaid State Plan

benefit. Through the waiver, speech and language pathology will be provided to maintain the individual's optimum condition.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Speech and language pathology is provided under this waiver when no other financial resource is available or when other available resources have been used. This waiver service is provided to individuals age 21 and over only. All medically necessary speech and language pathology services for children under the age of 21 are covered in the state plan pursuant to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Funding of copayments for therapeutic services is limited to those therapeutic services available in the CLASS program.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Direct Services Agency holding CLASS Medicaid provider agreement
Individual	Consumer directed services direct service provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech and Language Pathology

Provider Category:
Agency
Provider Type:
Direct Services Agency holding CLASS Medicaid provider agreement
Provider Qualifications

License *(specify):*
The agency must be licensed as a home and community support service agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

The service provider must be licensed as a speech-language pathologist or be a licensed assistant in speech-language pathology in accordance with Title 3 of the Texas Occupations Code, Subtitle G, Chapter 401.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DADS
Frequency of Verification:
DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews and is also responsible for ensuring that service providers meet staff qualifications. Each new contract is monitored within the first 12 months of the contract and at least every two years thereafter.

Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

DADS Regulatory Services licenses home and community support services agencies, and is responsible for ensuring that providers meet licensing requirements. Home and community support services agencies that are not accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. Upon license renewal, DADS Regulatory Services verifies that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission on Accreditation of Healthcare Organizations and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program. If an accredited and deemed home and community support service agency is a licensed and certified home health agency, DADS Regulatory Services coordinates with CMS prior to initiating a complaint investigation.

DADS has an internal policy to coordinate communications and operations between all involved DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech and Language Pathology

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

The service provider must be licensed as a speech-language pathologist or be a licensed assistant in speech-language pathology in accordance with Title 3 of the Texas Occupations Code, Subtitle G, Chapter 401.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Individual/employer and financial management services agency

DADS
Frequency of Verification:
Individual/employer and financial management services agency prior to hiring. Verify license renewal

DADS Community Services Contracts staff verifies provider qualifications during on-site reviews conducted every three years at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Financial management services are services provided by a financial management services agency to an employer, under the consumer directed services option to assist to individual/employers with managing funds associated with consumer directed services. The service includes initial orientation and ongoing training . The financial management services provider, referred to as the financial management services agency also provides assistance in the development, monitoring and revision of the individual's budget for each service delivered through the consumer directed services option and must maintain a separate account for each individual's budget. The financial management services agency provides assistance in determining staff wages and benefits subject to state limits, assistance in hiring by verifying employee's citizenship status and qualifications, and conducting required background checks. The financial management services agency verifies and maintains documentation of employee qualifications, including citizenship status, and documentation of services delivered. The financial management services agency also collects timesheets, processes timesheets of employees, processes payroll, withholding, filing and payment of applicable federal, state, and local employment-related taxes and insurance. The financial management services agency makes payments directly to the consumer directed services employee. The financial management services agency tracks disbursement of funds and provides periodic reports to the individual of all expenditures and the status of the individual's consumer directed services budget.

The financial management services agency must not provide other waiver services to the individual other than support consultation. The financial management services agency must not provide case management to the individual.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial management services agency holding a Medicaid provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Financial Management Services

Provider Category:
Agency
Provider Type:
Financial management services agency holding a Medicaid provider agreement

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The provider of financial management services must hold a Medicaid provider agreement to be a financial management services agency. The financial management services agency must successfully complete a mandatory three-day orientation and training conducted annually by DADS to obtain a Medicaid provider agreement to provide financial management services. The rules for the consumer directed services option, located at Title 40 of the Texas Administrative Code, Part 1, Chapter 41, detail the responsibilities of an employer agent, including the revocation of IRS Form 2678 if the individual terminates the consumer directed services option or transfers to another financial management services agency.

The financial management services agency must complete initial and periodic training. During monitoring reviews, financial management services agencies are required to meet 90 percent compliance. The monitoring assesses performance based on standards related to conducting background checks, licensure verification, orientation of the consumer directed services employer, new hire process, employer budgets and expenditure reports, and payroll. Current financial management services agencies are required to attend training at DADS at least once a year. Texas also holds quarterly conference calls with the financial management services agencies to discuss operational issues. Training and technical assistance are often provided on those calls.

The financial management services agency provider must be at least 18 years of age and must not be the individual's legal guardian; the spouse of the individual's legal guardian; the individual's designated representative; or the spouse of the individual's designated representative.

On request of an individual or an individual's legally authorized representative, the financial management services agency must have support consultation services available.

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS conducts monitoring reviews of financial management services agencies to determine compliance with the Medicaid provider agreement and CLASS rules and requirements. These reviews are conducted via desk review or at the location where the financial management services agency is providing financial management services. Texas monitors 100 percent of the financial management services agencies at a minimum every three years. DADS reports the results of the monitoring to HHSC. DADS assesses a financial management services agency's performance by using a standardized monitoring tool to:

1. Measure adherence to rules as described in the Texas Administrative Code;
2. Ensure the required background and registry checks were conducted prior to hire of the consumer directed services option employee;
3. Match payroll, optional benefits, and tax deposits to time sheets;
4. Assess adherence to state and federal tax laws specific to operating as a vendor fiscal/employer agent;
5. Ensure that the hours worked and the rate of pay are consistent with individual budgets;
6. Review administrative payments; and
7. Review the Medicaid provider agreements.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Support Consultation

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Support consultation is an optional service that may provide to an individual who chooses to participate in consumer directed services. This service is provided by a support advisor and provides a level of assistance beyond that provided by the consumer direct services agency through the financial management service. Support consultation helps the employer to meet the required employer responsibilities of the consumer directed services option and to successfully deliver program services.

Support consultation offers practical skills training and assistance to enable an individual or his/her legally authorized representative to successfully direct those services the individual or the legally authorized representative elect for self-direction. This service includes skills training related to recruiting, screening, and hiring workers, preparing job descriptions, verifying employment eligibility and qualifications, completion of

documents required to employ an individual, managing workers, and development of effective backup plans for services considered critical to the individual's health and welfare in the absence of the regular provider or in an emergency situation. This service provides sufficient information and assistance to assure individuals and their representatives understand the responsibilities involved with self-direction.

Support consultation may be provided by a qualified person associated with a financial management services agency selected by the individual or by an independent person hired by the individual. The support advisor does not provide any other waiver service except for support consultation services to the individual.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The scope and duration of support consultation will vary depending on an individual's need for support consultation.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer directed services direct service provider
Agency	Financial management services agency holding a Medicaid provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Support Consultation

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Individual provider must have a Support Advisor certificate issued by DADS to indicate successful completion of required training conducted or approved by DADS.

Other Standard *(specify):*

The certified support advisor must be at least 18 years of age. The support advisor must have a high school diploma or Certificate of High School Equivalency (GED credentials); pass a criminal background check; complete initial training required by and conducted or authorized by DADS and pass a test based on the initial training; and complete any ongoing training as required by DADS.

The support advisor must complete initial and periodic training provided by the employer. Support consultation may be provided by a qualified person associated with a financial management services agency selected by the individual or by an independent person hired by the individual.

The support advisor does not provide case management or any other waiver service except for financial management services to the individual.

The support advisor cannot be the individual's legal guardian; the spouse of the individual's legal guardian; the individual's designated representative; or the spouse of the individual's designated representative.

Verification of Provider Qualifications

Entity Responsible for Verification:
Individual/employer

Financial management services agency

DADS

Frequency of Verification:
Individual/employer and financial management services agency prior to completing service agreement.

DADS Community Services Contracts staff verifies provider qualifications during on-site and desk reviews of financial management services agencies conducted at a minimum every three years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Support Consultation

Provider Category:
Agency

Provider Type:
Financial management services agency holding a Medicaid provider agreement

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Individual provider must have a Support Advisor certificate issued by DADS to indicate successful completion of required training conducted or approved by DADS.

Other Standard *(specify):*
The certified support advisor must be at least 18 years of age. The support advisor must have a high school diploma or Certificate of High School Equivalency (GED credentials); pass a criminal background check; complete initial training required by and conducted or authorized by DADS and pass a test based on the initial training; and complete any ongoing training as required by DADS.

The support advisor must complete initial and periodic training provided by the employer. Support consultation may be provided by a qualified person associated with a financial management services agency selected by the individual or by an independent person hired by the individual.

The support advisor does not provide case management or any other waiver service except for financial management services to the individual.

The support advisor cannot be the individual's legal guardian; the spouse of the individual's legal guardian; the individual's designated representative; or the spouse of the individual's designated representative.

Verification of Provider Qualifications

Entity Responsible for Verification:
Financial Management Services Agency

DADS

Frequency of Verification:

Financial management services agency prior to completing service agreement.

DADS Community Services Contracts staff verifies provider qualifications during on-site and desk reviews of financial management services agencies conducted at a minimum every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Auditory Integration Training/Auditory Enhancement Training

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Auditory integration training/auditory enhancement training means specialized training that assists an individual to cope with hearing dysfunction or over-sensitivity to certain frequency ranges of sound by facilitating auditory processing skills and exercising the middle ear and auditory nervous system.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
An individual must have an audiogram performed by a licensed audiologist as a pre-requisite for auditory integration training/auditory enhancement training.

Auditory integration training/auditory enhancement training is provided under this waiver when no other financial resource is available or when other available resources have been used. Funding of copayments for therapeutic services is limited to those therapeutic services available in the CLASS program.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Direct services agency holding a CLASS Medicaid provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Auditory Integration Training/Auditory Enhancement Training

Provider Category:
Individual
Provider Type:
Direct services agency holding a CLASS Medicaid provider agreement
Provider Qualifications

License *(specify):*
Must be licensed as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

A qualified service provider of auditory integration/auditory enhancement training must be an audiologist or a licensed assistant in audiology licensed in accordance with Texas Occupations Code, Chapter 401.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DADS
Frequency of Verification:
DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews and is also responsible for ensuring that service providers meet staff qualifications. Each new contract is

monitored within the first 12 months of the contract and at least every two years thereafter.

Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

DADS Regulatory Services licenses home and community support services agencies, and is responsible for ensuring that providers meet licensing requirements. Home and community support services agencies that are not accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. Upon license renewal, DADS Regulatory Services verifies that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission on Accreditation of Healthcare Organizations and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program. If an accredited and deemed home and community support service agency is a licensed and certified home health agency, DADS Regulatory Services coordinates with CMS prior to initiating a complaint investigation.

DADS has an internal policy to coordinate communications and operations between all involved DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Behavioral Support

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Behavioral support services provide specialized interventions that assist an individual in increasing adaptive behaviors and replacing or modifying challenging or socially unacceptable behaviors that prevent or interfere with the individual's inclusion in the community and which consist of the following activities:
(1) Conducting a functional behavior assessment;
(2) Developing an individualized behavior support plan;(3) Training of and consultation with an individual, family member, or other persons involved in the individual's care regarding the implementation of the behavior support plan;
(4) Monitoring and evaluation of the effectiveness of the behavior support plan;
(5) Modifying, as necessary, the behavior support plan based on monitoring and evaluation of the plan's effectiveness; and
(6) Counseling with and educating an individual, family members, friends, or other persons involved in the individual's care about the techniques to use in assisting the individual to control maladaptive or Socially unacceptable behaviors.

Behavioral support services can include the full range of psychological activities within the scope of state licensure for psychologists and other licensed professionals in addition to specific behavioral support services. The scope of behavioral support services offered in this waiver exceeds the State Plan psychological services benefit and may be provided by a certified behavior analyst. Under the waiver, behavioral support services will be provided to maintain the individual's optimum condition.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Behavioral Support Services are provided under this waiver when no other financial resource is available or when other available resources have been used. Funding of copayments for therapeutic services is limited to those therapeutic services available in the CLASS program.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Direct services agency holding a CLASS Medicaid provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Support

Provider Category:
Agency
Provider Type:
Direct services agency holding a CLASS Medicaid provider agreement
Provider Qualifications

License *(specify):*
Must be licensed as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

The behavioral support service provider must be:
- a psychologist licensed in accordance with the Texas Occupations Code, Chapter 501;
- a provisional license holder licensed in accordance with the Texas Occupations Code, Chapter 501;
- a psychological associate licensed in accordance the Texas Occupations Code, Chapter 501;
- a licensed clinical social worker licensed in accordance with the Texas Occupations Code, Chapter 505; or
- a licensed professional counselor licensed in accordance with the Texas Occupations Code, Chapter 503.

Certificate *(specify):*
If not licensed, must be a board-certified Behavior Analyst certified by the National Behavior Analyst Certification Board, Inc.
Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DADS
Frequency of Verification:
DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews and is also responsible for ensuring that service providers meet staff qualifications. Each new contract is monitored within the first 12 months of the contract and at least every two years thereafter.

Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

DADS Regulatory Services licenses home and community support services agencies, and is responsible for ensuring that providers meet licensing requirements. Home and community support services agencies that are not accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months

thereafter. Upon license renewal, DADS Regulatory Services verifies that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission on Accreditation of Healthcare Organizations and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program. If an accredited and deemed home and community support service agency is a licensed and certified home health agency, DADS Regulatory Services coordinates with CMS prior to initiating a complaint investigation.

DADS has an internal policy to coordinate communications and operations between all involved DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Cognitive Rehabilitation Therapy

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Cognitive rehabilitation therapy is a service that assists 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.

Cognitive rehabilitation therapy is provided when determined to be medically necessary through an assessment conducted by an appropriate professional. Cognitive rehabilitation therapy is provided in accordance with the plan of care developed by the assessor, and includes reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The assessment is provided through the Medicaid State plan and is not included under this waiver.

Cognitive rehabilitation therapy is provided under this waiver when no other financial resource is available or when other available resources have been used. Funding of copayments for therapeutic services is limited to those therapeutic services available in the CLASS program.

The Cognitive Rehabilitation Therapy service included in appendix C-1 of CLASS is only available to individuals age 21 and over. Individuals under the age of 21 who are Medicaid eligible will continue to have access to appropriate therapy for learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry under the current State Plan services through occupational therapists, speech-language pathologists, and psychologists pursuant to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Direct services agency holding a CLASS Medicaid provider agreement
Individual	Consumer directed services direct service provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Cognitive Rehabilitation Therapy

Provider Category:
Agency

Provider Type:
Direct services agency holding a CLASS Medicaid provider agreement
Provider Qualifications

License *(specify):*
The agency must be licensed as a home and community support service agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

The service provider must be one of the following:
- a psychologist licensed by the Texas State Board of Examiners of Psychologists under Texas Occupations Code Chapter 501;
- a speech and language pathologist licensed under Title 3 of the Texas Occupations Code, Subtitle G, Chapter 401; or
- an occupational therapists licensed under Title 3 of the Texas Occupations Code, Subtitle H, Chapter 454.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DADS
Frequency of Verification:
DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews and is also responsible for ensuring that service providers meet staff qualifications. Each new contract is monitored within the first 12 months of the contract and at least every two years thereafter.

Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

DADS Regulatory Services licenses home and community support services agencies, and is responsible for ensuring that providers meet licensing requirements. Home and community support services agencies that are not accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. Upon license renewal, DADS Regulatory Services verifies that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission on Accreditation of Healthcare Organizations and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program. If an accredited and deemed home and community support service agency is a licensed and certified home health agency, DADS Regulatory Services coordinates with CMS prior to initiating a complaint investigation.

DADS has an internal policy to coordinate communications and operations between all involved

DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Cognitive Rehabilitation Therapy

Provider Category:
Individual
Provider Type:
Consumer directed services direct service provider
Provider Qualifications
License *(specify):*
The service provider must be one of the following:
- a psychologist licensed by the Texas State Board of Examiners of Psychologists under Texas Occupations Code Chapter 501;
- a speech and language pathologists licensed under Title 3 of the Texas Occupations Code, Subtitle G, Chapter 401; or
- an occupational therapists licensed under Title 3 of the Texas Occupations Code, Subtitle H, Chapter 454.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Individual/employer and financial management services agency

DADS
Frequency of Verification:
Individual/employer and financial management services agency prior to hiring.

DADS Community Services Contracts staff verifies provider qualifications during on-site reviews every three years at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Continued Family Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Continued family services are services provided to an individual18 years of age or older who resides with a support family, as described in Title 40 of the Texas Administrative Code, Part 1, Chapter 45, Subchapter E, Division 3, Section 531 (relating to Support Family Requirements), that allow the individual to reside successfully in a community setting by training the individual to acquire, retain, and improve self-help, socialization, and daily living skills or assisting the individual with activities of daily living. The individual must be receiving support family services immediately before receiving continued family services. Continued family services consist of services described in Title 40 of the Texas Administrative Code, Part 1, Chapter 45, Subchapter E, Division 3, Section 533 (relating to Support Family Duties).

Continued family services are available to allow the individual to attend high school, a program leading to a high school diploma, a Certificate of High School Equivalency (GED credentials), or transition to independence, including attending college or vocational or technical training.

Continued family services consist of the same services that a support family must provide, that are applicable to an individual 18 years of age or older, and are as follows:
(1) direct personal assistance activities of daily living (such as grooming, eating, bathing, dressing, and personal hygiene);
(2) assistance with meal planning and preparation;
(3) assistance with housekeeping;
(4) assistance with communication and mobility;
(5) reinforcement of behavioral, educational, and therapeutic activities;
(6) assistance with medications and the performance of tasks delegated by a registered nurse;
(7) supervision for the individual's safety and security;
(8) transportation related to routine family activities;
(9) assistance with participation in community activities; and

(10) habilitation.

The support family must:
(1) allow the individual's family members and friends access to the individual without arbitrary restrictions, unless exceptional conditions are justified by the service planning team, documented in the individual service plan, and approved by DADS;
(2) assist a school-age individual in receiving educational services in a six-hour-per-day program five days a week provided by the local school district;
(3) ensure that no individual receives educational services at a state school/state center educational setting, unless contraindications are documented with justification by the service planning team;
(4) ensure that a preschool-age individual receives an early childhood education with appropriate activities and services, including small group and individual play with peers without disabilities, unless contraindications are documented with justification;
(5) provide individuals with age-appropriate activities that enhance self-esteem and maximize functional level; and
(6) ensure the individual receives medical care prescribed by a physician, including:
(A) doctors' appointments;
(B) medications;
(C) evaluations, therapies, and treatment; and
(D) lab work and other medical tests.

The support family must not provide services to more than three unrelated children at any one time in their home. The support family must ensure that the child participates in age-appropriate community activities and the support family home environment is healthy and safe for the child.

The support family must provide service in a residence that the support family owns or leases. The residence must be a typical residence in the neighborhood and meet the needs of the child and the child's parents or legally authorized representative.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The individual must be receiving support family services immediately before receiving continued family services.

Waiver individuals are responsible for their room and board cost and contributing to the cost of their waiver services if they have any income left over after the post eligibility deductions have been made for their home and community-based waiver services. A separate payment will not be made for habilitation, meals, transportation, or Emergency Response Services since these services are integral to and inherent in the provision of continued family services.

Texas assures that the costs for room and board were not included in the reimbursement rate for continued family services. Since the standard payment amount has been determined by Congress to be adequate for meeting the maintenance needs of recipients in the community, the rate for room and board was capped at the SSI standard payment amount minus a personal needs allowance.

Payments for continued family services are not made for items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payments will not be made for the routine care and supervision that would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Direct Services Agency holding CLASS Medicaid provider agreement
Individual	Support Family Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Continued Family Services

Provider Category:

Agency

Provider Type:

Direct Services Agency holding CLASS Medicaid provider agreement

Provider Qualifications

License *(specify):*

The agency must be licensed as a home and community support service agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

Certificate *(specify):*

Other Standard *(specify):*

The continued family services provider must be an independent foster family verified by the Texas Department of Family and Protective Services and contracted with a direct services agency or verified by a child-placing agency licensed by the Texas Department of Family and Protective Services.

In addition to licensing regulations, the service provider must be age 18 or older.

Can be a family member if not the individual's spouse or the parent of an individual who is a minor child.

Must:
- have current hands-on training certification in cardiopulmonary resuscitation and choking prevention that includes an in-person evaluation by a qualified instructor verifying the service provider’s ability to perform these actions;
- complete an orientation, with the individual present, in the activities necessary to meet the needs and characteristics of the individual they will be providing services to;
- pass criminal history and other applicable registry checks; and,
- maintain a current driver’s license and insurance, if transporting the individual.

The provider must complete training on the following:
- an individual's rights and responsibilities;
- the complaints process;
- mandatory participation requirements;
- review of CLASS rules concerning the Rights and Responsibilities of an Individual; and,
- within 60 days of employment and annually, thereafter, training on how to recognize the signs and symptoms of abuse, neglect, and exploitation, the reporting requirements, and how to report.

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

DADS Regulatory Services licenses home and community support services agencies, and is responsible for ensuring that providers meet licensing requirements. Home and community support services agencies that are not accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. Upon license renewal, DADS Regulatory Services verifies that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission on Accreditation of Healthcare Organizations and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program. If an accredited and deemed home and community support service agency is a licensed and certified home health agency, DADS Regulatory Services coordinates with CMS prior to initiating a complaint investigation.

DADS has an internal policy to coordinate communications and operations between all involved DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Continued Family Services

Provider Category:
Individual

Provider Type:
Support Family Agency

Provider Qualifications

License *(specify):*
Licensed by the Texas Department of Family and Protective Services as a Child Placing Agency in accordance with Title 40 of the Texas Administration Code, Part 19, Chapter 749, Minimum Standards for Child-Placing Agencies, and Chapter 745, Licensing.

Certificate *(specify):*

Other Standard *(specify):*
The continued family services provider must be an independent foster family verified by the Texas Department of Family and Protective Services and contracted with a direct services agency or verified by a child-placing agency licensed by the Texas Department of Family and Protective Services.

In addition to licensing regulations, the service provider must be age 18 or older.

Can be a family member if not the individual's spouse or the parent of an individual who is a minor child.

Must:
- have current hands-on training certification in cardiopulmonary resuscitation and choking prevention that includes an in-person evaluation by a qualified instructor verifying the service provider's ability to perform these actions;
- complete an orientation, with the individual present, in the activities necessary to meet the needs and characteristics of the individual they will be providing services to;
- pass criminal history and other applicable registry checks; and,
- maintain a current driver's license and insurance, if transporting the individual.

Verification of Provider Qualifications

Entity Responsible for Verification:
Texas Department of Family and Protective Services

DADS

Frequency of Verification:
The Department of Family and Protective Services reviews Support Family Agencies in accordance with Title 40 of the Texas Administrative Code, Part 19, Chapter 749, Minimum Standards for Child-Placing Agencies, and Chapter 745, Licensing.

DADS Community Services Contracts conducts biennial contract monitoring reviews of support family agencies providing support family services to CLASS individuals.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Employment Assistance

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Employment assistance means assistance provided to an individual to help the individual locate paid employment in the community. Employment assistance includes:
- identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions;
- locating prospective employers offering employment compatible with an individual's identified preferences, skills, and requirements; and
- contacting a prospective employer on behalf of an individual and negotiating the individual's employment.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Documentation is maintained in the individual's record that the service is not available to the individual under a program funded under section 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.).

This service may not be provided to the individual with the individual present at the same time that respite, residential habilitation, supported employment, or prevocational services is provided.

The service does not include incentive payments, subsidies, or unrelated vocational training expenses such as the following:
(A) Incentive payments made to an employer to encourage hiring the individual;
(B) Payments that are passed through to the individual;
(C) Payments for supervision, training, support, and adaptations typically available to other workers without disabilities filling similar positions in the business; or
(D) Payments used to defray the expenses associated with starting up or operating a business.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer directed services direct service provider
Agency	Direct Services Agency holding CLASS Medicaid provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Employment Assistance

Provider Category:
Individual

Provider Type:
Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The service provider must be at least 18 years of age or older; maintain current driver's license and insurance if transporting individual; and satisfy one of these options:

Option 1:
- have a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and
- six months of paid or unpaid experience providing services to people with disabilities.

Option 2:
- have an associate's degree in rehabilitation, business, marketing, or a related human services field; and
- one year of paid or unpaid experience providing services to people with disabilities.

Option 3:
- have a high school diploma or Certificate of High School Equivalency (GED credentials); and
- two years of paid or unpaid experience providing services to people with disabilities.

Under the consumer directed services option, the provider cannot be the participant's legal guardian or the spouse of the legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:
Individual/employer and financial management services agency

DADS

Frequency of Verification:
Individual/employer and financial management services agency prior to hiring.

DADS Community Services Contracts staff verifies provider qualifications during on-site reviews every three years at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Employment Assistance

Provider Category:
Agency

Provider Type:
Direct Services Agency holding CLASS Medicaid provider agreement
Provider Qualifications

License *(specify):*
The agency must be licensed as a home and community support service agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

Certificate *(specify):*

Other Standard *(specify):*
The service provider must be at least 18 years of age or older; maintain current driver's license and insurance if transporting individual; and satisfy one of these options:

Option 1:
-have a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and
-six months of paid or unpaid experience providing services to people with disabilities.

Option 2:
- have an associate's degree in rehabilitation, business, marketing, or a related human services field; and
- one years of paid or unpaid experience providing services to people with disabilities.

Option 3:
- have a high school diploma or Certificate of High School Equivalency (GED credentials); and
- two years of paid or unpaid experience providing services to people with disabilities.

The provider must complete orientation and training as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 45.

Tasks delegated by a registered nurse must be performed in accordance with state law.

Verification of Provider Qualifications

Entity Responsible for Verification:
DADS
Frequency of Verification:
DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews and is also responsible for ensuring that service providers meet staff qualifications. Each new contract is monitored within the first 12 months of the contract and at least every two years thereafter.

Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

DADS Regulatory Services licenses home and community support services agencies, and is responsible for ensuring that providers meet licensing requirements. Home and community support services agencies that are not accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. Upon license renewal, DADS Regulatory Services verifies that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission on Accreditation of Healthcare Organizations and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed

the state licensing standards. Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program. If an accredited and deemed home and community support service agency is a licensed and certified home health agency, DADS Regulatory Services coordinates with CMS prior to initiating a complaint investigation.

DADS has an internal policy to coordinate communications and operations between all involved DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Minor Home Modifications

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
A minor home modification is a physical adaptation to an individual's residence that is necessary to address the individual's specific needs and that enables the individual to function with greater independence in the individual's residence or to control his or her environment.

Minor home modifications consist of the following categories and include the installation, maintenance, and repair not covered by warranty:
(1) Home Modifications;
(2) Specialized Accessibility/Safety Adaptations/Additions (including repair and maintenance); and
(3) Repair and maintenance of items on the authorized list in the CLASS Provider Manual as allowable by rule.

Except as provided by Title 40 of the Texas Administrative Code, Part 1, Chapter 45, Subchapter F, Division 2, §45.618(c) of this chapter (relating to Repair or Replacement of Minor Home Modification), minor home modifications include the repair and maintenance of a minor home modification purchased through the CLASS Program that is needed after one year has elapsed from the date the minor home modification is complete and that is not covered by a warranty.

Minor home modifications will be limited to those services identified by the service planning team, and approved by staff from DADS on the service plan as necessary to prevent institutionalization. The home modifications listed are essential to provide safe access to and within the home while facilitating self-reliance and independence. Home modifications are cost-effective since greater individual access and greater overall independence allow the individual to perform more activities of daily living with less assistance. This decreases reliance on paid staff.

Home modifications will be provided to meet the needs of the individual, which have been identified and approved in the individual's service plan, as necessary to prevent institutionalization.

Direct services agencies are required to obtain specifications and bids from qualified contractors for modifications that are estimated to cost more than $1000. Direct services agency providers are also required to inspect all completed modifications for workmanship and compliance with the written specifications. All services shall be provided in accordance with applicable state and local building codes.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Only minor home modifications listed in the CLASS Provider Manual are billable through the CLASS waiver.

The maximum lifetime expenditure for this service is $10,000. Once that maximum is reached, $300 per service plan year per individual will be allowed for repair, replacement, or additional modifications.

If an individual has an identified need for minor home modifications that exceed the lifetime maximum benefit, the case manager will work with the direct services agency, the individual, and the individual's legally authorized representative, to identify non-waiver resources to assist the individual to address the identified need.

The individual, legally authorized representative, and the service planning team must agree on the necessity of all minor home modifications. Any modification or combination of modifications costing more than $1000.00 must be agreed upon as necessary by the individual, legally authorized representative, and the service planning team based on prior written evaluations and recommendations by the most qualified licensed professionals who can justify the need and appropriateness of a requested minor home modification as identified in the CLASS Provider Manual. The written evaluation must document the necessity and appropriateness of the minor home modification to meet the specific needs of the individual.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☑ **Legally Responsible Person**

☑ **Relative**

☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Direct services agency holding a CLASS Medicaid provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Minor Home Modifications

Provider Category:

Agency

Provider Type:

Direct services agency holding a CLASS Medicaid provider agreement

Provider Qualifications

License *(specify):*

The agency must be licensed as a home and community support service agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

Certificate *(specify):*

Other Standard *(specify):*

The direct services agency must comply with the requirements for delivery of minor home modifications, which include requirements such as types of allowed modifications, periods for completion, specifications for the modification, inspections of the modification, and follow-up on the completion of the modification.

Qualified contractors provide minor home modifications in accordance with state and local building codes and meet Americans with Disability Act requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews and is also responsible for ensuring that service providers meet staff qualifications. Each new contract is monitored within the first 12 months of the contract and at least every two years thereafter.

Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

DADS Regulatory Services licenses home and community support services agencies, and is responsible for ensuring that providers meet licensing requirements. Home and community support services agencies that are not accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. Upon license renewal, DADS Regulatory Services verifies that an accredited home and

community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission on Accreditation of Healthcare Organizations and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program. If an accredited and deemed home and community support service agency is a licensed and certified home health agency, DADS Regulatory Services coordinates with CMS prior to initiating a complaint investigation.

DADS has an internal policy to coordinate communications and operations between all involved DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Therapies

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Massage Therapy
Massage therapy means the manipulation of soft tissue by hand or through a mechanical or electrical apparatus for the purpose of body massage and includes effleurage (stroking), petrissage (kneading), tapotement (percussion), compression, vibration, friction, nerve strokes, and Swedish gymnastics. The terms "massage," "therapeutic massage," "massage technology," "myotherapy," "body massage," "body rub," or any derivation of those terms are synonyms for "massage therapy."

Recreational Therapy
Recreational therapy means recreational or leisure activities that assist an individual to restore, remediate, or habilitate the individual's level of functioning and independence in life activities, promote health and wellness, and reduce or eliminate the activity limitations caused by an illness or disabling condition.

Music Therapy
Music therapy is the use of musical or rhythmic interventions to restore, maintain, or improve an individual's social or emotional functioning, mental processing, or physical health.

Aquatic Therapy
Aquatic therapy means a service that involves a low-risk exercise method done in water to improve an individual's range of motion, flexibility, muscular strengthening and toning, cardiovascular endurance, fitness, and mobility.

Aquatic therapy will only be considered a specialized therapy if provided by a licensed therapist other than a physical, occupational or speech therapist (such as, a recreational therapist, massage therapist): otherwise it is to be billed under the appropriate therapy service category.

Hippotherapy
Hippotherapy means the provision of therapy that involves an individual interacting with and riding horses. Hippotherapy is designed to improve the balance, coordination, focus, independence, confidence, and motor and social skills of the individual.

The service is delivered by a riding instructor certified by the Professional Association of Therapeutic Horsemanship International in a structured therapeutic riding program administered in cooperation with a licensed physical therapist, occupational therapist, physical therapist assistant, or occupational therapy assistant that has an expertise in hippotherapy.

Therapeutic Horseback Riding
Therapeutic horseback riding means the provision of therapy that involves an individual interacting with and riding on horses. Therapeutic horseback riding is designed to improve the balance, coordination, focus, independence, confidence, and motor and social skills of the individual.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Specialized therapies are provided under this waiver when no other financial resource is available or when other available resources have been used. Funding of copayments for therapeutic services is limited to those therapeutic services available in the CLASS waiver.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Direct services agency holding a CLASS Medicaid provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Therapies

Provider Category:
Agency
Provider Type:
Direct services agency holding a CLASS Medicaid provider agreement
Provider Qualifications
License *(specify):*
Must be licensed as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

Massage Therapy:
Massage Therapist licensed by the Texas State Department of Health Services in accordance with Texas Occupations Code, Chapter 455.

Hippotherapy:
Physical therapist or physical therapist assistant licensed, in accordance with Title 3 of the Texas Occupations Code, Chapter 453, or an occupational therapist or occupational therapy assistant licensed in accordance with Title 3 of the Texas Occupations Code, Subtitle H, Chapter 454, administered in cooperation with a riding instructor certified by the Professional Association of Therapeutic Horsemanship International.

Aquatic Therapy:
Licensed Massage Therapist certified in emergency water safety, water safety instruction, or as a lifeguard by the American Red Cross.
Certificate *(specify):*
Recreational Therapy:
Certified by the National Council of Therapeutic Recreation Certification, or the Consortium for Therapeutic Recreation/Activities Certification, Inc.

Music Therapy:
Registered music therapist certified by the Certification Board for Music Therapy.

Hippotherapy:
Service delivery by a riding instructor certified by the Professional Association of Therapeutic Horsemanship International in a structured therapeutic riding program administered in cooperation with a licensed physical or occupational therapist.

Aquatic Therapy:
Certified by the National Council of Therapeutic Recreation Certification and certified in water safety instruction, or as a lifeguard by the American Red Cross.

Therapeutic Horseback Riding:
Service provider must be a riding instructor who is certified by the Professional Association of Therapeutic Horsemanship International.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews and is also responsible for ensuring that service providers meet staff qualifications. Each new contract is monitored within the first 12 months of the contract and at least every two years thereafter.

Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

DADS Regulatory Services licenses home and community support services agencies, and is responsible for ensuring that providers meet licensing requirements. Home and community support services agencies that are not accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. Upon license renewal, DADS Regulatory Services verifies that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission on Accreditation of Healthcare Organizations and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program. If an accredited and deemed home and community support service agency is a licensed and certified home health agency, DADS Regulatory Services coordinates with CMS prior to initiating a complaint investigation.

DADS has an internal policy to coordinate communications and operations between all involved DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Support Family Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Support family services are services provided to an individual under 18 years of age who resides with a "support family," as described in Title 40 of the Texas Administrative Code, Part 1, Chapter 45, Subchapter E, Division 3, Section 531 (relating to Support Family Requirements), that allow the individual to reside successfully in a community setting by supporting the individual to acquire, maintain, and improve self-help, socialization, and daily living skills or assisting the individual with activities of daily living.

The support family must provide services to the CLASS individual as authorized on the individual service plan and defined in the individual program plan, including:
(1) direct personal assistance activities of daily living (such as grooming, eating, bathing, dressing, and personal hygiene);
(2) assistance with meal planning and preparation;
(3) assistance with housekeeping;
(4) assistance with communication and mobility;
(5) reinforcement of behavioral, educational, and therapeutic activities;
(6) assistance with medications and the performance of tasks delegated by a registered nurse;
(7) supervision for the individual's safety and security;
(8) transportation related to routine family activities;
(9) assistance with participation in community activities; and
(10) habilitation.

The support family must:
(1) allow the individual's family members and friends access to the individual without arbitrary restrictions, unless exceptional conditions are justified by the service planning team, documented in the individual service plan, and approved by DADS;
(2) assist a school-age individual in receiving educational services in a six-hour-per-day program five days a week provided by the local school district;
(3) ensure that no individual receives educational services at a state school/state center educational setting, unless contraindications are documented with justification by the service planning team;
(4) ensure that a preschool-age individual receives an early childhood education with appropriate activities and services, including small group and individual play with peers without disabilities, unless contraindications are documented with justification;
(5) provide individuals with age-appropriate activities that enhance self-esteem and maximize functional level; and
(6) ensure the individual receives medical care prescribed by a physician, including:
(A) doctors' appointments;
(B) medications;
(C) evaluations, therapies, and treatment; and
(D) lab work and other medical tests.

Support family services are available to allow the individual to attend school, or participate in a program leading to a high school diploma or a Certificate of High School Equivalency (GED credentials).

The support family must not provide services to more than three unrelated children at any one time in their home. The support family must ensure that the child participates in age-appropriate community activities and the support family home environment is healthy and safe for the child.

The support family must provide service in a residence that the support family owns or leases. The residence must be a typical residence in the neighborhood and meet the needs of the child and the child's parents or legally authorized representative.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The parents and support family services provider continue to access non-waiver services, to include the independent school district and other community resources for the individual.

Payments for support family services are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for support family services does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision that would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Support Family Agency
Agency	Direct Services Agency holding CLASS Medicaid provider agreement

Service Type: Other Service
Service Name: Support Family Services

Provider Category:
Agency
Provider Type:
Support Family Agency
Provider Qualifications

License *(specify):*
Licensed by the Texas Department of Family and Protective Services as a Child Placing Agency in accordance with Title 40 of the Texas Administration Code, Part 19, Chapter 749, Minimum Standards for Child-Placing Agencies, and Chapter 745, Licensing.

Certificate *(specify):*

Other Standard *(specify):*
The support family service provider must be an independent foster family verified by the Texas Department of Family and Protective Services and contracted with a direct service agency or verified by a child-placing agency licensed by the Texas Department of Family and Protective Services.

In addition to licensing regulations, the service provider must be age 18 or older.

Can be a family member if not the individual's spouse or the parent of an individual who is a minor child.

Must:
- have current hands-on training certification in cardiopulmonary resuscitation and choking prevention that includes an in-person evaluation by a qualified instructor verifying the service provider’s ability to perform these actions;
- complete an orientation, with the individual present, in the activities necessary to meet the needs and characteristics of the individual they will be providing services to;
- pass criminal history and other applicable registry checks; and,
- maintain a current driver’s license and insurance, if transporting the individual.

Verification of Provider Qualifications

Entity Responsible for Verification:
Texas Department of Family and Protective Services

DADS
Frequency of Verification:
The Department of Family and Protective Services reviews Support Family Agencies in accordance with Title 40 of the Texas Administrative Code, Part 19, Chapter 749, Minimum Standards for Child-Placing Agencies, and Chapter 745, Licensing.

DADS Community Services Contracts conducts biennial contract monitoring reviews of support family agencies providing support family services to CLASS individuals.

Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Support Family Services

Provider Category:

Agency

Provider Type:

Direct Services Agency holding CLASS Medicaid provider agreement

Provider Qualifications

License *(specify):*

The agency must be licensed as a home and community support service agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

Certificate *(specify):*

Other Standard *(specify):*

The support family service provider must be an independent foster family verified by the Texas Department of Family and Protective Services and contracted with a direct service agency or verified by a child-placing agency licensed by the Texas Department of Family and Protective Services.

In addition to licensing regulations, the service provider must be age 18 or older.

Can be a family member if not the individual's spouse or the parent of an individual who is a minor child.

Must:
- have current hands-on training certification in cardiopulmonary resuscitation and choking prevention that includes an in-person evaluation by a qualified instructor verifying the service provider's ability to perform these actions;
- complete an orientation, with the individual present, in the activities necessary to meet the needs and characteristics of the individual they will be providing services to;
- pass criminal history and other applicable registry checks; and,
- maintain a current driver's license and insurance, if transporting the individual.

The provider must complete training on the following:
- an individual's rights and responsibilities;
- the complaints process;
- mandatory participation requirements;
- review of CLASS rules concerning the Rights and Responsibilities of an Individual; and,
- within 60 days of employment and annually, thereafter, training on how to recognize the signs and symptoms of abuse, neglect, and exploitation, the reporting requirements, and how to report.

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 12 months of the contract and every two years thereafter.

Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

DADS Regulatory Services licenses home and community support services agencies, and is responsible for ensuring that providers meet licensing requirements. Home and community support services agencies that are not accredited by the Joint Commission on Accreditation of Healthcare

Organizations or the Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. Upon license renewal, DADS Regulatory Services verifies that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission on Accreditation of Healthcare Organizations and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program. If an accredited and deemed home and community support service agency is a licensed and certified home health agency, DADS Regulatory Services coordinates with CMS prior to initiating a complaint investigation.

DADS has an internal policy to coordinate communications and operations between all involved DADS departments when action is taken in regard to licenses. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transition Assistance Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Transition assistance services means services provided to a person who is receiving institutional services and is eligible for and enrolling into the CLASS Program.

Transition assistance services assist an individual in setting up a household in the community before being discharged from an intermediate care facility or a nursing facility and enrolling into the CLASS Program. Allowable expenses are those necessary to enable individuals to establish basic households and include:
- security deposits required to lease a home, including an apartment. or to establish utility services for the home;
-purchase essential furnishings for the home, including table, chairs, window blinds, eating utensils, and food preparation items;
- moving expenses required to move into or occupy the home and
- services necessary to ensure the health and safety of the individual in the home, such as pest eradication, allergen control, or a one-time cleaning before occupancy.

Room and board are not allowable expenses.

Transition assistance services do not include: monthly rental or mortgage expenses; food; regular utility charges; or household appliances or items that are intended for purely entertainment or recreational purposes.

Transition assistance services' funding is authorized for expenses that are reasonable and necessary as determined through the service plan development process; and that are clearly identified in the individual service plan, and for which individuals are unable to pay for or obtain from other sources.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
An individual does not qualify for transition assistance services if the individual's enrollment service plan includes support family services or continued family services.

Transition assistance services are one-time initial expenses for setting up a household that cannot exceed $2,500.

Transition assistance services are not available for individuals transitioning into any provider leased/owned living arrangements.

Expenses are limited to up to 180 consecutive days prior to discharge from the intermediate care facility or nursing facility.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency holding a Transition Assistance Services Medicaid provider agreement with DADS

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transition Assistance Services

Provider Category:

Agency

Provider Type:

Agency holding a Transition Assistance Services Medicaid provider agreement with DADS

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Transition assistance services provider employee must:
1) Be 18 years old;
2) Have a high school diploma or Certificate of High School Equivalency (GED credentials);
3) Not be the individual's spouse, the parent of a minor child, have legal conservatorship of the individual and not live in the individual's household;
4) Be capable of providing the required services.

The transition assistance services provider must comply with the requirements for delivery of transition assistance services, which include requirements such as allowable purchases, costs limits, and time frames for delivery. Transition assistance services providers must demonstrate knowledge of, and history in, successfully serving individuals who require home and community based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows.

DADS Community Services Contracts staff conducts at least biennial monitoring reviews.

Contracts staff may conduct an intermittent review for providers that do not meet an acceptable compliance level during routine reviews. Contracts staff responds to complaints received against a provider for failure to maintain provider qualifications. DADS levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. **Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*

c. **Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

CLASS providers, individuals/employers, and financial management services agencies must comply with the Title 4 of the Texas Health and Safety Code, Chapter 250, including taking the following actions regarding applicants, contractors, and employees:
-Obtain Texas criminal history record information from the Texas Department of Public Safety that relates to an unlicensed applicant, volunteer, contractor, or employee whose duties would or do involve direct contact with an individual; and
-Refrain from employing or contracting with, or immediately discharge, a person who has been convicted of an offense that bars employment under Title 4 of the Texas Health and Safety Code, Chapter 250, Section 250.006, or an offense that the provider or participant employer determines is a contraindication to the person's employment to contract to provide services to the individual.

Individuals choosing to self-direct services must choose a financial management services agency that provides guidance and assistance to the individual with employer-related tasks.

Financial management services agencies and case management agencies must complete a criminal history check before a person can become an employee, volunteer, or a contractor, in compliance with Title 40 of the Texas Administrative Code, Part 1, Chapter 41, and Title 40 of the Texas Administrative Code, Part 1, Chapter 49. Financial management services agencies and individual/employers or their designated representative must comply with rules in Title 40 of the Texas Administrative Code, Part 1, Chapter 41. These rules require a criminal history check before a person can become an employee or a contractor of the individual/employer in compliance with Title 40 of the Texas Administrative Code, Part 1, Chapter 41. When contracting with a service provider, the employer or designated representative must complete an agreement with the entity that certifies that the entity has checked and verified that each person delivering a services to the individual on behalf of the entity has not been convicted of an offense listed in Title 4 of the Texas Health and Safety Code,

Chapter 250, Section 250.006 within the previous five years. The financial management services agency is required to have verification of criminal history checks prior to the individual-employer hiring a contractor or employee.

All CLASS providers, financial management services agencies, and individual/employers are required to maintain documentation of the criminal history checks performed.

Financial management services agencies, case management agencies, and direct services agencies must screen all employees and contractors for exclusion prior to hiring or contracting, and on an ongoing monthly basis, by searching both the State and federal Office of Inspector General lists of excluded individuals and entities. All CLASS providers must develop and implement written policies and procedures that require the provider to review the list of excluded individuals and entities at the Texas HHSC Office of Inspector General website and the federal HHS Office of Inspector General website before hiring or contracting with an person or entity and at least once a month while the provider employs or contracts with the person or entity. If any exclusion is discovered the provider must immediately report the findings to DADS.

Financial management services agencies are required to document and maintain the time and the result of the registry check on the DADS Criminal Conviction History and Registry Checks form which is reviewed by DADS during a monitoring review and may be reviewed during a complaint investigation.

During the biennial contract monitoring reviews, DADS verifies that case management agencies and direct services agencies have conducted screening for exclusion and performed other applicable registry checks. At least every three years, DADS verifies that the financial management services agencies have conducted screening for exclusion and performed other applicable registry checks during the monitoring reviews.

In addition, regulatory boards (e.g., Texas Board of Nursing) conduct criminal background checks on licensed professionals and DADS Regulatory Services ensures during surveys that licenses are appropriate as part of the licensing process.

As part of on-site reviews of providers and financial management services agencies, DADS monitors if criminal history checks are conducted as required.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Providers, individual employers, and financial management services agencies must comply with the Texas Health and Safety Code, Chapters 250 and 253, including taking the following action regarding applicants, contractors, and employees:
-annually search the Nurse Aide Registry maintained by DADS in accordance with Texas Health and Safety Code, Chapter 250, and refrain from employing or contracting with, or immediately discharge, a person who is designated in the registry as having abused, neglected, or mistreated an individual of a facility or has misappropriated an individual's property; and
-annually search the Employee Misconduct Registry maintained by DADS, in accordance with Texas Health and Safety Code, Chapter 253, and refrain from employing or contracting with or immediately discharge, a person whose duties would or do involve direct contact with an individual, and who is designated in the registry as having abused, neglected, or exploited an individual or has misappropriated an individual's property.

Providers, individual/employers, and financial management services agencies are also required to perform Nurse Aide Registry and Employee Misconduct Registry checks on contractors.

DADS Regulatory Services staff that are involved in licensure, survey, and enforcement activities select a sample of individual records for monitoring as part of their reviews of providers, to verify if Nurse Aide Registry and Employee Misconduct Registry checks are being conducted as required.

Providers, financial management services agencies, and individual/employers are required to maintain documentation of the Nurse Aide Registry and Employee Misconduct Registry checks that they performed. Financial management services agencies and individual/employers document results on the Criminal Conviction History and Registry Checks form for all service providers who are not licensed.. The appropriate licensure boards are responsible for monitoring licensed professionals.

Each individual who chooses self-direction must choose a financial management services agency that provides guidance and assistance to the individual with employer-related tasks. The financial management services agency is required to have verification of registry checks prior to hiring on behalf of the individual.

During on-site reviews of providers and financial management services agencies, DADS monitors for completion of required registry checks.

For volunteers, the home and community support services agencies must comply with Title 40 of the Texas Administrative Code, Part 1, Chapter 97, Subchapter C.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Required information is contained in response to C-5.	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Required information is contained in response to C-5.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Required information is contained in response to C-5.

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility

Waiver Service	Provided in Facility
Residential Habilitation	☐
Supported Employment	☐
Support Consultation	☐
Behavioral Support	☐
Physical Therapy	☐
Specialized Therapies	☐
Adaptive Aids	☐
Prescribed Drugs	☐
Dietary	☐
Continued Family Services	☐
Case Management	☐
Employment Assistance	☐
Respite (In-Home and Out-–of-Home)	☑
Auditory Integration Training/Auditory Enhancement Training	☐
Dental Treatment	☐
Cognitive Rehabilitation Therapy	☐
Transition Assistance Services	☐
Support Family Services	☐
Nursing	☐
Minor Home Modifications	☐
Occupational Therapy	☐
Financial Management Services	☐
Prevocational Services	☐
Speech and Language Pathology	☐

Facility Capacity Limit:

Required information is contained in response to C-5.

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☐
Sanitation	☐
Safety	☐
Staff : resident ratios	☐
Staff training and qualifications	☐
Staff supervision	☐

Standard	Topic Addressed
Resident rights	☐
Medication administration	☐
Use of restrictive interventions	☐
Incident reporting	☐
Provision of or arrangement for necessary health services	☐

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Required information is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- ◉ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ○ **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ○ **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ◉ **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Reimbursement for waiver services provided to an individual by an individual's family member or guardian is subject to the following restrictions/conditions:

1. Payment will not be made for waiver services provided to an individual by the spouse of the individual, except for supported employment and employment assistance.
2 Payment will not be made for respite provided to a primary caregiver by a relative or legal guardian who is paid to also provide residential habilitation to the individual unless the service provider of respite does not have the same residence as the individual.
3. Payment for residential habilitation and respite can be made to the parent/legal guardian of an individual who is over the age of 17.
4. Payments will not be made for the routine care and supervision, which would be expected to be provided by a family member.
5. Following are the services which, if not self-directed, may be provided by a legal guardian or family member: residential habilitation, respite, minor home modifications, and nursing.
6. If services are self-directed the legal guardian or the parent of an individual who is under the age of 18 or the court appointed guardian of an adult cannot provide residential habilitation, respite, physical therapy, nursing, occupational therapy, speech and language pathology, and support consultation services.

Documentation requirements are the same for relatives and guardians who are service providers as for all other service providers. Providers must assure completion of required documentation and financial management services agencies require submission of required documentation before paying the provider of services and submitting a billing claim.

During biennial contract monitoring reviews of CLASS providers and reviews of financial management services agencies, conducted at least every three years, DADS determines compliance with policies concerning eligibility of individual providers and completion of required documentation.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The following processes are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in Title 42 of the Code of Federal Regulations, Section 431.51:

In order to obtain a Medicaid provider agreement for the CLASS waiver, a provider applicant must apply for such in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 49 relating to Contracting for Community Care Services. DADS accepts new provider applications on a continuous and ongoing basis. As part of the provider enrollment process, new providers are required to complete pre-application orientation.

Entities interested in becoming financial management services agencies must also participate in training and pass a knowledge test in order to obtain a Medicaid provider agreement.

Qualified CLASS direct services agencies agree to provide all CLASS waiver services except transition assistance services, support family services, continued family services, financial management services, case management, and support consultation. This model of service delivery accomplishes the following for CLASS individuals:
(1) ensures the availability of each service across the state, even in rural areas where, without the use of our current definition of qualified provider, not all services of the waiver would be readily accessible;
(2) recognizes that a vast majority of individuals are not single service users, but require supports across service disciplines that must be closely integrated and coordinated to achieve beneficial outcomes;

(3) promotes effective response to temporary or permanent changes in individuals' service needs as direct services agencies are required to make all services available when and as they are needed by individuals;
(4) establishes a single point of accountability for provision of needed services; and
(5) decreases administrative costs.

The CLASS waiver service delivery model promotes efficient service delivery, while providing the individual a choice of qualified CLASS agency providers or waiver service providers. In all 254 counties, no matter how sparsely populated, DADS endeavors to enroll a sufficient number of direct services agencies to ensure that individuals have a choice between at least two CLASS direct services agencies. In most cases, individuals have a choice among numerous CLASS direct services agencies. CLASS case managers are employees of independently contracted private agencies whose primary function is to monitor the individual's satisfaction with services provided by the direct services agency. The case manager also functions as an advocate for the individual, when requested, and has the responsibility to provide individuals with the most current list of direct services agencies, case management agencies, and financial management service agencies, in the event that an individual desires to receive services through the consumer directed services option. The CLASS website contains lists of all qualified direct services agencies, case management agencies, and financial management service agencies.

Information for obtaining a CLASS Medicaid provider agreement is provided by contacting the DADS Community Services Contracts unit. This information is also on the DADS website.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C.a.1 # and % of newly enrolled contracted licensed providers that initially met required contract and program standards and adhered to other standards prior to furnishing waiver services N: Number of newly enrolled licensed providers that met required contract and program standards and adhered to other standards prior to furnishing waiver services D: Number of newly enrolled licensed providers.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Health and Human Services Contract Administration and Tracking System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
C.a.2 Number and percent of monitored contracted licensed providers that met required contract and program standards. N: Number of monitored contracted licensed providers that met required contract and program standards. D: Number of monitored contracted licensed providers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Health and Human Services Contract Administration and Tracking System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Biennially	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C.b.1 Number and percent of all new non-licensed/non-certified providers that met initial qualifications. N: Number of all new non-licensed/non-certified providers who met initial qualifications. D: Number of all new non-licensed/non-certified providers.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Health and Human Services Contract Administration and Tracking System

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
C.b.2 Number and percent of contracted financial management services agencies who continue to meet contract requirements. N: Number of financial management services agencies who continue to meet contract requirements. D: Number of financial management services agencies monitored.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Health and Human Services Contract Administration and Tracking System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Every three years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
C.b.3 Number and percent of case management agencies and transition assistance service providers that continue to meet contract requirements. N: Number of case management agencies and transition assistance service providers that continue to meet contract requirements. D: Number of case management agencies and transition assistance service providers monitored.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Health and Human Services Contract Administration and Tracking System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Biennially	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C.c.1 Number and percent of direct service agencies and case management agencies that attended all required training in accordance with the approved waiver. N: Number of direct service agencies and case management agencies that attended all required training in accordance with the approved waiver. D: Number of direct service agencies and case management agencies monitored.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
DADS Contracts Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Biennially	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
C.c.2 Number and percent of financial management services agencies that attended all required training in accordance with the approved waiver. N: Number of monitored financial management services agencies that attended all required training in accordance with the approved waiver. D: Number of financial management services agencies monitored.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
QAI Data Mart; Health and Human Services Contract Administration and Tracking System

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☑ **Other** Specify: Every three years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
DADS Community Services Contracts Contract Enrollment and Administration staff verifies that all potential providers meet the application requirements specified in the waiver prior to DADS awarding a Medicaid provider agreement/contract.

DADS Regulatory Services surveyors monitor the performance of licensed home and community support services agencies through surveys and inspections. Surveyors conduct follow-up surveys and inspections to ensure the provider has effectively implemented any corrective action plans required due to cited state violations. Home and community support services agencies that are not accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey, and at least every 36 months thereafter. DADS Regulatory Services verifies upon license renewal that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission on Accreditation of Healthcare Organizations and the Community Health Accreditation Program, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Home and community support services agencies licenses are valid for two years. The Regulatory Services survey includes observation of the care of individuals.

Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by DADS Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by DADS Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program. If an accredited and deemed home and

community support service agency is a licensed and certified home health agency, DADS Regulatory Services coordinates with CMS prior to initiating a complaint investigation.

DADS Community Services Contracts staff is responsible for conducting monitoring reviews of all CLASS direct services agencies and case management agencies. Monitoring reviews are conducted at least biennially. DADS Community Services Contracts staff completes a readiness review, if there are individuals enrolled or pending to be enrolled, six months after the provider agreement has been awarded. Contract monitoring reviews are conducted at least every two years after the Medicaid provider agreement/contract has been awarded. DADS Community Services Contracts staff also responds to complaints received against a contractor for failure to maintain provider qualifications.

In preparation for on-site provider reviews, DADS Community Services Contracts staff:
Selects a valid random sample of individuals receiving services;
Retrieves information pertinent to the provider's operation from a database of complaints reported to DADS Community Services Contracts staff; and
Reviews results of the provider's past performance during on-site reviews.

While on-site, DADS Community Services Contracts staff gathers evidence of a provider's compliance with the waiver requirements as prescribed in program rules and with Medicaid provider agreement/contract requirements through:
- Interviews with providers; and
- Reviews of individual and provider records.

A representative sample of service provider records are reviewed to ensure criminal background checks are performed as required. This data is reported for the quarter in which the provider is monitored resulting in no overlaps in reporting/monitoring.

DADS Community Services Contracts staff monitors 100 percent of financial management services agencies every three years. DADS Community Services Contracts monitors each financial management services agency one year after the date the agency's Medicaid provider agreement is effective, and at least every three years thereafter. This data is reported for the year in which the provider is monitored, resulting in no overlaps in reporting/monitoring. The reviews are conducted via desk review or at the location where the financial management services agency is providing financial management services. DADS Community Services Contracts monitors financial management service agencies to determine compliance with the Medicaid provider agreement and with program rules and requirements. DADS Community Services Contracts staff also responds to complaints received against a financial management services agency.

DADS Contract Oversight and Support administers the Health and Human Services Contract Administration and Tracking System. The Health and Human Services Contract Administration and Tracking System is a custom-developed Health and Human Service Enterprise application with a consolidated database for contract information and reporting. On a monthly basis, DADS Community Services Contracts staff reports the complaint intake, complaint investigation findings, and contract and fiscal compliance monitoring results to DADS Contract Oversight and Support for entry into the Health and Human Services Contract Administration and Tracking System. DADS Contract Oversight and Support also enters information pertaining to contract actions and sanctions imposed against a contract. Through the Health and Human Services Contract Administration and Tracking System reporting features, information pertaining to contract expenditures, compliance, and overall history is available for analysis, trending and reporting by DADS Contract Oversight and Support.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DADS Regulatory Services requires a corrective action plan from home and community support services agencies for violations and deficiencies cited during a survey or investigation. In addition, staff may also impose enforcement actions for violations, including administrative penalties, denying approval for an initial license, suspending an existing license on an emergency basis and revoking a license. The severity of an administrative penalty is based on the severity of the violation, the history of previous violations, and the hazard of the violation to the health or welfare of individuals. Surveyors conduct follow-up surveys and

investigations to ensure the agency has effectively implemented any corrective action plan required due to cited state violations and federal deficiencies.

Technical assistance is shared with providers throughout the DADS Community Services Contracts review. If, during a contract monitoring review, a provider is discovered to be out of substantial compliance with contractual or programmatic requirements, the provider is required to submit a corrective action plan to DADS. The corrective action plan must contain the following elements:
- The title of the person responsible for the action;
- A description of the action to be accomplished;
- The date the action will be implemented; and
- The action to ensure compliance.

If a corrective action plan is requested from the provider, the provider is informed that they may contact DADS staff with any questions or requests for clarification of what constitutes an acceptable corrective action plan. Upon submittal, DADS reviews the corrective action plan and either approves or, if the submitted plan does not include all of the required elements, requests revisions and resubmission of the plan. Providers are informed that their failure to ensure DADS receives an acceptable corrective action plan by the date specified by DADS may result in DADS taking adverse action against the provider, up to and including termination of the Medicaid provider agreement/contract. DADS monitors the corrective action plan until the provider is in compliance.

HHSC conducts quarterly and annual monitoring, which includes reviewing comprehensive quarterly data reports from the quarterly quality measures and annual CMS-372 reports to determine compliance with delegated functions. These reports include data on all of the waiver's quality improvement strategy performance measures. These reports also include remediation activities and outcomes. The Quality Review Team process is the key formal mechanism for monitoring DADS' performance of delegated functions. The Quality Review Team meets quarterly and reviews the comprehensive quality reports from each waiver at least annually. Improvement plans are developed as issues are identified, and the Quality Review Team reviews, modifying if needed, and approves all improvement plans. All active improvement plans for all waivers are monitored at each quality review team meeting.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ○ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ◉ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- ☑ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
  Furnish the information specified above.

  The following set of services are limited to a maximum of $10,000 per service plan year: Dental Services and Adaptive Aids. The individual or legally authorized representative can choose those services that will most support the individual's needs for that plan year. This limit is based on the adaptive aids and dental cap of $10,000 specified in the prior renewal application. Since the current cost limit has not been fully utilized by most individuals as demonstrated by the most recent 372 cost report, the state continued the current $10,000 cap for dental services and adaptive aids. The individual can prioritize their adaptive aid and dental needs for each plan year. The state will annually review the cost limit to determine if individual needs or funding resources allow for an increase to the cost limit. The service planning team will inform waiver participants and legally authorized representatives of the limit and will refer participants to other community and state resources as needed.
- ☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
  Furnish the information specified above.
- ☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
  Furnish the information specified above.
- ☐ **Other Type of Limit.** The State employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

DADS is still assessing settings compliance in accordance with the transition plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Individual Plan of Care

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

  Specify qualifications:

- ☐ **Social Worker**

  Specify qualifications:

- ☐ **Other**

  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. **Service Plan Development Safeguards.** *Select one:*

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

The service planning team which includes the individual and legally authorized representative, case manager, the direct services agency, and other persons as chosen by the individual meet at least annually to review the individualÃ¢Â€Â™s goals, review non-waiver and waiver service needs, and develop the service plan to determine the services and providers to best meet the individualÃ¢Â€Â™s needs and preferences. The direct services agency chosen by the individual provides all direct services, except support family services, continued family services, and transition assistance services to the individual.

Annually, and on the individual's request, each individual chooses a case management agency to provide case management services. The case manager assists an individual in the following:
(A) assessing the individual's needs;
(B) enrolling the individual into the CLASS Program;
(C) developing the individual's service plan;
(D) coordinating the provision of CLASS Program services;
(E) monitoring the effectiveness of the CLASS Program services and the individual's progress toward achieving the outcomes identified for the individual in the service plan;
(F) revising the individual's service plan, as appropriate;
(G) accessing non-CLASS Program services and supports;
(H) resolving crisis situations in the individual's life; and
(I) advocating for the individual's needs.

Safeguards are built into the role of the case manager and the additional oversight provided by the DADS as the operating agency. The case manager may not provide direct waiver services to the individual and, therefore, may not be employed by or contract with a direct services agency to provide a direct service to an individual served by the case management agency employing the case manager.

The case manager is responsible for reviewing the service plan to ensure that it is reflective of the individualÃ¢Â€Â™s needs and preferences as identified in the service planning process which was developed with input from the individual and legally authorized representative. The case manager must ensure that each CLASS waiver service in the proposed service plan
- is necessary to protect the individual's health and welfare in the community;
- addresses the individual's related condition;
- is not available to the individual through any other source including the Medicaid State Plan, other governmental programs, private insurance, or the individual's natural supports;
- is the most appropriate type and amount of CLASS waiver service to meet the individual's needs; and
- is cost effective.

If the case manager determines the service plan does not meet the above criteria, the case manager sends written denial of a service to the individual and legally authorized representative and the direct services agency. The denial of a service by a case manager is not effective until it is reviewed and authorized by DADS. The case manager must submit the proposed service plan including the type and amount of waiver services in dispute and not in dispute to DADS for its review. Additionally, the case manager must submit to DADS the habilitation plan and the individual program plan describing the goals and objectives of all services. DADS reviews the documents and may request, additional documentation supporting the proposed service plan. DADS makes the final determination to approve or deny the proposed service plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The service planning team consists of the individual, legally authorized representative, case manager, direct services agency representative, and staff providing direct services. The individual, legally authorized representative or both may designate direct service staff to be involved in the service planning as well as invite other persons such as family members, friends, or advocates.

The case manager, who is selected by the individual or legally authorized representative, makes sure that the individual and legally authorized representative participate in developing a personalized service plan that meets the individual's identified needs, preferences, and service outcomes. The case manager supports the individual and legally authorized representative in setting goals that address the needs identified during assessment. The case manager also educates the individual, legally authorized representative, or both about service delivery options and services available through the CLASS waiver that will contribute to goal achievement. The case manager verifies and informs the individual and legally authorized representative of the following orally and in writing:
- eligibility criteria for participation in the CLASS waiver;
- the application and enrollment process;
- the individual'™s rights and responsibilities;
- the mandatory participation requirements;
- the right to request a fair hearing;
- the process by which the individual and legally authorized representative or person actively involved with the individual may file a complaint regarding case management;
- that the individual and legally authorized representative or person actively involved with the individual may report an allegation of abuse, neglect, or exploitation or make a complaint by calling DADS toll-free telephone number;
- the services and supports provided by the CLASS waiver and the limits on those services and supports; and
- the reasons an individual's CLASS services may be terminated.

The case manager assures that the individual and family or legally authorized representative, as appropriate, can contact the case manager to secure information regarding services, supports, and service delivery options; and can request to change the service plan due to changes in needs, goals, or preferences. At least quarterly, the case manager meets with the individual, legally authorized representative, or both and reviews the service plan and progress towards goals and service needs, including any changes which may have occurred since the last review. At least annually, the case manager presents information to the individual, legally authorized representative, or both about available waiver services and supports, the available service delivery options, which includes the consumer directed services option, and the available direct services agencies and case management agencies that serve the catchment area where the individual resides.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The case manager initiates, coordinates, and facilitates the service planning process to assure that an individual's service plan addresses the individual's needs, goals, and preferences as identified by the members of the service planning team, including the individual and legally authorized representative. The service planning team consists of the individual, legally authorized representative, case manager, direct services agency representative, and staff providing direct services. In addition, the individual, legally authorized representative, or both may designate direct service staff to be involved in the service planning and invite other persons such as family members, friends, or advocates.

When DADS releases an applicant from the interest list, DADS sends the applicant a list of case management agencies and direct services agencies serving their catchment area. The applicant chooses a case management

agency and direct services agency. DADS notifies the case management agency and direct services agency selected by the applicant. Within 14 calendar days of the date the case management agency is notified by DADS that it has been selected by the applicant as the case management agency, the case manager must meet with the individual face-to-face, unless there is documentation of a reason for a delay that is outside the case management agency's control. During this face-to-face visit with the individual and legally authorized representative or person actively involved with the individual, the case manager must verify that the individual resides in the catchment area for which the individualÃ¢Â€Â™s selected case management agency and direct services agency have a CLASS Medicaid provider agreement and provide an oral and written explanation of:
(A) CLASS waiver program services;
(B) the mandatory participation requirements of an individual;
(C) the consumer directed services option for managing services;
(D) the right to request a fair hearing;
(E) that the individual and legally authorized representative or person actively involved with the individual may report an allegation of abuse, neglect, or exploitation or make a complaint by calling DADS toll-free telephone number;
(F) the process by which the individual and legally authorized representative or person actively involved with the individual may file a complaint regarding the case management agency;
(G) voter registration, if the individual is 18 years of age or older; and
(H) transition assistance services, if the individual is receiving institutional services.

The case manager must also obtain the signature of the individual or legally authorized representative on a form designating the individual's choice of CLASS waiver services over services in an institution.

The case management agency must, within two business days of the case managerÃ¢Â€Â™s face-to-face visit, collect, and maintain a pre-enrollment assessment and provide the individualÃ¢Â€Â™s direct services agency with the assessment.

Within 14 days after receiving the pre-enrollment assessment from the applicantÃ¢Â€Â™s case manager, the direct services agency completes the initial face-to-face visit with the individual. As part of the initial face-to-face visit by the direct services agency, formal assessments regarding health, level of functioning, level of care evaluation, and therapeutic interventions are completed. Level of functioning is determined using the Related Conditions Eligibility Screening Instrument and the adaptive behavior level is determined by administering one of the following assessment tools:
- Inventory for Client and Agency Planning (ICAP);
- Scales of Independent Behavior (SIB-R);
- Vineland Adaptive Behavior Scales (VABS); or
- the American Association on Mental Deficiencies Adaptive Behavior Scales (AAMD).

Within 30 calendar days of notification by the direct services agency of DADS approval of diagnostic/functional eligibility for an individual, the service planning team convenes to develop the initial service plan. The case manager facilitates service planning team meetings that occur at a time and place that meets the needs of the individual and legally authorized representative. At least annually, the service planning team must review the service plan and initiate changes to the service plan based on the changes in the individual's needs, identified outcomes, and preferences that have been documented in the service plan. As applicable, the service planning team also reviews the nursing, dental, and other medical assessments; therapy evaluations; and social, psychological, and behavioral assessments. The individual, legally authorized representative or both must sign the service plan to indicate understanding of, and agreement with, the service plan. Thereafter, when a need is identified, the service planning team meets to amend the service plan.

At enrollment, and at least annually, the case manager must present to the individual, legally authorized representative, or both information regarding available services and supports and the available service delivery options. The case manager must also inform the individual, legally authorized representative, or both that the case manager will assist in transferring the individual's CLASS services from one direct services agency to another direct services agency or from one case management agency to another case management agency upon request from the individual. The case manager must assure that the individual, the legally authorized representative, or both are instructed about how to contact the case manager.

The individual, legally authorized representative, or both identify the desired outcomes and needs of the individual, and the case manager assures that the service planning process focuses on the identified desired outcomes and

needs. The case manager supports the individual and legally authorized representativeÃ¢Â€Â™s participation in the process by encouraging the expression of preferences, goals, and ambitions, and providing education about the services available through the waiver, as well as through other non-waiver resources for which the individual may be qualified. In addition, formal assessments regarding health, level of functioning, and therapeutic interventions are completed as the need is identified by the service planning team.

As part of the service planning process, the service planning team develops an individual program plan for each waiver service listed on the proposed service plan. The individual program plan describes the following:
- waiver services to be provided;
- frequency of service provisions;
- observable and measurable goals and objectives;
- title of person responsible for providing each service;
- justification for waiver services based on needs identified by the service planning team;
- duration of services; and
- support services provided through non-waiver resources.

The individual and legally authorized representative, case manager, and other service planning team members work together to develop a service plan that integrates waiver services and supports and non-waiver services, such that the individualÃ¢Â€Â™s goals may be achieved and services are complementary without being duplicative.

The service plan must include a description of actions and methods to be used to reach identified service outcomes, projected completion dates, and entity or person(s) responsible for implementing the methodology. The service plan must specify the type and amount of each service to be provided to the individual, as well as services and supports to be provided by non-waiver resources during the service plan year. The service planning team must document that the waiver services in the individualÃ¢Â€Â™s service plan: are necessary for the individual to live in the community; are the most appropriate type and amount of services to meet the individual's needs; prevent admission to an institution; and are sufficient when combined with non-waiver resources to assure the individual's health and welfare in the community.

At a minimum, the service planning process and resulting plan must address the following:
- the type of waiver services to be provided to the individual;
- the number of units of each waiver service;
- the estimated annual cost of all waiver services; and
- other services or supports to be provided to the individual through non-waiver sources, including Medicaid State Plan services, which must be accessed prior to waiver services.

At least quarterly, and more often if the individualÃ¢Â€Â™s needs change, the case manager must review the individualÃ¢Â€Â™s service plan, progress toward goals, and any changes in needs that require changes to the service plan.

The individual's case manager is responsible for monitoring the implementation of the plan. The direct services agency is responsible for ensuring implementation of the CLASS services listed in the service plan. The individual or legally authorized representative electing to utilize the consumer directed services option is responsible for ensuring implementation of self-directed services. Oversight of case management is performed by DADS.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

During the service planning process, the case manager ensures that information from the individual, legally authorized representative or both, other service planning team members, and from assessments is considered in determining any risks that might exist to health and welfare of the individual as a result of living in the community. The service planning team identifies risk factors for an individual by discussing relevant areas of an individualÃ¢Â€Â™s life with the individual and legally authorized representative and others who provide supports

to the individual and have been invited to participate in the service planning process.

Strategies to mitigate risks are incorporated into the plan, including waiver services and supports and non-waiver services and supports, formal and informal. When an individual requests a transfer to another case management agency, direct services agency, or service delivery option, the case manager assists the individual to transfer from one agency or service delivery option to another. All CLASS direct services agencies are required to have service backup plans for services that the service planning team determines are essential services. The use of a back-up plan is the primary means employed by the service planning team to mitigate risks to the individual. The use of informal supports and other resources is identified as a part of the back-up plan.

In the consumer directed services option, the service planning team identifies services critical to the health and welfare of the individual and for which a backup plan must be developed, documented in the service plan, and approved by the service planning team. Backup plans may include paid or unpaid service providers, third party resources, and other community resources.

The direct services agency has a responsibility under its licensure rules to ensure effective coordination of care with all service providers involved in the care of the individual. It is the direct services agency's responsibility to assess the status of an individual.

If a service has been identified as needed to ensure health and safety of the individual but the individual or their legally authorized representative refuses the offered service, the case manager will monitor the individualÃ¢Â€Â™s health and safety through the case management function. Linkage to non-waiver services and supports maybe provided to the individual and legally authorized representative. The Department of Family and Protective services may be contacted if the individual's health and safety is jeopardized.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

When DADS notifies an individual or legally authorized representative that individual is released from the interest list, and can begin the process of eligibility determination in order to enroll in CLASS services, the individual or legally authorized representative is sent a complete list of CLASS case management agencies and direct services agencies with Medicaid provider agreements that serve the catchment area in which the individual resides. Individuals are encouraged to contact case management agencies and direct services agencies to determine which case management agency and direct services agency best meet the individual's needs. The individual or legally authorized representative is also provided with a list of qualified case management agencies and direct services agencies annually and upon request.

An individual enrolled in CLASS or the legally authorized representative has the option of choosing from the available qualified providers employed by the direct services agency, or having a qualified direct service provider of his or her choice become employed by the chosen direct services agency, either directly or by contract, if the direct service provider meets the service provider criteria and agrees to the rate of compensation available through the waiver as payment in full.

During the initial contact with the individual prior to enrollment, the case management agency provides a description of the option to self-direct specific services by the individual, called the consumer directed services option. Each individual or legally authorized representative electing the consumer directed services option must receive support from a financial management services provider, referred to as a financial management services agency, chosen by the individual or legally authorized representative. If the individual requests the consumer directed services option the case manager provides a list of all financial services management services agencies.

DADS monitors case management agencies biennially and monitors whether the individuals within the sample were offered choice among providers upon initial enrollment and annually thereafter.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

HHSC, the single State Medicaid Agency, delineates through an executive directive the roles and responsibilities of DADS, the operating agency, and HHSC. The executive directive outlines HHSC monitoring and oversight functions. HHSC has delegated the day-to-day approval of service plans to DADS. DADS approves all service plans. DADS also performs at least biennial reviews of each CLASS direct services agency and case management agency which includes reviews of a provider's compliance with the approved service planning requirements. DADS quarterly and annually aggregates data and reports to HHSC. HHSC discusses with DADS any significant findings and if necessary develops a corrective action plan that DADS implements with HHSC oversight.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☑ **Case manager**
- ☑ **Other**

Specify:

CLASS direct services agency holding Medicaid provider agreement and, if appropriate, the financial management services agency.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

When DADS sends notification to an individual that the individual is released from the interest list and can begin the process of eligibility determination in order to enroll in CLASS services, the individual or legally authorized representative is sent a complete list of CLASS case management agencies and direct services agencies with a Medicaid provider agreement that serve the catchment area in which the individual resides and is asked to choose a case management agency and direct services agency serving their catchment area and return their choice sheet to DADS. DADS notifies the chosen case management agency and direct services agency and each agency then

contacts the individual to begin the enrollment process.

The direct services agency is responsible for implementing the service plan and backup plans to protect the individual's health and welfare. The direct services agency provides agency specific emergency contact numbers to the individual and legally authorized representative. The direct services agency is responsible for ensuring necessary services are available to protect the health and welfare of the individual. The direct services agency is required to adopt and enforce a written policy to ensure that backup services are available when an agency employee or contractor is not available to deliver the services.

The case manager is responsible for monitoring the implementation of the service plan and the individual's health and welfare. If the case management agency or direct services agency observes a change in the individual's needs, health, or welfare at any time during the service plan year, the agency is responsible for contacting the case manager who then convenes a service planning team meeting to determine how to address the needs through both CLASS waiver program services and non-waiver resources. At a minimum, the case manager meets face-to-face with the individual on a quarterly basis to review the service plan, the individual's progress towards goals, and any changes in the individual's service needs. If there is an indication of a change in needs, a revision to the service plan is made with the assistance of the individual, legally authorized representative, or both and the service planning team. At least annually, the case manager convenes the service planning team to plan waiver and non-waiver services for the upcoming year.

Case managers are required to monitor an individual's outcomes identified in the service plan at least every quarter or more frequently as necessary. Case managers are required to have face-to-face contact with individuals on a quarterly basis or more frequently as necessary. DADS verifies during contract monitoring reviews that an individual or legally authorized representative is provided with name and contact information for the assigned case manager to include information for an alternate contact in case of absence of the case manager.

The case manager is responsible for asking the individual or legally authorized representative if the backup plan, developed by the consumer directed services employer or direct services agency, is effective. If the plan is not working, the case manager notifies the direct services agency or if under the consumer directed services option, assists the individual with revising the plan as necessary to ensure the individual's health and safety. If the service planning process reveals that an individual has a need for health services, the case manager is responsible for ensuring appropriate waiver and non-waiver services are included in the service plan to address the need, and that the individual's health needs are being addressed by the direct services agency.

At least biennially, during monitoring reviews, DADS confirms that the service plan developed and approved by the service planning team was completed according to instructions, signed by the service planning team, approved by DADS; and, that services are being implemented according to the service plan. DADS confirms the case manager is monitoring service provision in accordance with program rules. DADS also confirms that quarterly reviews are documented by the case management agencies and direct services agencies, indicating that the services meet the individual's needs.

Additionally, DADS monitors case management agencies and direct services agencies to ensure compliance with requirements that the provider must safeguard the rights of the individual and legally authorized representative to exercise free choice of providers and to transfer to a new case management agency or direct services agency at any time. If DADS contract monitoring staff determines that an individual requested to transfer to another provider, DADS determines if the transfer occurred, and if it did not, why it did not occur.

The case management agency and direct services agency are responsible for ensuring that the individual's rights are protected, service plan monitoring occurs as stated in the individual's service plan, required documentation is completed, and follow-up action on contract monitoring findings is taken. As required, case management agencies and direct services agencies are responsible for submitting corrective action plans based on any problems identified during monitoring reviews. DADS reviews the submitted corrective action plans to determine if the plans are sufficient.

Quarterly and annually, DADS aggregates contract monitoring data and reports it to HHSC. HHSC discusses with DADS any significant findings and, if necessary, DADS develops a corrective action plan that DADS implements with HHSC oversight.

b. Monitoring Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.a.1 Number and percent of individuals with service plans that address individuals' assessed needs and personal goals, either by the provision of waiver services or through other means. N: Number of individuals with service plans that address individuals' assessed needs and personal goals. D: Total number of enrolled individuals.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
CLASS Database; DADS Quality Assurance and Improvement Data Mart

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.a.2 Number and percent of individuals' services plans that reflect the service plan addressed health and safety risk factors. N: Number of individuals who have service plans that address health and safety risk factors. D: Total number of enrolled individuals.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
CLASS Database; DADS Quality Assurance and Improvement Data Mart

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Biennially	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.b.1 Number and percent of service plans developed in accordance with policies and procedures. N: Number of individuals with service plans developed in accordance with policies and procedures. D: Total number of enrolled individuals.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
CLASS Database; DADS Quality Assurance and Improvement Data Mart

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.c.1 Number and percent of individuals' service plans that are reassessed and renewed annually prior to service plan expiration date. N: Number of individuals' service plans that were reassessed and renewed prior to service plan expiration date. D: Number of individual service plans requiring annual reassessment and renewal.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CLASS Database; DADS Quality Assurance and Improvement Data Mart

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	

		☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.c.2 Number and percent of service plans that are revised when warranted by reported changes in individual's needs. N: Number of service plans that were revised when warranted by reported changes in individual's needs D: Number of service plans reviewed indicating a change in the individual's needs.

Data Source (Select one):
Record reviews, off-site

If 'Other' is selected, specify:
CLASS Contracts Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Biennially	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.d.1 Number and percent of individual case records reflecting that relevant services were delivered in accordance with the individual's service plan (including type, scope, amount, duration, and frequency). N: Number of individual case records reflecting that relevant services were delivered in accordance with the individual's service plan. D: Number of individual case records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
CLASS Contracts Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Biennially	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.e.1 Number and percent of individuals who are afforded choice at enrollment between waiver services and institutional care. N: Number of individuals who are afforded choice at enrollment between waiver services and institutional care. D: Total number of newly enrolled individuals.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
CLASS Database; DADS Quality Assurance and Improvement Data Mart

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.e.2 Number and percent of individuals who are afforded choice between waiver providers. N: Number of individuals who are afforded choice between waiver providers. D: Total number of enrolled individuals.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
CLASS Database; DADS Quality Assurance and Improvement Data Mart

Responsible Party for data	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*		
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

D.e.3 Number and percent of individuals who are afforded choice between and among waiver services. N: Number of individuals who are given a choice between and among waiver services. D: Total number of enrolled individuals.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
CLASS Database; DADS Quality Assurance and Improvement Data Mart

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.e.4 Number and percent of individuals' case records that reflect individuals are afforded choice between service delivery methods. N: Number of individuals' case records that reflect individuals are afforded choice between service delivery methods. D: Number of individuals' case records reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
CLASS Contracts Database

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Biennially	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
At the time of enrollment, the individual or legally authorized representative chooses a CLASS case management agency and direct services agency from all providers serving their catchment area. The initial service plan is developed using a person-centered planning process. The case manager convenes a service planning team that must include the individual and the individualÃ¢Â€Â™s legally authorized representative, the case manager, and a representative of the direct services agency and, at the invitation of the individual or legally authorized representative, other individuals important in developing the service plan. The case manager is responsible for convening the individualÃ¢Â€Â™s service planning team and assuring the plan, is reviewed and revised at least annually and whenever indicated by changes in the individualÃ¢Â€Â™s service needs.

One hundred percent of authorized service plans are reviewed by DADS. If an incomplete or incorrectly completed service plan is submitted to DADS, the plan is returned to the provider for correction. When these plans are returned to the case management agency, a description of the error and required correction is included. The case manager must then resubmit the corrected plan, which is reviewed again by DADS staff. The feedback sent to the case manager with the remanded service plan is captured in the CLASS database.

DADS staff use the Service Authorization System to authorize waiver services and to collect, process, and report individual service authorization data. The Service Authorization System maintains the following information:
- Participant Information about individuals who are enrolled and their service authorizations. The system records contain information such as contact information, enrollment data, authorized service period, allotted amounts of each service, and service plan changes and reassessments.
- Provider Information about service providers. The system records contain information such as types of services and number of units each provider is authorized to deliver for each participant.
- Billing and Payment Information related to specific rate information for each type of service. Service Authorization System shows service amounts currently authorized and service amounts previously approved by DADS. The provider may bill for services only after DADS has authorized those services in the system.
- Medicaid Eligibility Service Authorization Verification reports that providers can access information about individuals for whom they are authorized to deliver services. This information includes Medicaid eligibility level of service, and service authorization.

One hundred percent of CLASS providers are reviewed by DADS Community Services Contracts staff at

least every two years. This monitoring includes a review of the service plans for individuals in the sample.

Based upon a directive issued by the HHSC Executive Commissioner, the State has a process that requires quarterly and annual reports from DADS to HHSC. The reports include data relating to all performance measures in the waiver that include service plan development and monitoring. All quarterly and annual reports are reviewed by HHSC. Quarterly and annual reporting allows the State to identify additional areas of remediation that require training or technical assistance based on performance measure reports that are representative of the waiver population. If HHSC identifies issues, HHSC employs a variety of mechanisms to resolve issues including informal conversations, elevated conversations, issuing an action memo, or issuing a corrective action plan.

HHSC and DADS have a process in place for the review and approval of any policy changes concerning the waivers. All policy changes, including any changes to the service planning process and provider agency monitoring, must be reviewed by HHSC prior to implementation.

HHSC and DADS meet regularly to discuss the CLASS waiver. These meetings provide opportunities for DADS to report to HHSC on their performance and for HHSC to provide feedback and guidance related to DADSÃ¢Â€Â™ performance, including service planning.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Technical assistance is shared with case management agencies and direct services agencies throughout the DADS Community Services Contracts review. If, during a contract monitoring review, a case management agency is discovered to have not submitted a service plan within the required timeframe or if a service plan is missing signatures, the case management agency is required to submit a corrective action plan to DADS. The corrective action plan must contain the following elements:

- a description of the non-compliance that DADS identified from the monitoring or investigation resulting in the corrective action plan;
- a description of the activities the contractor will perform to correct or prevent the non-compliance from reoccurring;
- the title of the person responsible for completion of the activities; and
- a schedule for accomplishing the activities.

If a corrective action plan is requested from the provider, the provider is informed that they may contact DADS staff with any questions or requests for clarification of what constitutes an acceptable corrective action plan. Upon submittal, DADS reviews the corrective action plan and either approves or, if the submitted plan does not include all of the required elements, requests revisions and resubmission. Providers are informed that their failure to ensure DADS receives an acceptable corrective action plan by the date specified by DADS may result in DADS taking adverse action against the provider, including termination of the Medicaid provider agreement. DADS monitors the corrective action plan until the provider is in compliance. If the provider does not comply within the time allotted, DADS may submit a Medicaid provider agreement/contract action recommendation to the Sanction Action Review Committee.

DADS Community Services Contracts staff submits Medicaid provider agreement/contract action recommendations to the Sanction Action Review Committee when a complaint investigation against a provider substantiates a reported allegation or DADS Community Services Contracts staff recommends the provider receive a contract action/sanction greater than only a corrective action plan. Sanction Action Review Committee members review the monitoring review results and, if applicable, review complaint investigation findings to ensure the circumstances support the recommended Medicaid provider agreement/contract action. The Sanction Action Review Committee makes a decision on the appropriate action to take, such as submission of a corrective action plan; placing a hold on individual referrals to the provider of new individuals; placing a hold on provider payments; financial recoupment; and involuntary contract termination.

Results of each contract monitoring review are documented and recorded in a database maintained by the State.

HHSC conducts annual monitoring, which includes reviewing data from the quarterly quality measures and annual CMS-372 reports and implementing the Quality Review Team processes, the key formal mechanism for monitoring DADSÃ¢Â€Â™ performance. The Quality Review Team meets quarterly and reviews comprehensive quality reports from each waiver at least annually. These reports include data on all of the waiverÃ¢Â€Â™s quality improvement strategy measures. These reports also include remediation activities and outcomes. Improvement plans are developed as issues are identified by DADS or HHSC, and the Quality Review Team reviews, making modifications if needed, and approves all improvement plans. All active improvement plans for all waivers are monitored at each quality review team meeting.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Participation in the consumer directed services option provides the individual or the legally authorized representative the opportunity to be the employer of persons providing those waiver services chosen for self-direction. An individual, through the consumer directed services option, may direct residential habilitation, respite, supported employment, employment assistance, nursing, physical therapy, occupational therapy, speech, and language therapy, and cognitive rehabilitation therapy. Any or all of these services may be self-directed. This option is available statewide to individuals receiving CLASS waiver services who are living in their own homes or family homes.

Under the traditional agency option (provider-managed service delivery method) individuals choose a direct services agency to provide any services that are not authorized for the consumer directed services option and any services available through the consumer directed services option that the individual or legally authorized representative chooses not to self-direct.

Each individual or legally authorized representative electing the consumer directed services option must receive support from a financial management services provider referred to as a financial management services agency, chosen by the individual or legally authorized representative. An individual or legally authorized representative may also use support consultation, which is available only to individuals who choose the consumer directed services option.

The individual or the legally authorized representative may appoint a designated representative to assist with or perform employer responsibilities to the extent approved by the employer. DADS will not pay the individual/employerÃ¢Â€Â™s designated representative for serving as the designated representative or for providing any services to the individual.

When choosing to self-direct authorized waiver services, the individual receiving those services or the legally authorized representative is the common-law employer of service providers and has decision-making authority over providers of those services. The employer assumes and retains responsibility to recruit, determine the competence of, hire, train, manage, and fire their employees.

In addition, the individual/employer has budget authority over the services he or she is directing. The individual/employer, with the assistance of the financial management services agency, budgets authorized funds for those services to be delivered through the consumer directed services option. DADS authorizes the funds for the services allocated for the consumer directed services option on the service plan.

The case manager informs the individual, legally authorized representative, or both of the option to self-direct the services indicated above at the time of enrollment in the waiver, at least annually thereafter, and upon request of the individual or legally authorized representative. The individual or legally authorized representative may elect at any time to choose the consumer directed services option, terminate participation in the consumer directed services option, or to change financial management services agencies.

Entities or individuals involved in supporting the individual receiving services, or the individual's legally authorized representative who is directing services and supports, include:
(1) The individualÃ¢Â€Â™s case manager, who provides information about the consumer directed services option and monitors service delivery through the option. The case management functions are global and apply to self-directed as well as provider-managed waiver services and non-waiver services; and
(2) A financial management services agency, chosen by the individual or legally authorized representative, to provide financial management services such as conduct payroll, file, and report taxes on behalf of the

individual/employer, and provide training related to employer activities. The financial management services agency must hold a Medicaid provider agreement with DADS on behalf of HHSC.
(3) If the individual or legally authorized representative has chosen to receive support consultation, a certified support advisor chosen by the individual or legally authorized representative, who assists the individual/employerin learning about and performing employer responsibilities; and
(4) If appointed by the individual/employer, a designated representativewho assists in meeting employer responsibilities to the extent directed by the individual/employer.

To participate in the consumer directed services option, an individual or legally authorized representative must:
(1) Select a financial management services agency;
(2) Participate in orientation and ongoing training conducted by the financial management services agency;
(3) Perform all employer tasks that are required for self-direction or appoint a designated representative capable of performing some or all of these tasks on the individualÃ¢Â€Â™s behalf; and
(4) Maintain a service backup plan for provision of services determined by the service planning team to be critical to the individualÃ¢Â€Â™s health and welfare.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

An individual is offered the opportunity to self-direct services when:
1. The individual lives in his or her own home, or the home of a family member; and
2. The service plan includes any service that is eligible for delivery using the consumer directed services option. These services include residential habilitation, respite, nursing, physical therapy, occupational therapy, supported employment, employment assistance, speech and language pathologytherapy, and cognitive rehabilitation therapy.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The case manager provides each individual and legally authorized representative a written and oral explanation of the consumer directed services option at the time of enrollment, at each annual review of the service plan, and at any time requested by the individual or legally authorized representative.

Each individual or legally authorized representative is provided information sufficient to assure informed decision-making and understanding of the consumer directed services option and of the traditional agency option (provider-managed service delivery option). The information includes the responsibilities and choices individuals can make with the election of the consumer directed services option. Consumer directed service materials are available in English and Spanish and can be provided upon request in other languages.

The information provided orally and in writing to the individual and the legally authorized representative by the case manager includes the following:
1. An overview of the consumer directed services option;
2. An explanation of responsibilities in the consumer directed services option for the individual or legally authorized representative, case manager, and the financial management services agency;
3. An explanation of benefits and risks of participating in the consumer directed services option;
4. A self-assessment for participation in the consumer directed services option;
5. An explanation of required minimum qualifications of service providers through the consumer directed services option; and
6. An explanation of employee/employer relationships that prohibit employment under the consumer directed services option.

The individual/employer may request an adjustment to the service plan at any time. In response to the individual's request to adjust the budget amount, the case manager convenes the service planning team to discuss the change in the budget amount and the justification for change the service plan.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

○ **The State does not provide for the direction of waiver services by a representative.**

◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☑ **Waiver services may be directed by a legal representative of the participant.**

☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The individual or the legally authorized representative serving as the consumer directed services employer may appoint an adult who is not the legally authorized representative as a designated representative to assist in performance of employer responsibilities to the extent desired by the individual or legally authorized representative. The consumer directed services employer documents the employer responsibilities that the designated representative may perform and those that the designated representative may not perform on the consumer directed services employer's behalf. The consumer directed services employer provides this documentation to the financial management services agency. The financial management services agency monitors performance of employer responsibilities performed by the consumer directed services employer and, when applicable, the designated representative in accordance with the consumer directed services employerÃ¢Â€Â™s documented directions. Neither the designated representative nor the spouse of the designated representative may be employed by, receive compensation from, or be a provider of waiver services for the individual. The consumer directed services employer may terminate the responsibilities of the designated representative at any time.

To ensure that designated representative functions in the best interests of the individual, safeguards are in place that include restrictions preventing the designated representative from:
- signing or representing himself as the employer,
- providing a waiver service, or
- being paid to perform employer responsibilities.

Applicants for employment are required to certify the status of relationship with the employer. If the person indicates that he or she is either designated representative or designated representativeÃ¢Â€Â™s spouse, the financial management services agency would not approve the applicant for hire. The financial management services agency maintains documentation of the designated representative. DADS monitors compliance through its financial management services agency contract monitoring.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Residential Habilitation	☑	☑
Supported Employment	☑	☑
Support Consultation	☑	☑
Physical Therapy	☑	☑
Employment Assistance	☑	☑
Respite (In-Home and Out-–of-Home)	☑	☑
Cognitive Rehabilitation Therapy	☑	☑
Nursing	☑	☑
Occupational Therapy	☑	☑

Waiver Service	Employer Authority	Budget Authority
Speech and Language Pathology	☑	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**
☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:
Financial Management Services

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Private entities furnish financial management services. These entities, called financial management services agencies, are procured through an open enrollment process and the State has Medicaid provider agreements with multiple entities to provide financial management services to individuals across the state.

DADS, on behalf of HHSC, executes a Texas Medicaid provider agreement with each financial management services agency. These agreements include additional State contract requirements.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Entities are compensated with a flat monthly fee per individual served.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☑ **Assist participant in verifying support worker citizenship status**
☑ **Collect and process timesheets of support workers**
☑ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
☑ **Other**

Specify:

Obtain criminal history check on behalf of the individual/employer and share information with the individual/ employer so the employer can make a hiring decision.

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [ ] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [x] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

HHSC delegates the responsibility of executing Medicaid provider agreements to DADS, including the day-to-day operations of financial management services and monitoring of financial management services agencies. DADS conducts monitoring reviews of each financial management services agency to determine if it is in compliance with the Medicaid provider agreement and with waiver rules and requirements. These reviews are conducted via desk reviews or at the location where the financial management services agencies are providing financial management services.

Texas monitors 100 percent of financial management services agencies at a minimum of every three years. DADS reports the results of the monitoring to HHSC. DADS assesses a financial management services agency's performance by:
1. Measuring adherence to rules in Title 40 of the Texas Administrative Code, Part 1, Chapter 41;
2. Matching payroll, optional benefits, and tax deposits to time sheets;
3. Ensuring that the hours worked and the rate of pay are consistent with individual budgets;
4. Reviewing administrative payments; and
5. Reviewing the provider agreements.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Residential Habilitation	☐
Supported Employment	☐
Support Consultation	☑
Behavioral Support	☐
Physical Therapy	☐
Specialized Therapies	☐
Adaptive Aids	☐
Prescribed Drugs	☐
Dietary	☐
Continued Family Services	☐
Case Management	☑
Employment Assistance	☐
Respite (In-Home and Out-–of-Home)	☐
Auditory Integration Training/Auditory Enhancement Training	☐
Dental Treatment	☐
Cognitive Rehabilitation Therapy	☐
Transition Assistance Services	☐
Support Family Services	☐
Nursing	☐
Minor Home Modifications	☐
Occupational Therapy	☐
Financial Management Services	☑
Prevocational Services	☐
Speech and Language Pathology	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

An individual/employer may voluntarily terminate participation in the consumer directed services option at any time. The case manager convenes the service planning team to revises the service plan for the transition of services previously delivered through the consumer directed services option to be delivered by the direct services agency chosen by the individual or legally authorized representative. The service planning team assists the individual as necessary to ensure continuity of all waiver services through the traditional agency option (provider-managed service delivery method) and maintenance of the individual's health and welfare during the transition from the consumer directed services option.

The financial management services agency closes the employerÃ¢Â€Â™s payroll and payable accounts and completes all deposits and filings of required reports with governmental agencies on behalf of the individual. When an individual voluntarily terminates self-direction of services, the case manager will assist the individual to begin services through the traditional agency option (provider-managed service delivery method) with no gap in coverage. The individual must wait 90 days before returning to the consumer directed services option.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

An individualÃ¢Â€Â™s service planning team, financial management services agency, or DADS may recommend termination of participation in the consumer directed services option if the individual, legally authorized

representative, or designated representative does not implement and successfully complete the following steps and interventions:
1. Address risks to the individual's health or welfare;
2. Successfully direct the delivery of appropriate waiver services through the consumer directed services option;
3. Meet employer responsibilities as listed in E-2-a(ii), Participant Employer Authority, and E-2-b(i), Participant Budget Authority, of this Appendix;
4. Successfully implement corrective action plans; or
5. Appoint a designated representative or access other available supports to assist the employer in meeting employer responsibilities.

DADS may require immediate termination from consumer direction in circumstances that jeopardize health and safety of the individual, when the designated representative is convicted of a crime, or if another regulatory agency recommends termination.

The individual's case manager and service planning team assist the individual to ensure continuity of all waiver services through the traditional agency option (provider-managed service delivery option) and maintenance of the individual's health and welfare during the transition from the consumer directed services option. The case manager must assist with revising the service plan for the transition of services previously delivered through the consumer directed services option that will be delivered by the direct services agency chosen by the individual or legally authorized representative. The financial management services agency closes the employer's payroll and payable accounts and completes all deposits and filing of required reports with governmental agencies on behalf of the individual.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		1740
Year 2		1840
Year 3		1940
Year 4		2040
Year 5		2140

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- [x] **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

- [x] **Recruit staff**
- [ ] **Refer staff to agency for hiring (co-employer)**
- [ ] **Select staff from worker registry**
- [x] **Hire staff common law employer**
- [x] **Verify staff qualifications**
- [x] **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Funds available in the individual's consumer directed services budget are used for this purpose.

- [x] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**

- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The service plan is developed in the same manner for the individual who elects the consumer directed services option as it is for the individual who elects to have services delivered through the traditional agency option (provider-managed service delivery option). The service plan must be approved by DADS.

The consumer directed services budget is based on the estimated cost of the self-directed services in the approved service plan and the adopted consumer directed services reimbursement rates. The consumer directed services budget is developed by the individual or legally authorized representative with assistance from the financial management services agency.

Funds from the consumer directed services budget are allocated to each self-directed service that has been included in the approved service plan.

The budget for each service, and any revisions, must be approved by the financial management services agency prior to implementation. The financial management services agency must ensure that projected expenditures are within the authorized budget for each service, are allowable and reasonable, and are projected over the effective period of the plan to ensure that sufficient funds will be available to the end date of the service plan. With approval of the financial management services agency, the individual or legally authorized representative may make revisions to a specific service budget that do not change the amount of funds available for the service based on the approved service plan.

Employer-related costs are paid for using the consumer directed services budget and include costs for equipment, supplies, or activities that will provide direct benefit to the individuals who self-direct services to support specific outcomes related to being an employer. These costs include: recruiting expenses, fax machine for sending employee time sheets to the financial management services agency, criminal conviction history checks from the Texas Department of Public Safety, acquiring other background checks of a potential service provider, purchased employee job-specific training, cardio-pulmonary resuscitation training, first-aid training, and Hepatitis B vaccination if elected by an employee. An individual may use up to a maximum of $600 per year of the consumer directed budget for employer-related support activities.

Support consultation has a specific reimbursement rate and is a component of the individual's service

budget. In conjunction with the service planning team, the individual or legally authorized representative determines the level of support consultation necessary to be included in the individual's service plan.

A revision to the budget for a particular service or a request to shift funds from one service to another is a service plan change and must be justified by the service planning team and authorized by DADS. With assistance of the financial management services agency, the individual or legally authorized representative revises the consumer directed services budget to reflect the revision in the service plan.

Information concerning budget methodology for the consumer directed services budget is available to the public in Title 40 of the Texas Administrative Code, Part 1, Chapter 41, Subchapter E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The individual or the legally authorized representative participates as a member of the service planning team that develops the individual's service plan. The individual or legally authorized representative is apprised of the budget as it is developed. The individual develops the consumer directed services budget based on the finalized service plan and authorized budget. The financial management services agency and the case manager inform the individual/employer of the amount authorized for the particular service before the budget is developed.

During the service planning process, the case manager informs the individual or legally authorized representative of procedures to request a revision to the service plan. The individual/employer may request an adjustment to the service plan at any time. In response to the individual's request to adjust the budget amount, the case manager convenes the service planning team to discuss the change in the budget amount and the justification for change the service plan. An individual whose services are reduced, denied, suspended, or terminated is entitled to a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A. The specific procedures for a fair hearing are provided in Appendix F, Individual Rights.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

An individualÃ¢Â€Â™s consumer directed services budget is calculated and monitored based on projected utilization and frequency of the services as determined by the service planning team. The financial management services agency is required to monitor payroll every pay period and expenditures, as processed for payment. The financial management services agency is required to report over- and under-utilization to the individual/employer and the case manager. When an over- or under-utilization is not corrected by the individual/employer or legally authorized representative, the financial management services agency notifies the case manager and the individual/employer. The case manager and the individual/employer identify the cause of the continuing deviation from projected utilization and develop a plan to correct the deviation or revise the service plan.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

During the initial face-to-face visit by the case manager with the individual/legally authorized representative (LAR), the case manager explains the individual has the right to request a fair hearing and explains the fair hearing process. Additionally, based on the case manager’s responsibility to protect the individual's rights and intervene to assist individuals in crisis, the case manager must also explain which services will not continue during the fair hearing process.

At the time of enrollment and at least annually, the case manager provides an oral and written explanation of an individual's right to request a fair hearing, to the individual or legally authorized representative (in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 45, Subchapter B, Section 45.212, Title 40 of the Texas Administrative Code, Part 1, Chapter 45, Subchapter G, Section 45.702, and Title 1 of the Texas Administrative Code, Part 15.) The case management agency documents that the explanation of the right to request a fair hearing is provided to the individual or legally authorized representative. This explanation includes a description of the individual's right to request a fair hearing if the individualâ€™s request for enrollment into the CLASS program is denied or is not acted upon with reasonable promptness, or if the individual's CLASS Program services are denied, suspended, reduced, or terminated (in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 45, Subchapter C, Section 45.301, and Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A, Section 357.3). At the time of enrollment, all individuals are given the choice of home and community-based services as an alternative to institutional care.

DADS or the case management agency sends DADS Form 3624 to the individual at least 10 days prior to the effective date of action in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A, Section 357.11, except as permitted in situations described in Title 42, Code of Federal Regulations Â§431.213, Title 42, Code of Federal Regulations Â§431.214, Title 40 of the Texas Administrative Code, Part 1, Chapter 45, Subchapter C, Section 45.409 and, if services are suspended because the individual is out of state. DADS Form 3624 describes the action DADS will take and explains the right to request a fair hearing (in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A, Section 357.11 and Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A, Section 357.3). DADS and the case manager retain a copy of the DADS Form 3624 in the individualâ€™s record. If an individual or legally authorized representative elects to request a fair hearing, DADS and the case manager

retain a copy of the written request for a hearing in the individualâ€™s record.

An individual may not be eligible to receive or continue to receive services while the fair hearing process is pending, in the following circumstances:
(1) Situations described in Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A, Section 357.11;
(2) When an individual has not requested a hearing before the effective date of action (in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A, Section 357.11) and, one of the following situations applies:
- Denial of waiver enrollment;
- The individual or a person in the individual's residence exhibits behavior that places the health and safety of the case management agency case manager or a direct services agency service provider in immediate jeopardy;
- Denial of service not previously authorized on the individual's service plan; or
- Suspension or termination of services because the individual leaves the State.

If an individual requests a fair hearing, the case manager completes the DADS Fair Hearing Request Summary, and sends it to DADS. The case manager must send the DADS Fair Hearing Request Summary to DADS within one business day after the date the case manager receives the request for appeal. DADS staff enters the information into the Texas Integrated Eligibility Redesign System for notification to the HHSC Fraud Hearings Section that conducts Fair Hearings. DADS maintains a hard copy folder of all appeals the State conducts. Fair hearing requests are tracked in the CLASS Database and in the Texas Integrated Eligibility Redesign System creating an electronic record of the request.

The HHSC hearing officer sends the Acknowledgement and Notice of Fair Hearing to the individual and to DADS, to acknowledge the request for a hearing and to set a time, date, and place for the hearing. DADS sends the information required by Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A, Section 357.15 to the individual or legally authorized representative at least 14 calendar days prior to the scheduled hearing. DADS enters the information contained in the Fair Hearing Request Summary regarding evidence for the hearing into the Texas Integrated Eligibility Redesign System.

HHSC Notice of Hearing Form is used by the Fair Hearings Office to announce the date, time, and location of a fair hearing and includes information advising an individual of free legal assistance that is available in the area of the individual’s residence within the State. Additionally, the CLASS case manager is required to protect the individual's rights and intervene to assist individuals in crisis, which requires the case manager to provide information regarding CLASS rules and policies that might have an impact on the fair hearing.

After the hearing is completed, the HHSC hearing office files the decision on the Update after Fair Hearing (Data Entry Form), in the appeal file (in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A, Section 357.23). DADS will implement the decision of the HHSC hearing officer within 10 calendar days of the date of the decision and send a DADS Action Taken on Hearing Decision to the Texas Integrated Eligibility Redesign System documenting that the decision has been implemented.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (◉) **No. This Appendix does not apply**
- (○) **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

HHSC, the single State Medicaid Agency, and DADS, the operating agency, operate the grievance/complaint system.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DADS Office of Consumer Rights and Services

DADS has identified the Office of Consumer Rights and Services as its centralized source for the receipt of complaints and grievances by individuals, legally authorized representatives, family members, and the general public, as well as concerns and questions regarding the facilities/agencies regulated by DADS, DADS' services, programs, or staff. The individual's case manager informs the individual or legally authorized representative verbally and in writing of the complaint or grievance process upon enrollment and annually thereafter.

The DADS Office of Consumer Rights and Services responds to all contacts and refers callers to the proper authorities. DADS Office of Consumer Rights and Services responds via telephone call, a letter, or email, to the complainant.

Complaints and grievances can be submitted by telephone by calling a toll-free line, by e-mail, or by written correspondence. DADS Consumer Rights and Services staff answer the toll-free line from 7 a.m. to 7 p.m. Monday through Friday. Voice mail is available 24 hours a day and is monitored from 8 a.m. to 5 p.m., central time, including weekends and holidays.

Complaints and grievances left on voice mail are monitored by Complaint Intake program specialists and returned on or before the next workday. Complaints and grievances may be anonymous. The identity of complainants and individuals is protected as allowed by law. An individual has the right to make a complaint, voice a grievance, or recommend changes in policy or service, without restraint, interference, coercion, discrimination, or reprisal.

CLASS providers are responsible for addressing complaints and grievances that they receive and ensuring appropriate action is taken. DADS Regulatory Services reviews these complaints and grievances and the actions taken by the home and community support services agencies during routine surveys. DADS Community Services Contracts reviews any complaints, grievances, and the actions taken by the case management agency and the financial management services agency during routine contract monitoring visits.

DADS Consumer Rights and Services staff triage and refer complaints and grievances that they receive regarding a DADS licensed agency or facility that is contracted to provide waiver services, to DADS Regulatory Services and DADS Community Services Contracts. DADS must acknowledge the complaint within 14 days after the date DADS receives it and conduct an inspection within a timeframe varying from two days to the next onsite visit, based on the allegations in the complaint.

If DADS Regulatory Services conducted the initial investigation, DADS Community Services Contracts staff must

initiate the complaint investigation within 45 workdays of the date the staff receives either the Report of Investigation or Statement of Licensing Violations and Plan of Correction form from DADS Regulatory Services. If DADS Regulatory Services does not initiate an investigation, DADS Community Services Contracts staff must initiate the complaint investigation within 45 workdays from the date DADS Consumer Rights and Services posted the intake to the designated Outlook mailbox.

The initiation of the complaint investigation begins when DADS Community Services Contracts staff makes the first contact with the complainant or the provider. Contact may be made face-to-face, by telephone or fax. DADS Community Services Contracts staff must complete the on-site or desk review investigation within 15 workdays from the date the investigation was initiated.

DADS Community Services Contracts office maintains a complaint log for the purpose of collecting, reviewing, and reporting complaint information. On a monthly basis, DADS Community Services Contracts staff compiles the Complaint Activity Report and the Complaint Resolution Activity Report and posts the reports electronically to a designated folder on the Health and Human Services Contract Administration Tracking System Reports shared drive. DADS Community Services Contracts staff is responsible for reporting contract management activities, including investigations, to DADS Contract Oversight and Support for entry into the Health and Human Services Contract Administration Tracking System.

With regard to specific allegations of abuse, neglect or exploitation, DADS investigates all allegations of this nature in licensed assisted living facilities and nursing facilities. Home and community support services agencies are required to report allegations of abuse, neglect, or exploitation to the Department of Family and Protective Services and DADS Regulatory Services. DADS Regulatory Services investigates these allegations to determine whether the licensed home and community support services agency responded appropriately to the allegations. The case management agency and the direct services agency must ensure that the individual and legally authorized representative are informed of how to report allegations of abuse, neglect, or exploitation to the Department of Family and Protective Services.

When DADS Consumer Rights and Services staff determines DADS has no jurisdiction to investigate, complaints are referred to other agencies, boards, or entities as required.

HHSC Office of Ombudsman
The HHSC Office of the Ombudsman assists the public when the DADS normal complaint process cannot, or does not, satisfactorily resolve an issue. The Office of the Ombudsman's services include:
- conducts independent reviews of complaints concerning agency policies or practices;
- ensures that policies and practices are consistent with the goals of HHSC;
- ensures that individuals are treated fairly, respectfully, and with dignity; and
- makes referrals to other agencies as appropriate

An individual may file a complaint with the Office of the Ombudsman by calling the toll-free-number, submitting the complaint online, or by faxing or mailing the complaint.

- The Ombudsman encourages individuals to first discuss the individual's issue with the HHSC or DADS person, program or office involved and to request assistance with the issue or complaint;
- If the HHSC or DADS normal complaint process cannot or does not satisfactorily resolve the issue, there are four ways to send a question or file a complaint with the Office of the Ombudsman;
- The Office of the Ombudsman will provide an impartial review of actions taken by the program or department; and
- The Office of the Ombudsman will seek a resolution.

Often it is necessary for the Office of the Ombudsman to refer an issue to another appropriate department or agency. If so, the Office of the Ombudsman will follow-up with the complainant to determine if a resolution has been achieved, or to refer the complainant to other available known resources.

The individual may choose any one or more of the following in seeking to resolve a complaint: file the complaint with the Office of Consumer Rights and Services; to file the complaint with the Ombudsman (however, the Ombudsman will required the individual to attempt one of the other methods first); or to file the complaint through the provider complaint system.

The Texas Medicaid Fair Hearing rules do not require an individual to file a grievance or complaint as a condition

for a fair hearing. An option for a fair hearing and an explanation of the fair hearing process is presented to an individual by the case manager when eligibility is denied, or when a service is reduced, denied, or terminated.

The case management agency is required to present an explanation of the fair hearing process at enrollment, renewal, or any time the individual requests the information. The case management agency is the entity responsible to assist the individual in exercising his or her fair hearing rights.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Every direct services agency is licensed as a home and community support services agency and is required to self-report allegations of abuse, neglect, and exploitation by its employees, the definition of which includes volunteers and contractors to both the Department of Family and Protective Services and DADS under Title 2 of the Texas Health and Safety Code, Chapter 142, Section 142.018 and Title 40 of the Texas Administrative Code, Part 1, Chapter 97, Section 97.249. The Department of Family and Protective Services investigates allegations of abuse, neglect, and exploitation of individuals over the age of 18 receiving services from in-home service providers and defines abuse, neglect, and exploitation in Title 2 of the Texas Human Resource Code, Chapter 48 and Title 40 of the Texas Administrative Code, Part 19, Chapter 705, Subchapter A. Under Title 2 of the Texas Human Resource Code, Chapter 48, Section 48.401, reportable conduct includes:
(A) Abuse or neglect that causes or may cause death or harm to an individual receiving agency services;
(B) Sexual abuse of an individual receiving agency services;
(C) Financial exploitation of an individual receiving agency services in the amount of $25 or more; and
(D) Emotional, verbal, or psychological abuse that causes harm to an individual receiving agency services.

All individuals, legally authorized representatives, direct services agency personnel, case management agency personnel, and financial management services agencies are provided the Department of Family and Protective Services toll-free number verbally and in writing and are instructed to report to the Department of Family and Protective Services immediately, but not later than twenty four hours after having knowledge or suspicion that an individual has been or is being abused, neglected, or exploited. All CLASS providers must report any instances of abuse, neglect, and exploitation immediately upon suspicion of such activities to the Department of Family and Protective Services and DADS Consumer Rights and Services. Individuals may report suspected instances of abuse, neglect, and exploitation to the Department of Family and Protective Services or to DADS Consumers Rights and Services via telephone or electronically through the Department of Family and Protective Services website.

The Department of Family and Protective Services investigates reports and makes a determination as to whether allegations of abuse, neglect, and exploitation are substantiated. DADS Regulatory Services conducts surveys for compliance with state licensing standards regarding reported incidents and complaints related to abuse, neglect, and exploitation for licensed home and community service support agencies. When a complaint investigation is finalized,

individuals are notified of the findings within 3 business days.

Out-of-home respite facilities are also required to immediately report abuse, neglect, and exploitation to DADS Consumer Rights and Services under DADS licensure rules. Direct services agencies which are licensed as home and community support services agencies are required to report abuse, neglect, and exploitation immediately, but no later than 24 hours after learning of the incident (in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 97, Section 97.249). Those reports are investigated by DADS Regulatory Services staff.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

At the time an individual is enrolled in CLASS and annually thereafter, all case management agencies and direct services agencies must ensure that the individual is informed orally and in writing of the processes for reporting allegations of abuse, neglect, or exploitation and provided the DADS Consumer Rights and Services toll-free telephone number. Facilities where out-of-home respite is provided must post the information in a conspicuous place. Evidence supporting compliance with these requirements is reviewed during DADS on-site licensure surveys and contract monitoring reviews of the provider.

The case management agency informs all waiver individuals of their rights, including their right to be free of abuse, neglect, and exploitation and provide individuals with information on how to report an allegation of abuse, neglect, or exploitation.

Financial management services agencies are required to provide an inÃ¢Â€Âperson orientation to individuals who initiate the consumer directed services option. In accordance with Title 40 of the Texas Administrative Code, Chapter 41, Section 41.307, financial management services agencies are required to review and leave with the employer and designated representative, if applicable, printed information on how to report allegations of abuse, neglect, and exploitation. The financial management services agency must provide to the employer or designated representative a printed or an electronic copy of the DADS Consumer Directed Services Employer Manual which includes a section of signs of abuse, neglect, and exploitation and how to report.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Department of Family and Protective Services (DFPS) has the jurisdiction to investigate reports and make determinations regarding allegations of abuse, neglect, and exploitation by all unlicensed providers (including employees of home and community support services agencies).

The Department of Aging and Disability Services (DADS) Regulatory division has jurisdiction to conduct surveys for compliance with state licensing standards and investigates reported incidents of abuse, neglect and exploitation occurring in licensed facilities. In addition, DADS Regulatory investigates incidents/complaints that are not abuse, neglect or exploitation allegations for licensed home and community support services agencies and licensed facilities.

Department of Aging and Disability Services and Department of Family and Protective Services have a Memorandum Of Understanding (MOU) outlining the responsibilities of each agency which supports the statutory responsibilities given to each agency.

DFPS

As previously referenced, the Texas Department of Family and Protective Services has jurisdiction to receive and investigate reports of abuse, neglect, and exploitation by all unlicensed providers and direct services agencies. Title 2 of the Texas Human Resources Code, Chapter 48 requires that Department of Family and Protective Services investigates persons thought to have knowledge of the circumstances regarding abuse, neglect, and exploitation. The Texas Human Resources Code also provides authority to act during an investigation, including the authority to gain access to records and a prohibition against interference with investigation or services. The Department of Family and Protective Services methods of investigation include interviews with the alleged victim, the alleged perpetrator,

and any person who is identified as potentially having relevant information in regard to the investigation, as well as individual service record review and review of other CLASS provider records (such as employee time sheets) which may contain relevant information.

The Department of Family and Protective Services (DFPS) assigns a priority level to allegations of abuse, neglect or exploitation at the time of intake based on the perceived ongoing threat level to the individual. In accordance with Title 40 of the Texas Administrative Code, Part 19, Chapter 705, Subchapter D, DFPS defines priority one allegations as allegations that the victim is in a state of serious harm or is in danger of death from abuse or neglect.

The Department of Family and Protective Services must initiate a case by contacting a person with current and reliable information within 24 hours of intake and must conclude the investigation within 30 days. The investigator may change the priority level based on information from the contact. The Department of Family and Protective Services must make the initial face-to-face contact with the alleged victim based on the priority level. Priority one cases require response within 24 hours; priority two cases require response within three calendar days; priority three cases require response within 7 calendar days; and priority four cases require response within 14 calendar days. The results of the investigation are reported to the complainant and other pertinent parties within 30 days by a letter generated from the Department of Family and Protective Services automated system.

Abuse, neglect, or exploitation reports are also recorded in the home and community support services agency Information Tracking database, which includes tracking of reports that are referred to DFPS for abuse, neglect, or exploitation investigation. The DADS Consumer Rights and Services Complaint Intake unit is responsible for entering all data into the home and community support services agency Information Tracking database.

DADS

Contracted providers are required to protect individuals from abuse, neglect, or exploitation under consumer rights rules and are required to report potential incidences of abuse, neglect, or exploitation. All provider agencies must comply with the complaint procedure requirements set out by DADS in Title 40 of the Texas Administrative Code, Part 1, Chapter 49 (relating to contracting for community services). All providers reporting abuse, neglect, and exploitation allegations involving an employee (the definition of which includes volunteer or contractor) of the agency must provide appropriate contact information. Pursuant to Title 40 of the Texas Administrative Code, Part 1, Chapter 49 (relating to contracting for community services), upon completion of a complaint self-investigation, provider agencies must notify the complainant of the results. Direct services agencies are given 30 days to fully investigate complaints and grievances not related to abuse, neglect, and exploitation in accordance with home and community support services agency licensing standards. Evidence supporting compliance with these requirements is reviewed during DADS on-site licensure surveys and contract monitoring reviews of the program provider.

DFPS notifies DADS upon determining and after investigation of substantiated abuse, neglect, or exploitation allegations. DADS may coordinate with the Department of Family and Protective Services to determine the resolution of the abuse, neglect, or exploitation allegation. DADS is responsible for receiving and reviewing reports of abuse, neglect, and exploitation from the Department of Family and Protective Services.

All complaints regarding incidents or concerns that do not meet the definition of abuse, neglect, or exploitation are under the jurisdiction of DADS and reported directly to DADS Consumer Rights and Services department. DADS Consumer Rights and Services receives such complaints from individuals, members of the public, case managers and direct services agency staff.

DADS evaluates all complaints (ANE and those that do not rise to the level of ANE) based on its own unique circumstances and assigns priorities accordingly. Priority one complaints require immediate response (i.e., on or before two working days). Immediate response by Regulatory Services is warranted when a provider allegedly creates or allows a present and ongoing situation in which the provider's noncompliance with one or more requirements of licensure or certification has failed to protect individuals from abuse, neglect or mistreatment, or has caused, or is likely to cause, serious injury, harm, impairment, or death to an individual.

DADS Consumer Rights and Services department refers all complaints internally within DADS to the appropriate unit (e.g. Community Services Contracts, Regulatory Services, etc.) or as appropriate to other agencies (i.e. HHS Ombudsman, Office of Inspector General, etc) for follow-up and resolution.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Texas Department of Family and Protective Services and DADS are responsible for handling all reports of abuse, neglect, and exploitation related to individuals receiving services in the community. As required by Title 2 of the Human Resources Code, Subtitle D, Chapter 48, Section 48.103, upon completion of an investigation in which abuse, neglect, or exploitation is validated against an employee of a direct services agency, Department of Family and Protective Services releases the investigation findings to DADS.

If a direct services agency has cause to believe that an individual served by the agency has been abused, neglected, or exploited by an employee, volunteer, or contractor, the agency must report the information immediately, but no later than 24 hours after learning of the incident, to the Department of Family and Protective Services and DADS. The direct services agency must complete DADS' Provider Investigation Report form and send the completed form to DADS' Complaint Intake Unit. A direct services agency must investigate complaints made by an individual or legally authorized representative, or a health care provider regarding the individualÃ¢Â€Â™s treatment or care. The direct services agency must document receipt of the complaint and initiate a complaint investigation within 10 days after receipt of the complaint.

The Department of Family and Protective Services provides DADS Regulatory Services with any confirmation of abuse, neglect, or exploitation by a direct services agency employee, volunteer, or contractor. DADS Regulatory Services also receives any referral to the Employee Misconduct Registry when there is a confirmed incident of abuse, neglect, or exploitation against a direct services agency employee, volunteer, or contractor. When DADS Regulatory Services receives that referral, the process to add that personÃ¢Â€Â™s name to the Employee Misconduct Registry is begun. That person is allowed all rights related to due process before placement on the Employee Misconduct Registry.

In preparation for biennial and some intermittent reviews of direct services agencies, DADS staff compiles data related to all critical incidents (including reports of abuse, neglect, and exploitation) reported by or involving the direct services agency. DADS may use this information in selecting the sample of individuals whose records will be reviewed and who may be interviewed to ensure the direct services agency conducted appropriate follow-up. DADS provides oversight on a continuous basis and aggregates the data quarterly and annually for reporting to HHSC.

DADS is responsible for all other critical events and incidents. All critical events and incidents reported to DADS as required by licensure regulations are investigated by DADS Regulatory Services and incidents pertaining to contract violations are forwarded to DADS Community Services Contracts for investigation. Investigation of some self-reported incidents may be completed without an on-site investigation. If further investigation is warranted to ensure compliance with federal, state, or local laws, an on-site investigation is scheduled.

Oversight activities occur on an ongoing basis. Information regarding validated instances of abuse, neglect or exploitation are monitored, tracked, and trended for purposes of training DADS staff and to prevent recurrence.

Providers are responsible for training their staff about reporting critical incidents and events.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

Complaints concerning use of restraint can be made to the Department of Aging and Disability Services or the Department of Family and Protective Services. The case manager and the provider must ensure that an individual or legally authorized representative is informed orally and in writing of the processes for filing complaints about the provision of services including: the toll-free telephone number of DADS Consumer Rights and Services to file a complaint; and the toll-free telephone number of Department of Family and Protective Services to file a complaint of abuse, neglect, or exploitation.
All direct service agencies are licensed as a home and community support services agency and are required to report allegations of abuse, neglect, and exploitation to both the Department of Family and Protective Services and the Department of Aging and Disability Services (DADS) under Texas Health and Safety Code §142.018 and 40 Texas Administrative Code §97.249.
The Department of Family and Protective Services investigates allegations of abuse, neglect, and exploitation of individuals receiving services from providers under Texas Human Resources Code Chapter 48. Texas defines Abuse, Neglect, and Exploitation in §48.401. "Reportable conduct includes:
(A) Abuse or neglect that causes or may cause death or harm to an individual receiving agency services;
(B) Sexual abuse of an individual receiving agency services;
(C) Financial exploitation of an individual receiving agency services in an amount of $25 or more; and
(D) Emotional, verbal, or psychological abuse that causes harm to an individual receiving agency services."
The Department of Family and Protective Services investigates reports and makes a determination as to whether abuse, neglect, and exploitation occurred. Department of Aging and Disability Services Regulatory Division monitors reported incidents and complaints related to abuse, neglect, and exploitation for licensed home and community support services agencies.
Out-of-Home Respite facilities are also required to immediately report abuse, neglect, and exploitation to DADS Consumer Rights and Services under DADS licensure rules. Those reports are investigated by DADS regulatory staff.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

Complaints concerning use of restrictive intervention can be made to the Department of Aging and Disability Services or the Department of Family and Protective Services. The case manager and the provider must ensure that an individual or legally authorized representative is informed orally and in writing of the processes for filing complaints about the provision of services including: the toll-free telephone number of DADS Consumer Rights and Services to file a complaint; and the toll-free telephone number of DFPS to file a complaint of

abuse, neglect, or exploitation.
All direct service agencies are licensed as a home and community support services agency and are required to self-report allegations of abuse, neglect, and exploitation to both the Department of Family and Protective Services and the Department of Aging and Disability Services under Texas Health and Safety Code §142.018 and 40 Texas Administrative Code §97.249.
The Department of Family and Protective Services investigates allegations of abuse, neglect, and exploitation of individuals receiving services from providers under Texas Human Resources Code Chapter 48. Texas defines Abuse, Neglect, and Exploitation in §48.401. "Reportable conduct includes:
(A) Abuse or neglect that causes or may cause death or harm to an individual receiving agency services;
(B) Sexual abuse of an individual receiving agency services;
(C) Financial exploitation of an individual receiving agency services in an amount of $25 or more; and
(D) Emotional, verbal, or psychological abuse that causes harm to an individual receiving agency services."
The Department of Family and Protective Services investigates reports and makes a determination as to whether abuse, neglect, and exploitation occurred. Department of Aging and Disability Services Regulatory Division monitors reported incidents and complaints related to abuse, neglect, and exploitation for licensed home and community support services agencies.
Out-of-Home Respite facilities are also required to immediately report abuse, neglect, and exploitation to DADS Consumer Rights and Services under DADS licensure rules. Those reports are investigated by DADS regulatory staff.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

Employees of each type of facility providing out-of-home respite are required to report unauthorized use of seclusion as these actions may constitute abuse or neglect of the individual being restrained or secluded. Facilities are required to post notices in public areas regarding reporting of abuse, neglect, or exploitation, including instructions on how to report and the telephone number of the appropriate agency to contact.

DADS monitors potential improper and unauthorized use of seclusion through on-site surveys and complaint investigations. Complaints concerning the use of seclusion can be made to DADS or the Department of Family

and Protective Services. The case manager and the direct services agency must assure that an individual or legally authorized representative is informed orally and in writing of the processes for filing complaints about the provision of waiver services including:
- the toll-free telephone number of DADS Consumer Rights and Services to file a complaint; and
- the toll-free telephone number of the Department of Family and Protective Services to file a complaint of abuse, neglect, or exploitation.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Direct services agencies licensed as home and community support services agencies, assisted living facilities providing out-of-home respite, adult foster care providers providing out-of-home respite, an intermediate care facilities providing out-of-home respite, and nursing facilities providing out-of-home respite, must provide medication management as required by their license.

In accordance with Title 40 of the Texas Administrative Code, Part 1, Title 97, a direct services agency is required to monitor all aspects of an individual's medication that the agency administers. Medication management is monitored at annual and semiannual reevaluations of the individual receiving services.

When an assisted living facility or a nursing facility, while providing out-of-home respite, administer or supervise an individual's medication, they are required to monitor all aspects of an individual's medication. Registered nurses review the individualÃ¢Â€Â™s medications upon admission and upon significant change in the individual's condition.

For individuals receiving out-of-home respite in an adult foster care setting, the adult foster care provider may administer medications only as allowed by state law or regulation as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 48, Subchapter K, Section 48.8907.

For individuals receiving out-of-home respite in an intermediate care facility, they may self administer medications if they meet the standards specified in Title 40 of the Texas Administrative Code Part 1, Chapter 90, Subchapter C, Section 90.42. Individuals to whom the facility administers medications are governed by Title 40 of the Texas Administrative Code, Part 1, Chapter 90, Subchapter C, Section 90.43.

The Department of Family and Protective Services monitors medication management and administration by child-placing agencies who provide support family services and continued family services, in accordance with Title 40 of the Texas Administration Code, Part 19, Chapter 749, Subchapter J. Support family services and continued family services providers are monitored through on-site quarterly visits by the licensed child-placing agencies. The licensed child-placing agencies are monitored through on-site inspections by the Department of Family and Protective Services.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Direct Services Agencies, Assisted Living Facilities Providing Out-of-Home Respite, and Nursing Facilities Providing Out-of-Home Respite
DADS Regulatory Services licenses and surveys home and community support services agencies, assisted living providers, and nursing facilities. Medication management is part of the license requirements for these providers. DADS oversees medication management provided by its contractors through licensure surveys and complaint investigations. Assisted living facilities are surveyed biennially and nursing facilities every 9 to 15 months. Home and community support services agencies that are not accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. The State imposes penalties such as requiring corrective action plans, administrative penalties and license revocation when harmful medication management practices are detected. DADS staff conduct follow-up surveys and inspections to ensure the provider has effectively implemented any corrective action plan required due to cited State violations. If a home and community support services agency administers medications, it must maintain a list of medication errors, which must be reviewed during the self- quality review.

Intermediate Care Facilities Providing Out-of-Home Respite
DADS Regulatory Services inspection and survey personnel perform inspections, surveys, follow-up visits, complaint investigations, investigations of abuse or neglect, and other contact visits from time to time, as they deem appropriate or as required for carrying out the responsibilities of licensing. Licensed intermediate care facilities have an annual recertification of health and life safety code survey every 12 months and at least every 15 months. Licensed intermediate care facilities also have a licensure inspection to assess compliance with the State Standards of Participation. Generally, all inspections, surveys, complaint investigations and other visits, whether routine or non-routine, made for determining the appropriateness of resident care and day-to-day operations of a facility will be unannounced.

Support Family Services and Continued Family Services
Caregivers must maintain a cumulative record of all prescription medication dispensed to a child and all nonprescription medication, excluding vitamins, dispensed to a child under five years old. Caregivers must maintain the medication record during the time that they provide services to the child. This record must include the:
(1) Child's full name;
(2) Prescribing health-care professional's name, if applicable;
(3) Medication name, strength, and dosage;
(4) Date (day, month, and year) and the time the medication was administered;
(5) Name and signature of the person who administered the medication;
(6) Child's refusal to accept medication, if applicable; and
(7) Reasons for administering the medication, including the specific symptoms, condition, and/or injuries of the child that the caregiver is treating, for PRN prescriptions and nonprescription medications (excluding vitamins) for children under five years old.

(a) Identification of any prohibited prescription medication, nonprescription medication, and vitamins for each child must be maintained in the medication record, which must be incorporated into the child's record.
(b) The medication records of prescription and nonprescription medication dispensed to the child must be incorporated into the child's record.
If a caregiver finds a medication error regarding a prescribed medication, the caregiver must contact a healthcare professional immediately, and follow the healthcare professional's recommendations.

If a caregiver finds a medication error regarding a nonprescription medication, the caregiver must take the appropriate and necessary actions as required by the circumstances.

For all medication errors, a caregiver must document the following within 24 hours:
(1) The time and date of the error;
(2) The medication error;
(3) The time and date of the call(s) to the licensed health-care professional, if applicable;
(4) The name and title of the health-care professional contacted, if applicable; and
The child-placing agency is responsible for the home's ongoing compliance with rules and must evaluate the home as follows:
(1) When there is an allegation of a deficiency, you must evaluate the rule and any rules related to the deficiency;
(2) When a change in the conditions of the verification or a major life change occurs, you must evaluate the rules related to the conditions or change;
(3) You must document the rules that were evaluated and the determination of the evaluation;
(4) During any contact with the foster family, including routine supervisory contacts and investigations, you must cite and address any deficiencies noted;
(5) Your documentation of deficiencies must include plans for achieving compliance; and
(6) You must also document a plan for follow-up to ensure compliance was achieved.

The Department of Family and Protective Services is the agency responsible for follow-up and oversight, in accordance with Title 40 of the Texas Administrative Code, Part 19, Chapter 749, Subchapter J. The Department of Family and Protective Services monitors child-placing agencies annually, identifying harmful practices, and using that information to improve quality. The Department of Family and Protective Services uses methods specific to the agency such as technical assistance or corrective action plans. Annually, DADS will obtain data from the Department of Family and Protective Services on child-placing agencies serving individuals in CLASS. DADS shares this information with HHSC and reviews the Department of Family and Protective Services actions regarding violations.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Direct services agencies, assisted living facilities, and nursing facilities must administer medications as required by licensure. Licensure only allows licensed nurses, certified medication aides (under the direct supervision of a licensed nurse), or persons who administer medication as delegated by a registered nurse.

A registered nurse who supervises a medication aide or delegates medication administration must provide ongoing supervision and any necessary training to the unlicensed person. Registered nurses must follow procedures for delegation in accordance with the Nurse Practice Act (Title 3 of the Texas Occupations Code, Subtitle E, Chapter 301 contains the Nurse Practice Act)..

Direct services agencies, assisted living facilities, and nursing facilities are required to monitor all aspects of an individual's medication, regardless of whether the provider administers the medication or the individual self-medicates. Home and community support services agencies registered nurses review the individual's medications annually and upon significant change in the individual's condition.

Licensing requirements for assisted living facilities require the facility to provide monthly counseling to an individual who self-medicates and secures their own medications. The assisted living facility must report any unusual reactions to the individual's physician. The assisted living facility must also document any time an individual fails to take medication.

Support Family Services and Continued Family Services
Department of Family and Protective Services Residential Child Care Licensing staff conduct inspections of licensed operations to determine if they meet minimum standards and licensing laws. Every licensed operation, including Child-Placing Agencies, must be inspected at least once every 12 months, and at a minimum one inspection per year must be unannounced. Other inspections may be announced or unannounced. At least one inspection every two years must be unannounced.

An inspection form or letter is completed when an inspection results in deficiencies along with the applicable standards, rules, and law. A follow-up inspection is conducted to ensure deficiencies are corrected. Action may be taken against an operation if deficiencies are not corrected in a timely manner, if deficiencies are repeated or if the operation has a pattern of deficiencies, or the violations threaten the health and safety of children. These actions can include putting the operation on a corrective action such as evaluation or probation, or an adverse action, such as suspending or revoking a permit to operate.

In addition to routine inspections, Licensing staff investigates reports that allege violations of the law or minimum standards. The type and scope of each investigation may vary based on the information received in the report. The goal of all investigations is to reduce risk to children and prevent further harm. The Department of Family and Protective Services reviews both the child-placing agencies' records and the records kept by the support family. Additionally, child-placing agencies meet with the support family at least quarterly to oversee all aspects of the child's care.

iii. Medication Error Reporting. *Select one of the following:*

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the State:

◉ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

Direct services agencies and out-of-home respite providers must comply with licensure requirements related to recording medication errors.

Under the Minimum Standards for Child Placing Agencies in Foster Care settings, at Title 40 of the Texas Administrative Code, Part 19, Chapter 749, Subchapter J, Division 6, §749.1561, medication errors include, but are not limited to the following:
A medication error includes, but is not limited to, the following:
(1) A child receives the wrong medication;
(2) A child receives medication prescribed to someone else;
(3) A child receives the wrong dosage of medication;
(4) A child receives medication at the wrong time;
(5) A medication dose is skipped or missed;
(6) A child receives expired medication;
(7) Not following the medication administration instructions, such as giving a child medication on an empty stomach when the medication should be given with food; and
(8) A child receives medication that was not stored as required to maintain the effectiveness of the medication, such as refrigerating or not refrigerating the medication or exposing the medication to heat or sunlight.

In addition, Title 40 of the Texas Administrative Code, Part 19, Chapter 749, Subchapter J, Division 6, §749.1563 indicates that a caregiver must do the following if the caregiver finds a medication error:
(a) If a caregiver finds a medication error regarding a prescribed medication, the caregiver must contact a health-care professional immediately, unless the error is the type described in paragraph (4) or (5) of §749.1561 of this title (relating to What is a medication error?), and follow the health-care professional's recommendations.
(b) If a caregiver finds a medication error regarding a nonprescription medication, the caregiver must take the appropriate and necessary actions as required by the circumstances.
(c) For all medication errors, a caregiver must document the following within 24 hours:
(1) The time and date of the error;
(2) The medication error;
(3) The time and date of the call(s) to the licensed health-care professional, if applicable;
(4) The name and title of the health-care professional contacted, if applicable; and
(5) The health-care professional's medical recommendations for ensuring the child's safety, if applicable.

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Direct Services Agencies, Assisted Living Facilities Providing Out-of-Home Respite, and Nursing Facilities Providing Out-of-Home Respite DADS Regulatory Services licenses and surveys home and community support services agencies, assisted living providers, and nursing facilities. Medication management is part of the license requirements for these providers. DADS oversees medication management provided by its contractors through licensure surveys and complaint investigations. Assisted living facilities are surveyed biennially and nursing facilities every 9 to 15 months. Home and community support services agencies that are not accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Community Health Accreditation Program, are surveyed during their first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter. The State imposes penalties such as requiring corrective action plans, administrative penalties and license revocation when harmful medication management practices are detected. DADS staff conduct follow-up surveys and inspections to ensure the provider has effectively implemented any corrective action plan required due to cited State violations. If home and community support services agency administers medications, it must maintain a list of medication errors, which must be reviewed during the self-quality review.

Intermediate Care Facilities Providing Out-of-Home Respite
DADS Regulatory Services inspection and survey personnel perform inspections, surveys, follow-up visits, complaint investigations, investigations of abuse or neglect, and other contact visits from time to time, as they deem appropriate or as required for carrying out the responsibilities of licensing. Licensed intermediate

care facilities have an annual recertification of health and life safety code survey every 12 months and at least every 15 months. Licensed intermediate care facilities also have a licensure inspection to assess compliance with the State Standards of Participation. Generally, all inspections, surveys, complaint investigations and other visits, whether routine or non-routine, made for determining the appropriateness of resident care and day-to-day operations of a facility will be unannounced.

Support Family Services and Continued Family Services
The Department of Family and Protective Services monitors the performance of Licensed Child- Placing Agencies which may provide support family services and continued family services.
(1) Department of Family and Protective Services conducts at least one annual, unannounced monitoring inspection of every main and branch office of a child-placing agency.
(2) Department of Family and Protective Services conducts announced and unannounced inspections every year of one fourth of all agency foster homes. Department of Family and Protective Services documents any deficiencies with minimum standards and cites the child-placing agency if the Department of Family and Protective Services feels they have violated the minimum standards that govern their verification and oversight of foster homes.
(3) The Department of Family and Protective Services investigates allegations of abuse, neglect, or exploitation. The Department of Family and Protective Services investigates all child deaths in Child-Placing Agencies or General Residential Operations.
(4) The Department of Family and Protective Services investigates complaints of violations of the minimum standards for child-placing agencies.

Child-placing agencies with a CLASS Medicaid provider agreement to deliver support family services and continued family services must report all serious incidents to DADS.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.a.1 Number and percent of individuals who are free from confirmed allegations of abuse. N: Number of individuals who are free from confirmed allegations of abuse. D: Number of enrolled individuals.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Assurance and Improvement Data Mart; Home and Community Support Services Agencies Intake Tracking System, and Compliance Assessment Regulation Enforcement System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
G.a.4 Number and percent of priority one complaints resolved by DADS Regulatory Services. N: Number of priority one complaints resolved by DADS Regulatory Services. D: Number of priority one complaints received.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Health and Human Services Contract Administration and Tracking System

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.5 Number and percent of individuals who received information on how to report abuse, neglect, or exploitation. N: Number of individuals who received information on how to report abuse, neglect, or exploitation D: Number of individuals' case records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CLASS Contracts database.

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%+/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other**	

	Specify: Biennially	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.6 Number and percent of individuals free from an allegation of abuse, neglect, or exploitation. N: Number of individuals without an allegation of abuse, neglect, or exploitation. D: Number of enrolled individuals.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DADS Quality Assurance and Improvement Datamart; DADS Home and Community Support Services Agency Intake and Tracking System; DADS Home and Community Support Services Agency Integrated

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.2 Number and percent of individuals who are free from confirmed allegations of neglect. N: Number of individuals who are free from confirmed allegations of neglect. D: Number of enrolled individuals.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Assurance and Improvement Data Mart; Home and Community Support Services Agencies Intake Tracking System, and Compliance Assessment Regulation Enforcement System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.3 Number and percent of individuals who are free from confirmed allegations of exploitation. N: Number of individuals who are free from confirmed allegations of exploitation. D: Number of enrolled individuals.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Quality Assurance and Improvement Data Mart; Home and Community Support Services Agencies Intake Tracking System, and Compliance Assessment Regulation Enforcement System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Texas Administrative Code requires providers to protect individuals from abuse, neglect, and exploitation and to report potential incidents of abuse, neglect, and exploitation. Providers are also required

to explain, during the initial face-to-face enrollment meeting and annually thereafter, the procedures for an individual or legally authorized representative to file a complaint regarding a CLASS provider and to review the individual's rights, which include the right to be free from abuse and neglect.

In accordance with state law, DADS maintains a State Employee Misconduct Registry that includes the names of unlicensed direct care staff DADS or the Department of Family and Protective Services has confirmed to have abused, neglected, or exploited an individual receiving services administered by DADS. In addition, in accordance with federal law, DADS maintains a Nurse Aide Registry that lists certified nurse aides. The Nurse Aide Registry indicates if an aide has been confirmed to have abused, neglected, or exploited a resident of a licensed nursing facility. Providers must consult these registries prior to offering employment to a non-licensed employee and must refrain from employing that person if either registry indicated the person was confirmed to have abused, neglected, or exploited an individual receiving program services.

Direct services agencies licensed as home and community support services agencies are required to report allegations of abuse, neglect, and exploitation directly to DADS and the Department of Family and Protective Services immediately upon suspicion of such activities. Case management agencies and financial management services agencies are governed by Texas Human Resources code Chapter 48 (48.051). This law requires a person having cause to believe that an elderly or disabled person is in the state of abuse, neglect, or exploitation to report the information required immediately.

During the quarterly monitoring contact, the case manager is responsible for determining if any existing situations jeopardize the individual's health and welfare. Additional contacts may be scheduled to ensure the individual's health and welfare.

DADS requires providers to maintain a complaint log and investigate/resolve complaints according to DADS Community Services complaint procedure rules. Additionally, the Community Services Contracts unit maintains a complaint log for the purpose of collecting, reviewing, and reporting complaint or incident information. On a monthly basis, Community Services Contracts staff compiles a Complaint Activity Report and a Complaint Resolution Activity Report and posts the reports internally.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DADS Consumer Rights and Services is the central point of intake for complaints and incidents. Complaints and incidents are entered into DADS' intake tracking database and assigned a priority. After Consumer Rights and Services completes the intake, it is forwarded electronically via the intake tracking system to DADS Regulatory Services. Complaint and incident intakes involving service provider non-compliance with contract requirements are also referred by Consumer Rights and Services via e-mail to DADS Community Services Contracts staff.

All case management agency staff and direct services agency staff must complete the training described below within 60 calendar days of employment and at least every 12 months thereafter:
- Abuse, Neglect and Exploitation
  - review of the statute on abuse neglect and exploitation at Human Resources Code, Chapter 48;
  - explanation of the signs and symptoms of abuse, neglect and exploitation;
  - overview of the reporting requirements of abuse, neglect and exploitation; and
  - learning how to report abuse and neglect to the Department of Family and Protective Services
- Rights and Responsibilities of Individuals
  - review information about the rights of the individual who receives CLASS services as outlined in the DADS Consumer Rights and Services booklet; and
  - review CLASS rules in Chapter 45, Subchapter C, §45.301 and §45.302 concerning the individual's right to a fair hearing and the individual's mandatory participation requirements.

DADS Community Services Contracts staff conducts complaint investigations involving the individual, direct services agency staff, or case management agency staff. Depending upon the nature of the complaint. DADS Community Services Contracts staff may also refer the complaint to DADS Regulatory Services, the Department of Family and Protective Services, the Texas Board of Nursing, or local law enforcement

agencies. DADS Community Services Contracts staff informs providers of complaint findings at the conclusion of the investigation, including whether the allegations were substantiated. If the investigation findings substantiate an immediate risk to the health or welfare of a waiver individual, the provider is required to take immediate action to resolve the situation. The provider is also required to develop and implement an immediate corrective action plan addressing the prevention of future occurrences of the situation or similar events. The purpose of the immediate corrective action plan is for the provider to communicate in writing the specific action taken to resolve the identified situation and the steps that will be taken to ensure the continued health and safety of the individuals served. The immediate corrective action plan must include the following elements:
- A description of the health and safety issue;
- Action taken to resolve the issue; and
- A plan to prevent the occurrence of the issue.

DADS Community Services Contracts staff does not investigate abuse, neglect, or exploitation. Allegations of this nature are handled in accordance with Title 2 of the Texas Human Resource Code, Subtitle D, Chapter 48 and the Memorandum of Understanding between DADS and the Department of Family and Protective Services. If at any time during the course of the investigation of the complaint, Community Services Contracts staff becomes aware of an immediate threat to an individual's health and safety or abuse, neglect, or exploitation, staff must report the situation within one hour to:
- DADS Consumer Rights and Services;
- Department of Family and Protective Services;
- DADS Regulatory Services; and
- DADS Community Services Contracts manager or manager's designee

The Department of Family and Protective Services and DADS share statutory authority and responsibility to investigate reported incidents and complaints involving abuse, neglect or exploitation of an individual receiving CLASS services by a facility employee, an employee of any agency serving the individual (case management agency ,direct services agency, financial management services agency, child placing agency), or a volunteer or contractor of any agency serving the individual (case management agency, direct services agency, financial management services agency, and child placing agency) under memorandums of understanding between the two departments. In addition, facilities are required, by rule, to conduct an investigation of allegations of abuse, neglect, and exploitation. The Department of Family and Protective Services records and tracks abuse, neglect, and exploitation reports in its Information Management Protecting Adults and Children in Texas system. DADS staff coordinates with Department of Family and Protective Services staff to determine the resolution of abuse, neglect, and exploitation allegations.

During contract monitoring reviews, DADS Community Services Contracts staff confirms that the individual and legally authorized representative have been informed of the complaint procedures and the process for reporting abuse, neglect, and exploitation. Providers that are unable to show evidence to support compliance with this requirement are cited and required to develop a corrective action plan and may receive other sanctions. DADS Sanction Action Review Committee reviews all substantiated allegations of contract noncompliance. The Sanction Action Review Committee review may result in a corrective action plan or sanction, such as suspension of individual referrals, holding vendor payments, or termination of the provider contract.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

HHSC and DADS have articulated the vision and infrastructure for the quality improvement strategy for the waivers in the Quality Oversight Plan, which was approved by both agencies' commissioners in 2010. The Quality Oversight Plan includes all waivers operated by DADS.

Central to the Quality Oversight Plan is the Quality Review Team, which consists of representatives from several agencies within the Texas Health and Human Services enterprise. The Quality Review Team process is the key formal mechanism for HHSC's monitoring DADS' performance of delegated functions. The Quality Review Team meets quarterly and reviews the comprehensive quarterly data reports from each waiver at least annually. These reports include data on all of the waiver's quality improvement strategy measures. These reports also include remediation activities and outcomes. Improvement plans are developed as issues or trends are identified, and the Quality Review Team reviews, modifying if needed, and approves all improvement plans. All active improvement plans for all waivers are monitored at each quality review team meeting. HHSC formally communicates the results from its monitoring to CMS and the public via the evidentiary review and annual report processes. In addition to directing the improvement activities for each waiver, the Quality Review Team will oversee implementation of the Quality Oversight Plan and related processes. This includes making recommendations for new or revised quality measures, identifying and facilitating access to new data sources, identifying new intra and inter-agency processes impacting any and all phases of the quality program, and other actions needed to assure continued improvement of Texas' Home and Community-Based Services waiver programs.

The Quality Review Team will review and revise, if necessary, the Quality Oversight Plan at least every three years. Revisions to the plan will be approved by HHSC leadership.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**

Responsible Party*(check each that applies):*	Frequency of Monitoring and Analysis*(check each that applies):*
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The Quality Review Team process is the key formal mechanism for HHSC's monitoring DADS' performance of delegated functions. The Quality Review Team meets quarterly and reviews comprehensive quality reports from each waiver program at least annually. These reports are generated from the DADS Quality Assurance and Improvement Data Mart and include data on the waivers' quality improvement strategy measures. These reports also include remediation activities and outcomes. HHSC and DADS staff present the reports and recommendations to the Quality Review Team. Priorities for system improvement are established by the Quality Review Team. The Quality Review Team develops strategies for implementation of system improvements through the use of improvement plans. Improvement plans are developed as issues are identified, and the Quality Review Team reviews; modifying, if needed; and, approves all improvement plans. All active improvement plans for all waivers are monitored at each quality review team meeting, to include updates on data to determine whether or not improvement activities had the intended effect.

The DADS Quality Assurance and Improvement Data Mart compiles data currently collected in multiple automated systems. The Data Mart produces standardized reports and provides capability for ad-hoc reporting. The areas covered by the reports include: individual demographics; service utilization; enrollments; levels of care; service plans; consumer-direction; critical incidents; provider compliance and oversight; transfers; and discharges. This system has the capability to provide management reports at the individual level or any level of aggregation needed.

To facilitate communication with the public which includes external stakeholders, waiver participants, families, service providers, and other interested parties, the agency has implemented Texas Quality Matters, which is a web-based medium that provides external stakeholders with an increased ability to access quality reporting information. Texas Quality Matters provides the State with the ability to conduct online surveys related to quality improvement.

Stakeholders have the opportunity to provide testimony on policies and rules governing the delivery of services in the CLASS program in writing and at meetings of the Medical Care Advisory Committee, the DADS Advisory Council, and the HHSC Advisory Council. DADS posts announcements for all stakeholder meetings on the DADS website prior to the meeting.

The Promoting Independence Advisory Committee studies and makes recommendations to the State regarding appropriate care settings for persons with disabilities. The Promoting Independence Advisory Committee is comprised of member representatives from all departments of the State Medicaid agency and external stakeholders.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

At least every three years, HHSC and DADS staff will evaluate and update, if necessary, the Quality Oversight Plan. State staff will examine issues such as whether or not the indicators of the Quality Oversight Plan are providing substantive information about each sub-assurance and whether the Quality Review Team composition is inclusive of key agency stakeholders. If areas for improvement exist, staff will make recommendations to the Quality Review Team, and the Quality Review Team will approve or revise staff's recommended changes. As the Quality Oversight Plan is revised, the State will update the Quality Improvement Strategy as necessary.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DADS conducts fiscal monitoring of CLASS direct services agencies and case management agencies on-site at least every two years. DADS contract monitoring staff select a six month period within the monitoring period, which can be up to 24 months, to review service delivery. DADS contract monitoring staff then select two of the six months to assess fiscal compliance. Financial management services agencies are monitored at a minimum of every three years and, typically a six-month sample of financial management services agencies' records are reviewed. The methods used in the monitoring process for the direct services, case management, and financial management services agencies include:
- Review of the provider's existing billing system and internal controls;
- Comparison of the agency's service delivery records with its billing records to verify that the payments DADS made to the agency were appropriate;
- Review of service plans and records; and
- Comparison of service delivery and other supporting documentation with service plans.

DADS may perform desk and on-site compliance reviews associated with claims the provider submits. DADS recovers improper payments, without extrapolation, when DADS verifies that the agency has been overpaid because of improper billing or accounting practices or for failure to comply with the provider agreement terms.

The direct services agency, case management agency, or financial management services agency must provide the documentation that DADS requests to support the agency's submitted claims information. If the agency fails to provide the requested information, DADS may take adverse action against the agency based on the terms of the Medicaid provider agreement. DADS may withhold payments and apply them to the exceptions that DADS identifies and may require corrective action for any finding based upon the monitoring results.

Direct services agencies, case management agencies, and financial management services agencies are not required to conduct independent financial audits. The Texas State Auditor's Office is responsible for an annual statewide financial and compliance audit. In addition, the HHSC Office of the Inspector General is responsible for performing audits of Medicaid provider agreements between DADS and case management agencies, direct services agencies, and financial management services agencies.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Financial Accountability Assurance:**
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*
    i. **Sub-Assurances:**

        a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

            Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
I.a.1 Number and percent of provider claims, including those from financial management services agencies, that are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. N: Number of provider claims that are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. D: Number of paid claims.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Claims Management System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
I.a.2 Number and percent of monitored financial management services agencies (FMSAs) whose claims were paid in accordance with the employee's established rate of pay and the service hours actually worked. N: Number of monitored FMSAs whose claims were paid in accordance with the employee's established rate of pay and the service hours actually worked. D: Total number of monitored FMSAs.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Quality Assurance and Improvement Data Mart; Health and Human Services Contract Administration Tracking System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
		☐ **Other**

	☐ **Continuously and Ongoing**	Specify:
	☑ **Other** Specify: Each FMSA is monitored every three years.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
I.a.3 Number and percent of financial management services agencies reviewed evidencing that quarterly expenditure reports were sent to the employers. N: Number of financial management services agencies reviewed evidencing that quarterly expenditure reports were sent to the employers. D: Number of financial management services agencies reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Health and Human Services Contract Administration and Tracking System; Quality Assurance and Improvement Data Mart

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Each FMSA is monitored every three years.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
I.a.4 Number and percent of financial management services agencies who operated in accordance with Section 3504 of the IRS code. N: Number of financial management services agencies who operated in accordance with Section 3504 of the IRS code. D: Number of financial management services agencies reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*		
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Each FMSA is monitored every three years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

For waiver services delivered through the agency directed option and the consumer directed services option, direct services agencies, case management agencies, and financial management services agencies send claims for reimbursement for waiver services provided to individuals to the State's contracted Medicaid Management Information System. Providers may submit claims electronically via the Medicaid Management Information System.

The State's Claims Management System is a comprehensive, computer-based, automated claims processing system for providers. This system has numerous edits to assure that providers submit accurate billings. Providers are unable to submit billing claims through the automated Claims Management System for any wavier services until the system confirms that DADS has authorized the service plan and the authorized service plan has been entered into the Service Authorization System.

The Claims Management System also edits claims for the validity of the information and compliance with business rules for the service and program and calculates the payment amount and applicable reductions for claims approved for payments. Prior to issuing payment, the automated Claims Management System verifies that an individual's current authorized service plan has sufficient units to cover amounts claimed and prevents duplicate claims for services already paid.

The Claims Management System verifies that an individual was Medicaid eligible on the date of service delivery specified in a request for reimbursement and allows payment only for claims for services provided within the eligibility period. The Claims Management System will reject provider claims if the Service Authorization System does not reflect that the waiver individual meets eligibility criteria. The Claims Management System automatically rejects any claim entered for a service not authorized on an individual's service plan as authorized in the Service Authorization System. The Claims Management System also automatically rejects any claim that is entered with an unauthorized billing code.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Texas monitors 100 percent of case management agencies and direct services agencies biennially. During biennial on-site monitoring reviews, DADS Community Services Contracts staff determines a case management agency's and a direct services agency's compliance with standards pertaining to fiscal accountability and verifies that the services billed were actually rendered. As part of the fiscal component of biennial on-site monitoring reviews, DADS Community Services Contracts staff verifies that billings submitted to and paid by DADS are for billable time and activities by verifying that billing forms are completed according to DADS instructions.

Case management agencies and direct services agencies must maintain documentation supporting the claims. If the case management agency or the direct services agency fails to maintain the required

documentation, DADS recovers improper payments. DADS also recovers payments when DADS Community Services Contracts staff verifies the case management agency or the direct services agency was overpaid because of improper billing. The State has mechanisms in place for the return to the Centers for Medicare & Medicaid Services of any federal matching funds received for improper billing.

DADS Community Services Contracts staff prepares a written report itemizing claims found in error during each review. A summary of each review, including the name of the case management agency or the direct services agency, the dollar amount to be subtracted from pending or future payments to the case management agency or the direct services agency, if applicable, and any follow-up action to be taken, is scanned and is sent electronically on a monthly basis to the DADS Contract Oversight and Support area. DADS Contract Oversight and Support staff enters the case management agency or the direct services agency monitoring information into the Health and Human Services Contracts Administration and Tracking System. DADS Contract Oversight and Support staff uses the data entered into this system to track monitoring. DADS Community Services Contracts staff conducts intermittent reviews to ensure that the case management agency or the direct services agency has taken the necessary steps to attain and maintain compliance at the required performance level.

HHSC has delegated to DADS the responsibility of executing Medicaid provider agreements, including day-to-day operations of financial management services and monitoring of financial management services agencies. Texas monitors 100 percent of financial management services agencies at a minimum of every three years. These reviews are conducted via desk reviews or at the location where the financial management services agencies are providing financial management services. DADS reports the results of the monitoring to HHSC. DADS assesses a financial management services agency's performance by:
1. Measuring adherence to rules in Title 40 of the Texas Administrative Code, Part 1, Chapter 41;
2. Matching payroll, optional benefits, and tax deposits to time sheets;
3. Ensuring that the hours worked and the rate of pay are consistent with individual budgets;
4. Reviewing administrative payments; and
5. Reviewing the provider agreements.

DADS recovers improper payments, without extrapolation, when DADS verifies that the agency has been overpaid because of improper billing or accounting practices or for failure to comply with the provider agreement terms. DADS staff prepares a written report itemizing claims found in error during each review. A summary of each review, including the name of the financial management services agency, the dollar amount to be subtracted from pending or future payments to the financial management services agency, if applicable, and any follow-up action to be taken, is scanned and is sent electronically on a monthly basis to the DADS Contract Oversight and Support area. DADS Contract Oversight and Support staff enters the monitoring information into the Health and Human Services Contracts Administration and Tracking System. DADS Contract Oversight and Support staff uses the data entered into this system to track monitoring. DADS staff conducts intermittent reviews to ensure that the financial management services agency has taken the necessary steps to attain and maintain compliance at the required performance level. DADS staff recommends further action or possible sanctions if the financial management services agency remains out of compliance.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

HHSC, the single State Medicaid agency, determines payment rates every two years, coincident with the State's legislative biennium. Payment rates are determined for each service. The rates for services are prospective and uniform statewide. HHSC reimburses providers for contracted client services through reimbursement amounts determined as described in Title 1 of the Texas Administrative Code, Part 15, Chapter 355, and in reimbursement methodologies for each program. HHSC determines payment rates after analysis of financial and statistical information, and the effect of the payment rates on achievement of program objectives, including economic conditions and budgetary considerations. Statewide, uniform reimbursements and reimbursement ceilings are approved by HHSC. Methodology rules are developed and recommended for approval to HHSC. HHSC has oversight authority with respect to the state's reimbursement methodology and cost determination rules. The rates for the CLASS waiver are available on the HHSC Rate Analysis Department webpage.

In order to ensure adequate financial and statistical information upon which to base reimbursement, HHSC requires each contracted provider to submit a periodic cost report or supplemental report. HHSC uses cost reports to determine rates for the following services: residential habilitation services; prevocational services; employment assistance; supported employment; cognitive rehabilitation therapy; respite care; nursing; physical therapy; occupational therapy; speech and language pathology; case management; behavioral support; auditory integration training/auditory enhancement training; and dietary services. Providers of these services are required to submit annual cost reports to the HHSC Rate Analysis Department. Providers are responsible for eliminating all unallowable expenses from the cost report prior to submission of the cost report. The HHSC Office of Inspector General reviews all cost reports and a sample of cost reports are reviewed on-site. The HHSC Office of Inspector General removes any unallowable costs and corrects any errors detected on the cost report in the course of the review or on-site audit. Audited cost reports are used in the determination of statewide prospective rates.

Unit of service reimbursements are determined as described in Title 1 of the Texas Administrative Code, Part 15, Chapter 355, Section 355.505. In general, recommended unit of service rates for each service are determined as follows and are used as a historical cost basis: 1) total allowable costs for each provider are determined from the audited cost report; 2) each provider's total allowable costs are projected from the historical cost reporting period to the prospective reimbursement period; 4) payroll taxes and benefits are allocated to each salary item; 5) total

projected allowable costs are divided by the number of units of service to determine the projected cost per unit of service; 6) the allowable costs per unit of service for each contracted provider are arrayed and weighted by the number of units of service and the median cost per unit of service is calculated; and 7) the median cost per unit of service for each waiver service is multiplied by 1.044.

When historical costs are unavailable, such as in the case of changes in program requirements, payment rates may be based on a pro forma approach. This approach involves using historical costs of delivering similar services, where appropriate data are available, and estimating the basic types and costs of products and services necessary to deliver services meeting federal and state requirements. The rates for transition assistance services, continued family services, support family services, and support consultation are modeled using a pro forma approach.

Minor home modifications, adaptive aids, dental treatment, and prescriptions are paid at cost.

Specialized therapies are paid at cost up to maximum dollar amount.

The CLASS providers are given additional payments for their efforts in acquiring specialized therapies for individuals; these payments are called requisition fees. The rates for the requisition fees are modeled using a pro forma approach that uses the historical data of provider's costs to deliver services.

In setting the rates for financial management services provided under the consumer directed services option, the reimbursement rate to the financial management services provider, the financial management services agency, is a flat monthly fee, determined by modeling the estimated cost to carry out the financial management responsibilities of the financial management services agency. The payment rate available for the individual's budget for the self-directed service is modeled based on the payment rate to the traditional agency less an adjustment for the traditional agency's indirect costs.

The Financial Management Services Agency (FMSA) is responsible for providing this information to the CDS employer. For individuals not in the CDS option, the document created during the service planning team meeting, the individual plan of care (IPC), contains the rates for each service. This form is reviewed and signed by the individual and/or LAR.

HHSC publishes notice of proposed adjustments at the earliest feasible date but not later than 10 state working days before the effective date of the adjustment, in the Texas Register. HHSC holds a public hearing before it approves rates, to allow interested persons to present comments relating to the proposed rates, and HHSC provides notice of the hearing to the public. The notice of the public hearing includes the location, date, and time for the hearing; information about the proposed rate changes and identifies the name, address, and telephone number of the staff member to contact for the materials pertinent to the proposed rates. At least ten working days before the public hearing takes place, material pertinent to the proposed statewide uniform rates is made available to the public. The public may present comments at the hearing or submit written comments regarding the proposed rates. Information about payment rates is made available to waiver participants through HHSC and DADS websites as well as through the Texas Register via a public notice.

Providers of residential habilitation services have the option of participating in the Attendant Compensation Rate Enhancement. The 76th Texas Legislature directed the Texas Department of Human Services (a legacy agency for DADS) to provide incentives for increased wages and benefits for community care attendants. In response, HHSC adopted rules at Title 1 of the Texas Administrative Code, Part 15, Chapter 355, Section 112 to establish procedures for community care providers to obtain additional funds for increased attendant wages, benefits, insurance, and mileage reimbursement. Community care providers who choose to participate in Attendant Compensation Rate Enhancement and receive additional funds must demonstrate compliance with enhanced spending requirements. For providers who choose not to participate in Attendant Compensation Rate Enhancement, the attendant compensation rate will remain constant over time, except for adjustments necessitated by increases in the federal minimum wage.

Participation in the Attendant Compensation Rate Enhancement is voluntary. Enrollment in Attendant Compensation Enhancement Rate is held in July prior to the rate year. Providers may choose to participate in Attendant Compensation Rate Enhancement by submitting to HHSC a signed Enrollment Contract Amendment choosing to enroll and indicating the level of enhanced add-on rate they desire to receive. Requested add-on rate levels will be granted beginning with the lowest level and granting successive levels until requested enhancements are granted within available funds. Funding for the enhancement add-on rate levels is limited by biennial legislative appropriations.

Providers participating in the Attendant Compensation Rate Enhancement agree to spend approximately 90 percent of their total attendant revenues, including their enhanced add-on rate revenues, on attendant compensation. Attendant compensation includes salaries, payroll taxes, benefits, and mileage reimbursement. Participating providers must submit reports to HHSC documenting their spending on attendant compensation.

Determination of each provider's compliance with the attendant compensation spending requirement will be made on an annual basis from reports submitted to HHSC. Participants failing to meet their spending requirement for the reporting period will have their enhanced add-on revenues associated with the unmet spending requirements recouped. At no time will a participating providerÃ¢Â€Â™s attendant care rate after their spending recoupment be less than the rate paid to providers not participating in receiving the enhanced add-on rates.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

For services delivered through the agency option and consumer directed services option, providers electronically submit claims for reimbursement for waiver services that were provided to individuals to the CMS-approved State Medicaid Management Information System.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The State's contracted Medicaid Management Information System is the claims processing system that verifies that an individual was Medicaid-eligible on the date of service delivery specified in a request for reimbursement and allows payment only on claims for services provided within the eligibility period.

Prior to processing claims, the automated claims management system edits claims for the validity of the information and compliance with business rules for the service and program, and calculates the payment amount and applicable reductions for claims approved for payment. For example, unless the system verifies that an individualÃ¢Â€Â™s current authorized service plan has sufficient units to cover amounts claimed or that an authorized level of care is registered in the claims management system, the claim will be denied.

As noted in the Financial Integrity and Accountability section above, DADS staff conducts on-site reviews to determine a providerÃ¢Â€Â™s compliance with standards pertaining to fiscal accountability and to verify the services billed were actually rendered.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☑ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

  Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- ☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

  Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- ◉ **No. The State does not make supplemental or enhanced payments for waiver services.**
- ○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

◉ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

○ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

○ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**

○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**

○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

◉ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**

○ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
- ( ) **This waiver is a part of a concurrent □1115/□1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a**

prepaid ambulatory health plan (PAHP). The 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- ☐ **Appropriation of State Tax Revenues to the State Medicaid agency**
- ☑ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

The non-federal share used to draw down the federal funds is appropriated directly to DADS for the CLASS waiver by the Texas State Legislature. DADS is the department designated by HHSC, the single State Medicaid Agency, as the Medicaid operating agency for the CLASS waiver. There are no inter-governmental transfers or certified public expenditures.

The non-federal share is exclusively from State general revenue appropriations. There are no local sources of funds or certified public expenditures. CLASS waiver non-federal share funds are appropriated to DADS as a specific line item in the biennial legislative appropriations for the provision of CLASS waiver services. If another agency were designated to operate the CLASS waiver, those funds would be removed from DADS and appropriated to that agency specifically for the provision of CLASS waiver services. DADS CLASS waiver appropriations remain in the state comptrollerÃ¢Â€Â™s account designated for the CLASS waiver. Once the single State Medicaid Agency has approved a claim via the Health and Human Services Accounting System, federal funds are drawn and combined with the state appropriation from the state comptroller's account designated for the CLASS waiver to make payments to the provider.

- ☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- ◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ○ **Applicable**

Check each that applies:

- ☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement

(indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

○ **The following source(s) are used**

Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**

◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Individuals in the CLASS waiver live in their own homes or the home of a family member. Payment of the cost of room and board is the responsibility of the individual except when the individual is receiving out-of-home respite services under the waiver. Room and board is included in the rate for out-of-home respite services.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	42976.47	20445.16	63421.63	107932.58	2989.07	110921.65	47500.02
2	13695.16	44745.00	58440.16	110091.23	3029.12	113120.35	54680.19
3	15267.50		65518.50			115398.81	49880.31

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
		50251.00		112293.05	3105.76		
4	15577.98	51874.00	67451.98	114538.91	3206.08	117744.99	50293.01
5	15894.45	53576.00	69470.45	116829.69	3311.24	120140.93	50670.48

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	**5250**		5250
Year 2	**5869**		5869
Year 3	**5885**		5885
Year 4	**5885**		5885
Year 5	**5885**		5885

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay for WY 1 assumed a point-in-time service level of 4845, with an estimated monthly attrition of eleven individuals per month, which were replaced with new enrollees. For WY 2, the average length of stay for an individual assumes a point-in-time service level of 5633, with estimated monthly attrition of 0.37 percent (based on WY1 experience), which will be replaced with new enrollees. The State used the phase-in/phase-out schedule to calculate the Factor C values as well as the Point-In Time (PIT). In this instance, the term "phase-in/phase-out" are a budgetary management tool only and not the same as the terms described in the CMS Technical Guide. For waiver year two, the state used actual enrollments through April 2016 (as obtained from claims payment data), and then assumed monthly enrollments of 133 per month for the remainder of the year to achieve the end-of-the year PIT target for waiver year two. A monthly attrition rate of 0.37% was assumed based on FY 2015 experience. For years three through five, the PITs were held at year-end waiver two level.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

In State Fiscal Year (SFY) 2015 (WY 1), the Factor D estimates were based on utilization data from an ad hoc report for SFY 2013 using claims payment data through April 2014, and using current rates (effective September 2013). For services where a unit rate is established, the State assumed no inflation through WY 1 (SFY 2015), and assumed a 2% annual inflator for rates for Waiver Years two through five. For those

services not involving unit rates (Adaptive Aids, Dental, and Minor Home Modifications, the State assumed an annual inflation rate of 2% over the cost per service derived from the ad hoc report for SFY 2013. For prescriptions, we assumed an annual rate of 5% over the cost of service derived from the CMS 372 for SFY 2012.

For waiver years two through five, 90% of the drug costs previously reported as a D cost were moved to D' as the result of managed care. Also, 91% of the units previously reported as Residential Habilitation waiver services are now being delivered as a State Plan service through Community First Choice (CFC). Therefore, these costs were removed from the calculation of D and are now being reported as D'. However, some Residential Habilitation hours remain in D for transportation. Finally, the number of individuals served and annual units of service were adjusted as the result of updating the point-in-time and Factor C values.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

In State Fiscal Year (SFY) 2015 (WY 1), for Factor D', the State assumed an annual inflation rate of 5% over the D' cost from the CMS 372 for SFY2012 and for "Pharma and other Medical Products" Personal Consumption Expenditure Indices (PCE) published by IHS Global Insight in September 2015 to inflate the D' cost forward from the base year cost as shown in the CMS 372 for SFY 2012. Estimated inflators are as follows: SFY 2013, 0.5%; SFY 2014, 3.01%; SFY 2015 (WY 1), 3.85%; SFY 2016 (WY 2), 1.34%; SFY 2017 (WY 3), 2.53%; SFY 2018 (WY 4), 3.23%; SFY 2019 (WY 5), 3.28%.

For SFY 2016 (WY 2) and beyond, the base cost was updated based upon FY 2014 CMS 372, using the same inflators. As noted above, the following costs were moved from D costs to D':
1) 91% of Residential Habilitation waiver services are now being delivered as a CFC State Plan service at an average monthly cost of $2594.27 per month. (Based upon payments from September 2015 through March 2016, 66.74% of payments for long-term care services for CLASS clients were for CFC services.)
2) 90% of the drug costs previously reported as a D cost were moved to D' as the result of managed care.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

For Factor G, the State assumed an annual inflation rate of 2% over the actual G cost for SFY 2012.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

For Factor G', the State assumed an annual inflation rate of 5% over the actual G' cost for SFY 2012) and for "Pharma and other Medical Products" Personal Consumption Expenditure Indices (PCE) published by IHS Global Insight in September 2015 to inflate the D' cost forward from the base year cost as shown in the CMS 372 for SFY 2012. Estimated inflators are as follows: FY 2013, 0.5%; FY 2014, 3.01%; FY 2015 (WY 1), 3.85%; FY 2016 (WY 2), 1.34%; FY 2017 (WY 3), 2.53%; FY 2018 (WY 4), 3.23%; FY 2019 (WY 5), 3.28%.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Case Management	
Prevocational Services	
Residential Habilitation	
Respite (In-Home and Out-–of-Home)	
Supported Employment	
Adaptive Aids	
Dental Treatment	

Waiver Services	
Dietary	
Nursing	
Occupational Therapy	
Physical Therapy	
Prescribed Drugs	
Speech and Language Pathology	
Financial Management Services	
Support Consultation	
Auditory Integration Training/Auditory Enhancement Training	
Behavioral Support	
Cognitive Rehabilitation Therapy	
Continued Family Services	
Employment Assistance	
Minor Home Modifications	
Specialized Therapies	
Support Family Services	
Transition Assistance Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**10387492.50**
Case Management	Per Month	5250	11.00	179.87	**10387492.50**	
Prevocational Services Total:						**1303922.10**
Prevocational Services	Per Hour	221	426.00	13.85	**1303922.10**	
Residential Habilitation Total:						**156741980.80**
Consumer directed services direct service provider	Per Hour	2656	2066.00	13.05	**71609212.80**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	4820	1162.00	15.20	**85132768.00**	
			GRAND TOTAL:			**225626485.06**
			Total Estimated Unduplicated Participants:			**5250**
			Factor D (Divide total by number of participants):			**42976.47**
			Average Length of Stay on the Waiver:			345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite (In-Home and Out-–of-Home) Total:						**10678466.08**
Consumer directed services direct service provider	Per Day	1794	16.00	215.24	**6178248.96**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Day	1348	14.00	238.46	**4500217.12**	
Supported Employment Total:						**762946.62**
Consumer directed services direct service provider	Per Hour	131	113.00	25.27	**374071.81**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	131	113.00	26.27	**388874.81**	
Adaptive Aids Total:						**1971152.40**
Adaptive Aids	Per Item	1029	4.00	478.90	**1971152.40**	
Dental Treatment Total:						**405301.98**
Dental Treatment	Per Item	461	1.00	879.18	**405301.98**	
Dietary Total:						**2211.20**
Dietary	Per Hour	8	5.00	55.28	**2211.20**	
Nursing Total:						**2222948.50**
Consumer directed services direct service provider	Per Hour	10	1829.00	29.60	**541384.00**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	4853	10.00	34.65	**1681564.50**	
Occupational Therapy Total:						**233713.45**
Consumer directed services direct service provider	Per Hour	23	23.00	71.95	**38061.55**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	149	18.00	72.95	**195651.90**	
Physical Therapy Total:						**680581.99**
Consumer directed services direct service provider	Per Hour	5	52.00	76.43	**19871.80**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	371	23.00	77.43	**660710.19**	
Prescribed Drugs Total:						**7250656.12**
Prescribed Drugs	Per Rx	2489	19.00	153.32	**7250656.12**	

GRAND TOTAL:	**225626485.06**
Total Estimated Unduplicated Participants:	**5250**
Factor D (Divide total by number of participants):	**42976.47**
Average Length of Stay on the Waiver:	345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech and Language Pathology Total:						**191911.93**
Consumer directed services direct service provider	Per Hour	5	22.00	75.29	**8281.90**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	83	29.00	76.29	**183630.03**	
Financial Management Services Total:						**6021620.00**
Financial Management Services	Per Hour	2710	11.00	202.00	**6021620.00**	
Support Consultation Total:						**30.74**
Support Consultation	Per Hour	1	2.00	15.37	**30.74**	
Auditory Integration Training/Auditory Enhancement Training Total:						**78145.86**
Auditory Integration Training/Auditory Enhancement Training	Per Hour	39	38.00	52.73	**78145.86**	
Behavioral Support Total:						**264119.13**
Behavioral Support	Per Hour	81	41.00	79.53	**264119.13**	
Cognitive Rehabilitation Therapy Total:						**436700.00**
Consumer directed services direct service provider	Per Hour	1	420.00	79.00	**33180.00**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	13	388.00	80.00	**403520.00**	
Continued Family Services Total:						**47114.20**
Continued Family Services	Per Day	2	365.00	64.54	**47114.20**	
Employment Assistance Total:						**464169.24**
Consumer directed services direct service provider	Per Hour	79	114.00	25.27	**227581.62**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	79	114.00	26.27	**236587.62**	
Minor Home Modifications Total:						**669289.88**
Minor Home Modifications	Per Item	206	1.00	3248.98	**669289.88**	
Specialized Therapies Total:						**24764896.14**
Specialized Therapies	Per Hour	3274	89.00	84.99	**24764896.14**	

GRAND TOTAL:	**225626485.06**
Total Estimated Unduplicated Participants:	**5250**
Factor D (Divide total by number of participants):	**42976.47**
Average Length of Stay on the Waiver:	345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support Family Services Total:						**47114.20**
Support Family Services	Per Day	2	365.00	64.54	**47114.20**	
Transition Assistance Services Total:						**0.00**
Transition Assistance Services	Per Item	1050	0.00	2432.11	**0.00**	
				GRAND TOTAL:		**225626485.06**
				Total Estimated Unduplicated Participants:		**5250**
				Factor D (Divide total by number of participants):		**42976.47**
				Average Length of Stay on the Waiver:		345

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**10767854.30**
Case Management	Per Month	5869	10.00	183.47	**10767854.30**	
Prevocational Services Total:						**1375103.34**
Prevocational Services	Per Hour	247	394.00	14.13	**1375103.34**	
Residential Habilitation Total:						**14897849.08**
Consumer directed services direct service provider	Per Hour	2969	172.00	13.31	**6796991.08**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	5388	97.00	15.50	**8100858.00**	
Respite (In-Home and Out-–of-Home) Total:						**11371077.53**
Consumer directed services direct service provider	Per Day	2006	15.00	219.54	**6605958.60**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Day	1507	13.00	243.23	**4765118.93**	
Supported Employment Total:						**811572.30**
				GRAND TOTAL:		**80376881.86**
				Total Estimated Unduplicated Participants:		**5869**
				Factor D (Divide total by number of participants):		**13695.16**
				Average Length of Stay on the Waiver:		319

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consumer directed services direct service provider	Per Hour	147	105.00	25.78	**397914.30**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	147	105.00	26.80	**413658.00**	
Adaptive Aids Total:						**1685256.00**
Adaptive Aids	Per Item	1150	3.00	488.48	**1685256.00**	
Dental Treatment Total:						**462728.16**
Dental Treatment	Per Item	516	1.00	896.76	**462728.16**	
Dietary Total:						**2030.04**
Dietary	Per Hour	9	4.00	56.39	**2030.04**	
Nursing Total:						**2277741.17**
Consumer directed services direct service provider	per Hour	11	1663.00	30.19	**552265.67**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	5425	9.00	35.34	**1725475.50**	
Occupational Therapy Total:						**248147.82**
Consumer directed services direct service provider	Per Hour	26	20.00	73.39	**38162.80**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	166	17.00	74.41	**209985.02**	
Physical Therapy Total:						**706765.80**
Consumer directed services direct service provider	Per Hour	6	43.00	77.96	**20113.68**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	414	21.00	78.98	**686652.12**	
Prescribed Drugs Total:						**805593.96**
Prescribed Drugs	per Rx	278	18.00	160.99	**805593.96**	
Speech and Language Pathology Total:						**201071.16**
Consumer directed services direct service provider	Per Hour	6	28.00	76.80	**12902.40**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	93	26.00	77.82	**188168.76**	
Financial Management Services Total:						**6240951.60**
					6240951.60	

GRAND TOTAL:	**80376881.86**
Total Estimated Unduplicated Participants:	**5869**
Factor D (Divide total by number of participants):	**13695.16**
Average Length of Stay on the Waiver:	319

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Financial Management Services	Per Month	3029	10.00	206.04		
Support Consultation Total:						**31.36**
Support Consultation	Per Hour	1	2.00	15.68	**31.36**	
Auditory Integration Training/Auditory Enhancement Training Total:						**82821.20**
Auditory Integration Training/Auditory Enhancement Training	Per Hour	44	35.00	53.78	**82821.20**	
Behavioral Support Total:						**277430.40**
Behavioral Support	Per Hour	90	38.00	81.12	**277430.40**	
Cognitive Rehabilitation Therapy Total:						**479379.60**
Consumer directed services direct service provider	Per Hour	1	420.00	80.58	**33843.60**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	15	364.00	81.60	**445536.00**	
Continued Family Services Total:						**48055.90**
Continued Family Services	Per Day	2	365.00	65.83	**48055.90**	
Employment Assistance Total:						**490466.24**
Consumer directed services direct service provider	Per Item	88	106.00	25.78	**240475.84**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Item	88	106.00	26.80	**249990.40**	
Minor Home Modifications Total:						**762210.80**
Minor Home Modifications	Per Item	230	1.00	3313.96	**762210.80**	
Specialized Therapies Total:						**26334688.20**
Specialized Therapies	Per Hour	3660	83.00	86.69	**26334688.20**	
Support Family Services Total:						**48055.90**
Support Family Services	Per Day	2	365.00	65.83	**48055.90**	
Transition Assistance Services Total:						**0.00**
Transition Assistance Services	Per Item	1174	0.00	2480.75	**0.00**	

GRAND TOTAL:	**80376881.86**
Total Estimated Unduplicated Participants:	**5869**
Factor D (Divide total by number of participants):	**13695.16**
Average Length of Stay on the Waiver:	319

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**12114507.90**
Case Management	Per Month	5885	11.00	187.14	**12114507.90**	
Prevocational Services Total:						**1540256.08**
Prevocational Services	Per Hour	248	431.00	14.41	**1540256.08**	
Residential Habilitation Total:						**16655071.66**
Consumer directed services direct service provider	Per Hour	2977	188.00	13.58	**7600400.08**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	5403	106.00	15.81	**9054671.58**	
Respite (In-Home and Out—of-Home) Total:						**12453267.54**
Consumer directed services direct service provider	Per Day	2011	16.00	223.93	**7205171.68**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Day	1511	14.00	248.09	**5248095.86**	
Supported Employment Total:						**906784.20**
Consumer directed services direct service provider	Per Hour	147	115.00	26.30	**444601.50**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	147	115.00	27.34	**462182.70**	
Adaptive Aids Total:						**2297929.00**
Adaptive Aids	Per Item	1153	4.00	498.25	**2297929.00**	
Dental Treatment Total:						**472899.90**
Dental Treatment	Per Item	517	1.00	914.70	**472899.90**	
Dietary Total:						**2070.72**
Dietary					**2070.72**	
				GRAND TOTAL:		**89849225.96**
				Total Estimated Unduplicated Participants:		**5885**
				Factor D (Divide total by number of participants):		**15267.50**
				Average Length of Stay on the Waiver:		350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Per Hour	9	4.00	57.52		
Nursing Total:						**2594470.30**
Consumer directed services direct service provider	per Hour	11	1870.00	30.79	**633350.30**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	5440	10.00	36.05	**1961120.00**	
Occupational Therapy Total:						**270975.32**
Consumer directed services direct service provider	Per Hour	26	22.00	74.86	**42819.92**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	167	18.00	75.90	**228155.40**	
Physical Therapy Total:						**793755.44**
Consumer directed services direct service provider	Per Hour	6	52.00	79.52	**24810.24**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	415	23.00	80.56	**768945.20**	
Prescribed Drugs Total:						**943243.20**
Prescribed Drugs	per Rx	279	20.00	169.04	**943243.20**	
Speech and Language Pathology Total:						**227248.98**
Consumer directed services direct service provider	Per Hour	6	28.00	78.34	**13161.12**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	93	29.00	79.38	**214087.86**	
Financial Management Services Total:						**7020815.12**
Financial Management Services	Per Month	3037	11.00	210.16	**7020815.12**	
Support Consultation Total:						**31.98**
Support Consultation	Per Hour	1	2.00	15.99	**31.98**	
Auditory Integration Training/Auditory Enhancement Training Total:						**91725.92**
Auditory Integration Training/Auditory Enhancement Training	Per Hour	44	38.00	54.86	**91725.92**	
Behavioral Support Total:						**308702.94**
Behavioral Support	Per Hour	91	41.00	82.74	**308702.94**	

GRAND TOTAL:	**89849225.96**
Total Estimated Unduplicated Participants:	**5885**
Factor D (Divide total by number of participants):	**15267.50**
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Cognitive Rehabilitation Therapy Total:						**523912.20**
Consumer directed services direct service provider	Per Hour	1	420.00	82.19	**34519.80**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	15	392.00	83.23	**489392.40**	
Continued Family Services Total:						**49019.50**
Continued Family Services	Per Day	2	365.00	67.15	**49019.50**	
Employment Assistance Total:						**547557.12**
Consumer directed services direct service provider	Per Item	88	116.00	26.30	**268470.40**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Item	88	116.00	27.34	**279086.72**	
Minor Home Modifications Total:						**780835.44**
Minor Home Modifications	Per Item	231	1.00	3380.24	**780835.44**	
Specialized Therapies Total:						**29205126.00**
Specialized Therapies	Per Hour	3670	90.00	88.42	**29205126.00**	
Support Family Services Total:						**49019.50**
Support Family Services	Per Day	2	365.00	67.15	**49019.50**	
Transition Assistance Services Total:						**0.00**
Transition Assistance Services	Per Year	1177	0.00	2530.37	**0.00**	
				GRAND TOTAL:		**89849225.96**
				Total Estimated Unduplicated Participants:		**5885**
				Factor D (Divide total by number of participants):		**15267.50**
				Average Length of Stay on the Waiver:		350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**12356616.80**
Case Management	Per Month	5885	11.00	190.88	**12356616.80**	
Prevocational Services Total:						**1571253.60**
Prevocational Services	Per Hour	248	431.00	14.70	**1571253.60**	
Residential Habilitation Total:						**16989453.94**
Consumer directed services direct service provider	Per Hour	2977	188.00	13.85	**7751512.60**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	5403	106.00	16.13	**9237941.34**	
Respite (In-Home and Out—of-Home) Total:						**12702339.86**
Consumer directed services direct service provider	Per Day	2011	16.00	228.41	**7349320.16**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Day	1511	14.00	253.05	**5353019.70**	
Supported Employment Total:						**925041.60**
Consumer directed services direct service provider	Per Hour	147	115.00	26.83	**453561.15**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	147	115.00	27.89	**471480.45**	
Adaptive Aids Total:						**2343910.64**
Adaptive Aids	Per Item	1153	4.00	508.22	**2343910.64**	
Dental Treatment Total:						**482355.83**
Dental Treatment	Per Item	517	1.00	932.99	**482355.83**	
Dietary Total:						**2112.12**
Dietary	Per Hour	9	4.00	58.67	**2112.12**	
Nursing Total:						**2646391.70**
Consumer directed services direct service provider	per Hour	11	1870.00	31.41	**646103.70**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	5440	10.00	36.77	**2000288.00**	
Occupational Therapy Total:						**276402.44**
	Per Hour		22.00	76.36	**43677.92**	

GRAND TOTAL:	**91676421.02**
Total Estimated Unduplicated Participants:	**5885**
Factor D (Divide total by number of participants):	**15577.98**
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consumer directed services direct service provider		26				
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	167	18.00	77.42	**232724.52**	
Physical Therapy Total:						**809618.97**
Consumer directed services direct service provider	Per Hour	6	52.00	81.11	**25306.32**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	415	23.00	82.17	**784312.65**	
Prescribed Drugs Total:						**990394.20**
Prescribed Drugs	per Rx	279	20.00	177.49	**990394.20**	
Speech and Language Pathology Total:						**231800.97**
Consumer directed services direct service provider	Per Hour	6	28.00	79.91	**13424.88**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	93	29.00	80.97	**218376.09**	
Financial Management Services Total:						**7161124.52**
Financial Management Services	Per Month	3037	11.00	214.36	**7161124.52**	
Support Consultation Total:						**32.62**
Support Consultation	Per Hour	1	2.00	16.31	**32.62**	
Auditory Integration Training/Auditory Enhancement Training Total:						**93565.12**
Auditory Integration Training/Auditory Enhancement Training	Per Hour	44	38.00	55.96	**93565.12**	
Behavioral Support Total:						**314859.09**
Behavioral Support	Per Hour	91	41.00	84.39	**314859.09**	
Cognitive Rehabilitation Therapy Total:						**534361.80**
Consumer directed services direct service provider	Per Hour	1	420.00	83.83	**35208.60**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	15	392.00	84.89	**499153.20**	
Continued Family Services Total:						**49997.70**
Continued Family Services	Per Day	2	365.00	68.49	**49997.70**	

GRAND TOTAL:	**91676421.02**
Total Estimated Unduplicated Participants:	**5885**
Factor D (Divide total by number of participants):	**15577.98**
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Assistance Total:						**558581.76**
Consumer directed services direct service provider	Per Item	88	116.00	26.83	**273880.64**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Item	88	116.00	27.89	**284701.12**	
Minor Home Modifications Total:						**796451.04**
Minor Home Modifications	Per Item	231	1.00	3447.84	**796451.04**	
Specialized Therapies Total:						**29789757.00**
Specialized Therapies	Per Hour	3670	90.00	90.19	**29789757.00**	
Support Family Services Total:						**49997.70**
Support Family Services	Per Day	2	365.00	68.49	**49997.70**	
Transition Assistance Services Total:						**0.00**
Transition Assistance Services	Per Item	1177	0.00	2580.98	**0.00**	
				GRAND TOTAL:		**91676421.02**
				Total Estimated Unduplicated Participants:		**5885**
				Factor D (Divide total by number of participants):		**15577.98**
				Average Length of Stay on the Waiver:		350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**12603904.50**
Case Management	Per Month	5885	11.00	194.70	**12603904.50**	
Prevocational Services Total:						**1602251.12**
Prevocational Services	Per Hour	248	431.00	14.99	**1602251.12**	
				GRAND TOTAL:		**93538848.02**
				Total Estimated Unduplicated Participants:		**5885**
				Factor D (Divide total by number of participants):		**15894.45**
				Average Length of Stay on the Waiver:		350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						**17329432.98**
Consumer directed services direct service provider	Per Hour	2977	188.00	14.13	**7908221.88**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	5403	106.00	16.45	**9421211.10**	
Respite (In-Home and Out--of-Home) Total:						**12956423.42**
Consumer directed services direct service provider	Per Day	2011	16.00	232.98	**7496364.48**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Day	1511	14.00	258.11	**5460058.94**	
Supported Employment Total:						**943637.10**
Consumer directed services direct service provider	Per Hour	147	115.00	27.37	**462689.85**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	147	115.00	28.45	**480947.25**	
Adaptive Aids Total:						**2390768.56**
Adaptive Aids	Per Item	1153	4.00	518.38	**2390768.56**	
Dental Treatment Total:						**492003.05**
Dental Treatment	Per Item	517	1.00	951.65	**492003.05**	
Dietary Total:						**2154.24**
Dietary	Per Hour	9	4.00	59.84	**2154.24**	
Nursing Total:						**2699606.80**
Consumer directed services direct service provider	per Hour	11	1870.00	32.04	**659062.80**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	5440	10.00	37.51	**2040544.00**	
Occupational Therapy Total:						**281936.90**
Consumer directed services direct service provider	Per Hour	26	22.00	77.89	**44553.08**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	167	18.00	78.97	**237383.82**	
Physical Therapy Total:						**825778.21**
Consumer directed services direct service provider	Per Hour	6	52.00	82.73	**25811.76**	
					799966.45	

GRAND TOTAL:	**93538848.02**
Total Estimated Unduplicated Participants:	**5885**
Factor D (Divide total by number of participants):	**15894.45**
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	415	23.00	83.81		
Prescribed Drugs Total:						**1039888.80**
Prescribed Drugs	Per Rx	279	20.00	186.36	**1039888.80**	
Speech and Language Pathology Total:						**236438.91**
Consumer directed services direct service provider	Per Hour	6	28.00	81.51	**13693.68**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	93	29.00	82.59	**222745.23**	
Financial Management Services Total:						**7304440.55**
Financial Management Services	Per Month	3037	11.00	218.65	**7304440.55**	
Support Consultation Total:						**33.28**
Support Consultation	Per Hour	1	2.00	16.64	**33.28**	
Auditory Integration Training/Auditory Enhancement Training Total:						**95437.76**
Auditory Integration Training/Auditory Enhancement Training	Per Hour	44	38.00	57.08	**95437.76**	
Behavioral Support Total:						**321164.48**
Behavioral Support	Per Hour	91	41.00	86.08	**321164.48**	
Cognitive Rehabilitation Therapy Total:						**545063.40**
Consumer directed services direct service provider	Per Hour	1	420.00	85.51	**35914.20**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Hour	15	392.00	86.59	**509149.20**	
Continued Family Services Total:						**50997.80**
Continued Family Services	Per Day	2	365.00	69.86	**50997.80**	
Employment Assistance Total:						**569810.56**
Consumer directed services direct service provider	Per Item	88	116.00	27.37	**279392.96**	
Direct services agency holding a CLASS Medicaid provider agreement	Per Item	88	116.00	28.45	**290417.60**	
Minor Home Modifications Total:						**812380.80**

GRAND TOTAL:	**93538848.02**
Total Estimated Unduplicated Participants:	**5885**
Factor D (Divide total by number of participants):	**15894.45**
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Minor Home Modifications	Per Item	231	1.00	3516.80	**812380.80**	
Specialized Therapies Total:						**30384297.00**
Specialized Therapies	Per Hour	3670	90.00	91.99	**30384297.00**	
Support Family Services Total:						**50997.80**
Support Family Services	Per Day	2	365.00	69.86	**50997.80**	
Transition Assistance Services Total:						**0.00**
Transition Assistance Services	Per Item	1177	0.00	2632.60	**0.00**	

GRAND TOTAL:	**93538848.02**
Total Estimated Unduplicated Participants:	**5885**
Factor D (Divide total by number of participants):	**15894.45**
Average Length of Stay on the Waiver:	350