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This manual is intended to inform YES Waiver Providers across the state of Texas of policies and procedures that must be implemented in order to achieve successful implementation of the YES Waiver program. This manual should be used in conjunction with the YES Waiver User Guide as together, these resources will provide greater clarification and technical assistance to YES Waiver Providers and their direct service staff.

The following terms will be used throughout the manual and are defined below:

- **YES Waiver Providers** – any entity that has a contract with HHSC or a subcontractor to provide YES Waiver services. They include Local Mental Health Authorities and Local Behavioral Health Authorities (LMHA/LBHAs), Wraparound Provider Organizations (WPOs), and Comprehensive Waiver Providers (CWPs).

- **YES Program Manager/Supervisor** – the staff person responsible for daily oversight and management of the YES Waiver program, Team Lead(s), and Wraparound Facilitator(s). YES Program Manager/Supervisor to Wraparound Facilitators ratio – 1:7

- **Team Lead** – the staff person(s) responsible for providing regular support to Wraparound Facilitators at an organization. Team Lead to participant caseload ratio – 1:5

- **Direct service staff** – any staff that has direct contact with YES Waiver participants in any capacity at the organization.
1000 Youth Empowerment Services Waiver Overview

Mission and Vision

The mission of the Youth Empowerment Services (YES) Waiver is to ensure that Texas children and youth with serious emotional disturbances (SED) have access to a robust array of community-based services and supports. The program vision is that YES Waiver services are family-centered, coordinated, and effective at preventing out-of-home placement and promoting lifelong independence and self-defined success.

Background and History

Texas strives to provide a continuum of services and supports for families with youth who have serious mental, emotional, and behavioral difficulties. Under the direction of the 78th and 79th Texas Legislatures, the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS) developed the 1915(c) YES Waiver. The Centers for Medicare and Medicaid Services (CMS) approved the YES Waiver in February 2009. In 2013, the 83rd Legislature directed the YES Waiver to expand statewide which was approved by CMS effective September 2015.

The YES Waiver provides short-term, comprehensive home and community-based mental health services to children and youth at risk of institutionalization or out-of-home placement due to their SED.

Children and youth may be enrolled in the YES Waiver program from ages 3 through 18. The average length of stay in the YES Waiver program is 11 to 18 months. However, each participant’s needs will determine their duration in the program. The program provides flexibility in the funding of intensive community-based services and supports for youth and their families.

Waiver enrollment vacancies are allocated by service area to Local Mental Health Authorities or Local Behavioral Health Authorities (LMHA/LMBHAs). Allocation of YES Waiver vacancies is determined by HHSC using information on population size, community need, and local infrastructure. HHSC re-evaluates allocations at least
annually or more often as needed. Unused vacancies will be reallocated to areas with greater demand for services.

**Objectives and Goals of the Waiver**

The objective of the Waiver is to provide community-based services, in lieu of institutionalization, to eligible youth in accordance with the approved Waiver and program capacity.

The goals of the Waiver are to:

- reduce out-of-home placements by all youth-serving agencies;
- reduce inpatient psychiatric treatment by all youth-serving agencies;
- provide a more complete continuum of community-based services and supports;
- ensure families have access to non-traditional support services identified in a family-centered planning process;
- prevent entry and recidivism into the foster care system and relinquishment of parental custody; and
- improve the clinical and functional outcomes of children and youth.

**YES Services and Provider Selection**

Interested individuals are added to the YES Waiver Inquiry List by calling the LMHA/LBHA Inquiry Line.

All participants enrolled in YES Waiver receive Wraparound facilitation from their choice of a Wraparound Provider Organization (WPO). Through the Wraparound planning process, participants will identify strengths, formal and natural supports, strategies, and outcomes to meet underlying needs and achieve the family vision and team mission. YES participants have access to an array of services coordinated and delivered by the participant’s choice of Comprehensive Waiver Provider (CWP). CWPs are obligated to develop a sufficient network of direct service providers to serve families in accordance with the Wraparound Plan. All services the participant receives through the YES Waiver program must be documented in the Wraparound Plan.
Service Array

In addition to Wraparound, the services available through the Waiver are:

- Adaptive Aids and Supports (AA&S);
- Community Living Supports (CLS);
- Employment Assistance;
- Family Supports;
- Minor Home Modifications;
- Non-Medical Transportation;
- Paraprofessional Services;
- Respite (In-Home and Out-of-Home);
- Specialized Therapies:
  - Animal-Assisted Therapy;
  - Art Therapy;
  - Music Therapy;
  - Nutritional Counseling; and
  - Recreational Therapy;
- Supported Employment;
- Supportive Family-Based Alternatives (SFA); and
- Transitional Services.

Variance of Services

The types, locations, and/or availability of services may vary.

Access to Services

Under its contract with HHSC, YES Waiver Providers are required to provide Waiver participants, including those with a disability (e.g., deafness, hard of hearing, and blindness), information about the Waiver in a format and language that is easily understandable and based on the demographics of the population.

Documents that are provided to Waiver participants throughout the enrollment process and service provision will be available in both English and Spanish. If the participant’s primary language is something other than English or Spanish, the LMHA/LBHA, WPO, and CWP are required to enlist the assistance of an interpreter.
Medicaid State Plan Services

Participants enrolled in the Waiver may access all Texas Medicaid State Plan behavioral health services, in addition to YES services delivered by the WPO and CWP. Participants in the Waiver are deviated into Level of Care–YES (LOC–YES) in accordance with the Texas Resilience and Recovery (TRR) mental health system. For more information about LOC-YES, see the “Level of Care” section in the Texas Resilience and Recovery Utilization Management Guidelines for Children’s Mental Health available at:


Contact Information

Further information regarding the Waiver is available through the Health and Human Services Commission:

<table>
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<tr>
<th>Email address</th>
<th><a href="mailto:YESWaiver@hhsc.state.tx.us">YESWaiver@hhsc.state.tx.us</a></th>
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<td><a href="https://hhs.texas.gov/services/mental-health-substance-use/childrens-mental-health/yes-waiver">https://hhs.texas.gov/services/mental-health-substance-use/childrens-mental-health/yes-waiver</a></td>
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<td>Office</td>
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Submitting Complaints and Requests for Fair Hearings

The first step to submit a complaint regarding YES Waiver services is to contact the management of the organization providing the service.

If a resolution cannot be determined and the complaint needs to be escalated, then the participant and legally authorized representative (LAR) should contact their LMHA/LBHA’s Clients’ Rights Department. Any complaint that cannot be resolved, should be submitted through the HHSC Office of the Ombudsman by filing a formal complaint.

**Office:**
Texas Health and Human Services Commission Office of the Ombudsman  
Attn: Behavioral Health Ombudsman  
P.O. Box 13247, Mail Code: H700 Austin, TX 78711-3247

**Toll Free Phone Number:**  
Behavioral Health Ombudsman  
1-800-252-8154

For further information regarding client complaints, including online submissions, please visit:  

Complaints involving allegations of abuse, neglect, or exploitation are referred immediately to the Texas Department of Family and Protective Services (DFPS), the department with statutory responsibility for investigation of such allegations.

**Visibility and Access**
YES Waiver Providers must post the client rights department or protection officer contact information at their local agency. The contact information must be made available upon request and must be posted in both English and Spanish in a
prominent area visible to participants. The posting must include the name, telephone number, and mailing address for the client rights department and/or protection officer. Waiver participants who wish to submit a complaint by phone must be allowed to access the provider’s telephone.

**Right to Fair Hearing**

A participant enrolled in Medicaid may request a Fair Hearing if:

- the participant was found eligible for the Waiver, but was not given the choice of Waiver services as an alternative to institutional care;
- the participant was not given the opportunity to receive services from the WPO provider they chose; or
- Waiver services were denied, suspended, reduced, or terminated.

An interested individual and/or a participant whose request for eligibility for the Waiver program is denied or is not acted upon with reasonable promptness, or a Waiver participant whose Waiver services have been terminated, suspended, or reduced by HHSC, is entitled to a fair hearing in accordance with 26 Texas Administrative Code (TAC) §307.15, Subchapter A. The LMHA/LBHA and/or WPO must notify the participant and LAR of their right to a fair hearing, conducted in accordance with 1 TAC 357, Subchapter A. The notice informs the Waiver participant of the right to continue to receive services while the hearing is pending and the actions the participant or LAR must take for services to continue.

All notification letters and request forms are offered in both English and Spanish or another language if requested.

The LMHA/LBHA must respond to phone calls and emails from HHSC YES Waiver staff and provide any requested information regarding Fair Hearings within **three business days**. LMHA/LBHA providers are also expected to engage in communication with HHSC YES Waiver staff throughout the Fair Hearing process.

**Notification of Right to Fair Hearing**

**Demographic Eligibility**

If during the demographic eligibility screening process an individual is found ineligible for YES services, the LMHA/LBHA must verbally inform the individual of their right to request a Fair Hearing. Within **seven business days** from the date of the demographic eligibility screening, the LMHA/LBHA must mail the Denial of
Eligibility and Fair Hearing Request forms, which should include the reason for denial, via certified mail. Notices may also be delivered in person to the LAR but will require an LAR signature to confirm the notices were received. Both documents and the certified mail confirmation must be added to the individual’s file.

**Initial Clinical Eligibility**

During the initial clinical eligibility process the LMHA/LBHA must verbally inform the individual and the LAR of the individual’s right to a fair hearing. If the individual and LAR needs any assistance with the fair hearing request process, the LMHA/LBHA staff shall provide them with the necessary assistance. If HHSC determines that the individual is ineligible for YES services, the LMHA/LBHA must notify the individual in writing within seven business days from the date of denial from HHSC. The LMHA/LBHA must mail the Denial of Eligibility form and the Fair Hearing Request form, which should include the reason for denial, via certified mail. Notices may also be delivered in person to the LAR but will require an LAR signature to confirm the notices were received. Both documents and certified mail confirmation must be added to the individual’s file.

**Changes in Service for Enrolled Participants**

The WPO must notify Waiver participants and their LAR of their right to request a fair hearing by sending the Denial of Eligibility and Fair Hearing Request Forms whenever the participant is denied continued eligibility in the Waiver program or when any Waiver services documented on the Wraparound Plan are denied, reduced, suspended, or terminated. Per 1 TAC §357.11, the written notice to an individual of the individuals’ right to a hearing must be mailed at least 10 calendar days before the date the individual’s eligibility or service is scheduled to be reduced, suspended, or terminated, except as provided by federal rules.

If a fair hearing is requested before the date a Medicaid recipient’s service, including a service that requires prior authorization, is scheduled to be reduced, suspended, or terminated, the agency may not take that proposed action before a decision is rendered after the hearing in accordance with 1 TAC §357.11.
Consistency with Law

No policy or portion of any policy in this manual is operative if it is determined to be inconsistent with applicable law, rule, or CMS approved YES Waiver documents.
General Requirements

General requirements for an individual to participate in the YES Waiver program include:

- meeting demographic criteria;
- meeting clinical eligibility criteria;
- a reasonable expectation must exist that, without Waiver services, the individual would qualify for inpatient care under the Medicaid Clinical Criteria for Inpatient Psychiatric Care for Clients;
- choosing, or having the LAR choose, the Waiver as an alternative to care in an inpatient psychiatric facility; and
- if enrolled, active participation of the individual and LAR regarding:
  - specified clinical assessments;
  - person-centered planning for community-based services and supports through the Wraparound process; and
  - therapeutic activities for improved clinical outcomes.

An LMHA/LBHA maintains an Inquiry List and administers YES assessments to the individual and submits the information into Clinical Management for Behavioral Health Services (CMBHS) in order for HHSC to determine whether or not the individual is eligible for the YES program. Once determined eligible by HHSC, the LMHA/LBHA completes the enrollment process with the individual and LAR and initiates services.

Additional assessment and planning of appropriate services and service delivery is necessary for an individual with a co-occurring diagnosis of:

- Intellectual and Developmental Disabilities (IDD) – developmental disability (mild, moderate, severe, profound, or unspecified);
- Autism Spectrum Disorder – Rett’s Disorder, Childhood Disintegrative Disorder, Asperger’s Disorder, Pervasive Developmental Disorder (PDD) Not Otherwise Specified; or
- Substance Use Disorder.

[See POLICY - 0 5200 Co-Occurring Diagnosis].
Youth in Substitute Care

Communication with Appropriate Parties

For individuals in substitute care, any phone calls and correspondence shall be copied to the LAR and DFPS Caseworker. If the DFPS caseworker is not engaging in the process, the LMHA/LBHA and/or WPO may contact the DFPS Regional Program Director for support. If the Regional Program Director is not responsive, the LMHA/LBHA or WPO shall contact the HHSC YES Waiver staff.

The Managing Conservator and/or Medical Consenter may make decisions for the YES participant within the authority allowed by DFPS and the Texas Family Code.

Additional information can be found on the DFPS website including:

- the Child Protective Services (CPS) Handbook:
  - https://www.dfps.state.tx.us/handbooks/CPS/default.asp;
- information relative to the role of the Medical Consenter:
  - https://www.dfps.state.tx.us/Child_Protection/Medical_Services/Medical_Consenter.asp; and
- A Guide to Medical Services at CPS:
  - https://www.dfps.state.tx.us/Child_Protection/Medical_Services/default.asp.

Dual Program Enrollment Not Allowed

In order to participate in the Waiver, an individual cannot be dually enrolled in, or receive services from, another 1915(c) waiver or 1915(i) state benefit plan program, including, but not limited to, the following:

- Texas Health and Human Services (HHSC) 1915(c) waiver programs:
  - Community Living Assistance and Support Services (CLASS);
  - Home and Community-Based Services (HCS/HCBS);
  - Medically Dependent Children Program (MDCP);
  - Consolidated Waiver Program (CWP);
  - Deaf Blind with Multiple Disabilities (DBMD);
  - Community-Based Alternatives (CBA); or
  - Texas Home Living (TxHmL).
- HHSC 1915(i) state plan benefit programs, including Home and Community-Based Services—Adult Mental Health (HCBS-AMH).
• Home and Community Based Services (HCBS) STAR+PLUS waiver.
Demographic Criteria

To participate in the YES Waiver program, an individual must meet the following demographic criteria:

- be 3 through 18 years old;
- be eligible to receive Medicaid under an authorized Medicaid Eligibility Group included in the Waiver (see “YES Waiver - Medicaid Overview” at: https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/yes/yes-waiver-medicaid-overview.pdf);
- reside in:
  - the service area of the assessing LMHA; and
  - a non-institutional setting with the individual’s LAR; or
  - the individual’s own home or apartment, if legally emancipated; or
  - a public or private residential treatment center (RTC) (excluding the state operated facility, Waco Center for Youth) or public or private hospital with a planned discharge date of 30 calendar days or less.

Demographic Eligibility Met

If an individual meets demographic eligibility criteria, the LMHA/LBHA shall be responsible for completing the initial face-to-face clinical assessment.

The clinical assessment must be completed within seven business days of completing the demographic eligibility screening.

If the LMHA/LBHA has reached maximum enrollment capacity, the LMHA/LBHA will still be responsible for ongoing maintenance of the Inquiry List, submission of requests for reserved capacity slots, and initiation of clinical eligibility determinations in accordance with YES policy [see POLICY 0 2200 Clinical Criteria and Assessment and POLICY 0 4000 Local Mental/Behavioral Health Authority Responsibilities: Inquiry List].
Demographic Eligibility Not Met

Within **seven business days** of determining that an individual does not meet demographic criteria, the LMHA/LBHA shall:

- send the Denial of Eligibility and Fair Hearing Request forms to the individual and LAR, and if the individual is in substitute care, the Managing Conservator or Medical Consenter;
- refer individuals who live outside of the service area to the LMHA/LBHA in their county of residence for intake and screening of TRR services; and
- provide referrals to other services as applicable.
2200 Clinical Criteria and Assessment

Policy Statement

Clinical eligibility for the YES Waiver requires an individual to have functional impairment or acute, severe psychiatric symptomatology, as identified by the specific domain scores from the Child and Adolescent Needs and Strengths (CANS) assessment as part of the clinical eligibility determination.

In addition, a reasonable expectation must exist that, without Waiver services, the individual would qualify for inpatient care under the Texas Medicaid Clinical Criteria for Inpatient Psychiatric Care for Clients.

Clinical Assessment

Clinical eligibility must be determined prior to initial enrollment and annually, thereafter.

The LMHA/LBHA is responsible for completing the initial assessment for clinical eligibility and the WPO is responsible for completing the 90-day YES Assessment (CANS) and the annual renewal YES Assessments for clinical eligibility. The LMHA/LBHA and WPO must complete the assessment for an individual’s clinical eligibility through a two-part assessment process using the YES Assessment and Clinical Eligibility (CE) document in CMBHS. The YES Assessment consists of the CANS assessment and community data questionnaire. The YES Assessment must be used to determine clinical eligibility for all individuals who are interested in participating in the YES Waiver program. Some of the information required to complete the YES Assessment may be auto-populated from the Mental Health Uniform Assessment (UA), if an available UA has been completed in the past 90 calendar days [see YES User Guide for further information]. The TRR provider is responsible for maintaining required assessments for TRR services in accordance with Utilization Management (UM) Guidelines.

The Child and Adolescent Needs and Strengths Assessment (CANS) is:

- a set of standardized measures used in Texas to determine the level of service for community-based children's mental health care;
- a multi-purpose tool developed to support care planning and Level of Care decision making;
• a tool used to facilitate quality improvement initiatives; and
• a tool that allows for the monitoring of outcomes of services.

The CANS was developed from a collaborative perspective to facilitate the linkage between the assessment process and the design of individualized service plans which include the application of evidence-based practices.

Qualifications to Perform Clinical Assessment and Clinical Eligibility (CE) Document

Assessments for clinical eligibility must be performed face-to-face by a:

• Licensed Practitioner of the Healing Arts (LPHA); or
• Qualified Mental Health Professional for Community Services (QMHP-CS)
  ‣ An LPHA must review and sign the assessment, confirm the individual would qualify for inpatient care under the Medicaid Clinical Criteria for Inpatient Psychiatric Care for Clients, and make their own recommendation regarding Level of Care.

Clinical Eligibility Determination Process

Initial Eligibility

Initial clinical eligibility can only be assessed by the LMHA/LBHA in accordance with the following process:

• Once the individual has met demographic criteria, the LMHA/LBHA must schedule and administer a face-to-face clinical assessment conducted by an LPHA or QMHP-CS with the individual and LAR. The assessment must be completed within seven business days when the LMHA/LBHA has not reached maximum capacity.
• A Level of Care (LOC) authorization is necessary to access TRR services including Intensive Case Management and other Texas Medicaid State Plan services. LOC authorization must be deviated to LOC-YES for all enrolled participants.
• Authorization for TRR services through LOC-YES occurs independently from enrollment into the YES Waiver. An LOC-YES authorization is effective for 90 calendar days.
• When the LMHA/LBHA is at maximum capacity an individual may not be assessed for clinical eligibility until 30 calendar days in advance of a
vacancy becoming available. It is recommended that an assessment be scheduled as far in advance as allowable. The LMHA/LBHA must complete the clinical eligibility assessment no later than seven business days following the vacancy becoming available.

- Within **five business days** of completing the YES Assessment, the LMHA/LBHA must:
  - verify the individual’s Medicaid eligibility. A Medicaid Eligibility Verification (MEV) request must be submitted to CMBHS. Instructions on submitting an MEV request to CMBHS are available at: https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/yes/cmbhs-mh-medicaid-eligibility-verification.pdf. Additionally, the individual’s Medicaid status must be verified through the Texas Integrated Eligibility Redesign System (TIERS) at: https://www.txtiers.net/portal.
  - For an individual with Medicaid, an initial CE document shall be entered into CMBHS.
  - For an individual without Medicaid, a pending CE document is entered into CMBHS, and the LMHA/LBHA must then assist the individual in applying for Medicaid.

**Annual Renewal Eligibility**

Clinical eligibility must be re-assessed annually by the WPO in accordance with the following process.

Prior to completing an annual renewal Individual Plan of Care (IPC), a clinical re-assessment must be performed by the selected WPO to determine whether the participant continues to meet clinical eligibility to participate in the Waiver. The assessment should consider prior documented progress the participant has made, recent critical incidents, hospitalizations, juvenile justice involvement, and any other contributing documentation that the participant, LAR, and Child and Family Team (CFT) believe should be considered during the annual renewal. The YES Assessment, must be reflective of the CFTs collective understanding and agreement of the participant’s underlying needs, strengths, and progress.

The YES Assessment should be administered every 90 days and discussed monthly during the CFT meeting. For this reason, the outcome of the annual re-assessment should not deviate from the prior CANS in a way that does not trend with the participant’s prior documented progress unless there is additional information that conveys a rapid change in progress.
Additionally, if the Wraparound Facilitator for the participant is not the person performing the clinical re-assessment, the Wraparound Facilitator is responsible for sharing with the assessor, participant, and the LAR any information related to the following:

- hospitalization history for the past three months;
- juvenile justice history for the past three months;
- critical incidents for the past three months; and
- any other information the CFT believes would be relevant and necessary to provide a holistic representation of the participant’s experience at the time of annual renewal.

The clinical re-assessment must be reflective of the documentation provided at the time of the assessment. HHSC reserves the authority to authorize or deny clinical eligibility. The participant should be formally notified of the eligibility determination after the WPO receives authorization from HHSC through CMBHS.

An ‘Annual Renewal’ CE must be entered in CMBHS before the previously authorized CE expires.

To avoid a lapse in service authorization and program eligibility, the annual renewal assessment can be scheduled up to 30 calendar days prior to, but no later than, 10 business days of the CE expiration date. Early scheduling and submission of annual renewal documentation will ensure that there is not a lapse in services and that adequate time is given for the HHSC review and approval process, electronic data transmission, and notification to the participant for the right to a fair hearing.

Assessment Criteria

An individual must meet the clinical Level of Care criteria in accordance with all Criteria A through E in order to qualify for the YES Waiver program. HHSC reserves the authority to authorize or deny clinical eligibility. The participant should be formally notified of the eligibility determination after the LMHA/LBHA or WPO receives authorization from HHSC through CMBHS.

Criterion A

Criterion A indicates that an individual’s level of functioning supports an expectation that the individual can actively participate and benefit from mental-health-focused Waiver services delivered through a Wraparound process.
Exception

This exception policy is only applicable to individuals who meet all eligibility criteria except Criterion A. In these cases, the clinician may provide additional information to HHSC which:

- justifies how the individual can participate in and benefit from mental health focused Waiver services; and
- will sufficiently address the individual’s reason for referral and needs that may result in psychiatric institutionalization.

The HHSC YES Waiver Department will evaluate the additional information to determine eligibility for Waiver services.

Criterion B

Individuals must exhibit mental health needs that require the intensity of mental health services available through the YES Waiver as determined by the YES Assessment including the CANS.

Criterion C

Outpatient therapy or partial hospitalization must have been attempted and failed or a psychiatrist must have documented reasons why an inpatient Level of Care is required. Previously attempted outpatient therapy is defined as therapy at any mental health clinic, school-based counseling, and/or partial hospitalization.

Criterion D

A Medicaid-eligible individual must meet at least one of the following Medicaid Clinical Criteria for Inpatient Psychiatric Care for Clients:

1. The individual is presently a danger to self, demonstrated by at least one of the following:
   (A) recent suicide attempt or active suicidal threats with a deadly plan and an absence of appropriate supervision or structure to prevent suicide;
   (B) recent self-injurious behavior or active threats of same with likelihood of acting on the threat and an absence of appropriate supervision or structure to prevent self-injury; i.e., intentionally cutting, burning, or the like;
(C) active hallucinations or delusions directing or likely to lead to serious self-harm or debilitating psychomotor agitation or intellectual disability resulting in a significant inability to care of self; or
(D) significant inability to comply with prescribed medical health regimens due to concurrent primary psychiatric illness and such failure to comply is potentially hazardous to the life of the individual.

2. The individual is a danger to others. This behavior should be attributable to the individual’s specific SED/mental health diagnosis in accordance with the current Diagnostic and Statistical Manual (DSM) and can be adequately treated only in a hospital setting. Danger is presented by:
   (A) recent life-threatening action or active homicidal threats of same with a deadly plan and availability of means to accomplish the plan with the likelihood of acting on the threat;
   (B) recent serious assaultive or sadistic behavior or active threats of same with the likelihood of acting on the threat and an absence of appropriate supervision or structure to prevent assaultive behavior; or
   (C) active hallucinations or delusions directly or likely to lead to serious harm of others.

3. The individual exhibits acute onset of psychosis or severe thought disorientation, or there is significant clinical deterioration in the condition of the individual with chronic psychosis, rendering them unmanageable and unable to cooperate in treatment. This individual is in need of assessment and treatment in a safe and therapeutic setting.

4. The individual has a severe eating or substance use disorder, which requires 24-hour a day medical observation, supervision, and intervention.

5. The proposed treatment or therapy requires 24-hour a day medical observation, supervision, and intervention.

6. The individual exhibits severe disorientation to person, place, or time.

7. The individual’s evaluation and treatment cannot be carried out safely or effectively in other settings due to severely disruptive behaviors, including, but not limited to, physical, psychological, or sexual abuse.

8. The individual requires medication therapy or complex diagnostic evaluation where level of functioning precludes cooperation with the treatment regimen.

**Physician Review Required**

If an individual meets all criteria for clinical eligibility except for Criterion D, the Texas Medicaid Inpatient Psychiatric Admission Guidelines, a physician must review the assessment, which can be done through:
• chart review;
• face-to-face assessment; or
• telemedicine assessment with the individual.

The physician must also provide their signature to indicate that they agree the individual does not meet Criterion D. The LMHA/LBHA shall secure a physician signature, notate the name of the physician on the CE in CMBHS, and maintain a copy of the document in the individual’s file.

Criterion E

The individual must have a valid mental health diagnosis as the principal admitting diagnosis, excluding a single diagnosis of substance use disorder, autism, intellectual disability (ID) or developmental disability (DD).

Clinical Eligibility Determination – Initial and Annual Renewal

The YES Assessment and CE document must be submitted in CMBHS for HHSC to review. A CE document must be submitted in CMBHS for every assessed individual whether or not eligibility criteria is met. HHSC reserves the authority to approve or deny clinical eligibility. The individual should be formally notified of the eligibility determination after formal notice is received from HHSC through CMBHS.

Clinical Eligibility Met and Intake Process

Once the initial CE document is authorized by HHSC, the LMHA/LBHA begins the intake process with the participant and LAR and provides them with:

- the YES Waiver Enrollment Packet available at: https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers;
- the YES Family Guide;
- a copy of the Department of State Health Services/Health and Human Services Handbook of Consumer Rights: Mental Health Services, available at: https://hhs.texas.gov/sites/default/files/documents/about-hhs/your-rights/office-ombudsman/mh-consumer-rights-handbook.pdf; and
For the complete enrollment process for an individual with or without Medicaid, [see POLICY 0 2500 Enrollment Process]. More information can be found in the YES Waiver User Guide and the “YES Waiver – Medicaid Overview” document at:


Once enrolled, Wraparound services will be initiated, and the participant and LAR shall be offered the choice of any qualified WPO within their service area. The Wraparound Facilitator must be assigned to the participant within two business days and the participant and LAR must meet with the Wraparound Facilitator within seven business days from enrollment.

If the participant and LAR select a WPO other than the LMHA/LBHA, all documents shall be sent to the selected provider in accordance with [POLICY 0 5400 Participant Transfers].

**Clinical Eligibility Not Met**

If the initial CE submitted by the LMHA/LBHA or the annual renewal CE submitted by the WPO is not authorized or if clinical eligibility is denied by HHSC for any reason, within seven business days of the denial, the LMHA/LBHA or WPO shall:

- send the Denial of Eligibility and Fair Hearing Request Forms to the individual, LAR and/or the DFPS Caseworker, if the individual is in substitute care;
- refer the individual to intake and screening for TRR services as appropriate; and
- provide referrals to other services as appropriate.
2300 Medicaid Criteria

Policy Statement

In order to receive YES Waiver services, an individual must obtain and maintain Medicaid coverage. The LMHA/LBHA shall assist interested individuals in applying for Medicaid in order to participate in the Waiver. The WPO shall assist enrolled participants in submitting required application materials in order to maintain Medicaid. For more information about Medicaid, refer to the “YES Waiver – Medicaid Overview” document at:


YES Waiver services, including Wraparound and the CWP service array, cannot begin prior to authorization of the participant’s Individual Plan of Care (IPC). If a participant receives Waiver services prior to the authorization of the IPC, the YES Waiver Provider who coordinated the service will not receive payment for the service(s) rendered.

Financial Criteria

An individual must meet the applicable federal financial participation limits to obtain Medicaid benefits in one of the Medicaid Eligibility Groups, as follows:

1. Low-income families with children, as provided in §1931 of the Social Security Act (“Act”);
2. Supplemental Security Income (SSI) recipients;
3. Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act; and
4. All State Plan groups, EXCEPT:
   a. Early Aged Widow(er) – §1634(b);
   b. Disabled Widow(er) – §1634 (d);
   c. Disabled Adult Children – §1634(c).
STAR Kids Coordination

YES participants in DFPS conservatorship are enrolled in STAR Health. All other YES participants will be enrolled in STAR Kids. Coordination with the managed care organization (MCO) for all non-Waiver services including other state plan services is required.

The WPO shall ensure coordination with the child’s MCO through STAR Kids or STAR Health, in accordance with 26 TAC §301.321.

Individual Without Medicaid

An individual who is otherwise not eligible to receive Medicaid must obtain Medicaid to participate in the Waiver. The individual must meet the SSI disability requirements under the special income limit group. Parental income and resources are not included in determining a youth’s income.

The special income limit is 300% of the SSI full Federal Benefit Rate (FBR).

If an individual receives Social Security, Railroad Retirement benefits, or previously received SSI benefits and was denied Medicaid for reasons other than not meeting disability requirements, the disability requirement for the special income limit group will be considered met. For all others, HHSC will provide a disability determination.

Medicaid Disability Determination

When a disability determination is required for an individual who is applying for Medicaid, the LMHA/LBHA or WPO must assist the individual and the LAR with completing and submitting the applicable forms and documents online at:


Failure to submit all documentation will result in a delay in Medicaid eligibility determination.

Qualified Income Trust

If individuals are ineligible for Medicaid benefits because their income exceeds the special income limit, the individual or LAR has the option of establishing a Qualified Income Trust (QIT). Information on how to establish a QIT is available in 1 TAC §358.339.
HHSC will determine a required co-payment amount for an individual who has a QIT and also receives a Waiver service. A Waiver Provider must collect the co-payment prior to billing HHSC for services.

**Medicaid Application**

For additional information regarding the Medicaid application, forms, and supporting documentation requirements, [see POLICY 0 2400 Medicaid Benefits].

**No Response During Enrollment Process**

If the individual has Medicaid but the LMHA/LBHA does not receive a response from the individual, LAR, or DFPS Caseworker for an individual in substitute care regarding enrolling in the YES program, the LMHA/LBHA must make at least two phone calls and send at least two letters via certified mail to the LAR and the individual within a **60 calendar day** period. If the LMHA/LBHA still does not receive a response from the LAR or the individual, the LMHA/LBHA will send the Letter of Withdrawal.
Medicaid Application Process and Requirements

The LAR and Medical Consenter are responsible for completing and submitting all applicable Medicaid forms and supporting documentation online at:

https://www.yourtexasbenefits.com/Learn/Home.

The LMHA/LBHA and WPO shall make the Medical Consenter aware of the H1826 form. The H1826 form authorizes the release of information to the LMHA/LBHA and/or WPO to assist in the application process.

Initiating Medicaid

If the participant is not already enrolled in a suitable form of Medicaid, the LMHA/LBHA or WPO shall assist the LAR and/or Medical Consenter through the Medicaid application process including completing and submitting required forms and documentation.

Maintaining Medicaid

Once enrolled in the Waiver, participants are required to maintain Medicaid benefits in order to receive Waiver services. The WPO must assist a participant and LAR in renewing Medicaid benefits in accordance with HHSC rules. YES Waiver Providers are responsible for verifying a participant’s Medicaid benefits at the beginning of each month and prior to rendering YES Waiver services. Services delivered to a participant without active Medicaid may not be reimbursed.

Forms

The following forms may be necessary during the Medicaid application process:

- completed H1200 – Application for Assistance including information for the YES participant only;
- completed H1746A – Medicaid for Employed People with Disabilities (MEPD) Referral Cover Sheet;
include the following statement in the ‘Comments’ section: “Medical Necessity, Level of Care, and Waiver clinical eligibility have been established. This is a children’s mental health Waiver and parental income does not apply. Services will begin as soon as financial certification is complete”;
• the name and phone number for the LMHA/LBHA case manager/ Wraparound Facilitator;
• include financial verification such as bank statements dated to the first of the month if any resources are listed; and
• completed H1826 – Case Information Release authorizing the LMHA/LBHA or WPO to access information from the case record.

If the participant has never received disability-related Medicaid, then additional documentation may be required.

Supporting Documents

Supporting documentation includes, but is not limited to:

• school records, such as:
  ‣ Admission, Review, and Dismissal (ARD) report;
  ‣ Individual Education Program (IEP) report; or
  ‣ Section 504 report;
• Form DDS 9954A – Speech and Language Report;
• Form DDS 9954 – School Activity Report;
• bank statements, if participant has access to account or participant name is listed on the account;
• copy of trust fund document, if applicable;
• copy of participant’s life insurance policy, if applicable;
• medical history;
• psychiatric diagnosis; and
• psychiatric hospital discharge paperwork, if applicable.

Determination of Medicaid Benefits

Upon receipt of a completed Medicaid application, the HHSC Access and Eligibility Section makes a determination of Medicaid benefits within:

• 45 calendar days, when disability determination is not required; or
• 90 calendar days, when a disability determination is required.
Notice of Approval or Denial

Notice of the approval or denial of Medicaid is sent directly to the LAR or Medical Consenter. If a completed H1826 Case Information Release Form was submitted with the application, the WPO will also receive notification of the approval or denial of the application. The LAR or Medical Consenter is responsible for notifying the WPO of the approval or denial of Medicaid for the participant.

Approval

Upon approval of Medicaid benefits, HHSC establishes the Medicaid Effective Date (MED) in the Texas Integrated Eligibility Redesign System (TIERS).

Denial

Within **seven business days** of notification of Medicaid denial, the WPO must:

- assure the individual and LAR receive the Denial of Eligibility form and the Fair Hearing Request Form;
- inform the individual and LAR that they may call the Inquiry Line to be added to the Inquiry List in the order their call was received if the Medicaid determination is overturned;
- provide referrals to other services through the LMHA/LBHA or the community as applicable.

Pre-Engagement Services

The LMHA/LBHA may bill for Pre-Engagement services through a manual billing process, in accordance with [POLICY 0 9000.8 Billing: Pre-Engagement Services] if:

- a participant and family choose a WPO other than the LMHA/LBHA; or
- a participant is determined clinically eligible for the Waiver by HHSC but is not approved for Medicaid.

The LMHA/LBHA is required to complete the YES Pre-Engagement Invoice template and the B-13 State of Texas Purchase Voucher. Once completed the documents must be signed and either emailed or mailed to the following addresses:

<table>
<thead>
<tr>
<th>Email</th>
<th><a href="mailto:YESWaiver@hhsc.state.tx.us">YESWaiver@hhsc.state.tx.us</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mail</td>
<td>C/O HHSC YES Waiver</td>
</tr>
<tr>
<td></td>
<td>8317 Cross Park Dr, Suite 350</td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78754</td>
</tr>
</tbody>
</table>
2500 Enrollment Process

Participants With Medicaid

Policy Statement: Clinical Eligibility Determination

A CE document submitted by the LMHA/LBHA and authorized by HHSC is valid for 365 days from the CE date in Clinical Management for Behavioral Health Services (CMBHS). The CE is not equivalent to length of stay for the participant in the Waiver and does not guarantee that the participant will need Wraparound services for an entire year. Length of stay will be determined based on the participant’s unique needs and reason for referral. Wraparound has been proven most effective within 11 – 18 months.

Procedure: Enrollment Service Initiation

The WPO shall follow these steps to initiate services:

1. Within 10 business days of being selected by the participant and/or receiving a CE authorization:
   (A) Maintain an authorization for LOC-YES from the STAR Kids or STAR Health MCO;
   (B) Develop an effective Crisis Safety Plan during the initial meeting with the participant and LAR; and
   (C) Initiate the Wraparound process and complete the IPC.

2. Within an additional five business days of the CE authorization:
   (A) Submit a Medicaid Eligibility Verification (MEV) into CMBHS and confirm eligibility status.
   (B) Submit the initial IPC (initial service authorization request) in accordance with [POLICY 0 5100 Individual Plan of Care Requests].

Authorization Number Verification

After the initial IPC is authorized by HHSC, the WPO must review the IPC in CMBHS and confirm that the Texas Medicaid Healthcare Partnership (TMHP) has assigned the IPC an authorization number and communicate authorization status to the CWP. This should not be the final IPC. Once the CFT meets with both natural and formal supports, the team will edit the IPC to better meet the needs of the participant and will continue to update the IPC throughout the Wraparound process.
Participants Without Medicaid

Policy Statement: CE Pending

A CE document is authorized by the HHSC YES Waiver staff in ‘Pending Status’ in CMBHS for a participant who does not have Medicaid.

Procedure: Pending CE Authorized

After HHSC authorizes the pending CE, the LMHA/LBHA is responsible for:

- assisting the LAR or Medical Consenter with the Medicaid application process; and
- continuing the Wraparound process and developing an effective Crisis and Safety Plan.

Procedure: Pending CE Denied

If an individual’s pending CE is denied by HHSC, within seven business days the LMHA/LBHA must:

- send the individual and LAR the Denial of Eligibility and Fair Hearing Request forms; and
- provide referrals to other services in the LMHA/LBHA or the community as applicable.

Medicaid Application

Pending

If 90 days pass before Medicaid is approved and YES Waiver services have not begun (not including TRR services) for a participant whose Medicaid application is pending, the LPHA must complete a new YES Assessment and enter it into CMBHS. The LMHA/LBHA or WPO should assist the participant and LAR in contacting Regional Medicaid representatives if applicants are unable to obtain Medicaid within 90 days.
Approved

If the participant’s Medicaid application is approved by the HHSC Access and Eligibility Section, the LPHA must submit the ‘Initial’ CE in CMBHS to the HHSC YES Waiver Department within **seven business days**.

The LMHA/LBHA then completes the process of enrolling the participant into the Waiver [see POLICY 0 2500 Enrollment Process].

Denied

If the individual’s Medicaid application is denied by the HHSC Access and Eligibility Section, within **seven business days** the LMHA/LBHA must:

- send the Denial of Eligibility and Fair Hearing Request forms;
- refer the individual to intake and screening for TRR services as appropriate;
- and
- provide referrals to other services as applicable.
2600 Participant Rights and Responsibilities

Participant Rights

Participants in the YES Waiver have guaranteed rights and responsibilities. These rights include:

- choice of community-based services rather than institutional care;
- choice of Wraparound Provider Organization (WPO);
- choice of service providers;
- choice of CFT members and option to add members at any time; and
- option to file complaints and request Fair Hearings in accordance with POLICY 0 1100 Complaints and Fair Hearings.

All services shall be identified through Wraparound using a strengths-based, family-driven planning process within the CFT meeting and shall be documented in the Wraparound Plan and the IPC.

Participant Responsibilities

In order for the participant, LAR, and Wraparound Facilitators to maximize the benefits from this Waiver and its service array, the following responsibilities are expected of Waiver participants:

- active participation in CFT meetings and in the development and updating of the Crisis and Safety Plan, Wraparound Plan, transition plan, and IPC by:
  - identifying and reaching out to individuals as potential members the CFT;
  - working with all CFT members in identifying and agreeing to desired services for the participant;
  - participating in scheduling and attending service appointments and being engaged throughout the meetings/appointments;
  - notifying the Wraparound Facilitator when unable to attend a scheduled meeting; and
  - agreeing to reschedule missed appointments as necessary.
- engagement in discussion to modify the IPC with the CFT at any time during the Wraparound process. Reasons for modifications include, but are not limited to:
  - identification of additional services that may assist in treatment;
• determination that the type or quantity of a service is no longer clinically necessary or beneficial treatment;
• participant’s request to opt out; or
• participant’s decision not to participate in the program.

• participation in ongoing eligibility determinations and authorizations by:
  • scheduling and attending the face-to-face assessments, including participating in the discussion with the CANS administrator;
  • answering questions regarding Medicaid and informing the YES Waiver Providers if any changes are made to Medicaid status;

• provision of notification to the Wraparound Facilitator of any changes in living arrangements or location of residence including:
  • change in primary residence that is not with the LAR;
  • moving outside of the Waiver service area; and
  • accessing residential or institutional services that are not community-based.

• provision of notification to the Wraparound Facilitator of any changes in financial status that may affect eligibility to participate in the Waiver including:
  • personal income and resources (LAR income and resources are not considered); and
  • notification that Medicaid benefits are denied, will be denied, or that additional information is required to determine eligibility or complete the application.

• participants and/or their LARs will work together with their Wraparound Facilitator and all members of the CFT should be part of the decision-making process when determining the most appropriate services for the participant. All decisions related to needs, strategies, services, and role assignments shall be listed on the Wraparound Plan.

CFT members shall regularly discuss any barriers or concerns about needs, strategies, services, and role assignments with the Wraparound Facilitator and the CFT.

**Enrollment Packet Forms**

Acknowledgment of participants rights and responsibilities will be documented through the forms included in the YES Waiver Enrollment Packet.
All of the forms included in the Enrollment Packet must be completed at the time of initial enrollment by the LMHA/LBHA and annually at the time of annual renewal by the WPO.

The enrollment forms are available in both English and Spanish and can be found here:


**Freedom of Choice**

In accordance with federal rule, a participant and LAR have the freedom to choose:

- to receive services through either an institutional program or through the YES Waiver;
- the WPO for Wraparound services and coordination of YES Waiver services;
- the CWP from which to receive YES Waiver services; and to the extent possible, the individuals directly providing YES Waiver services.

**Institutional Program or YES Waiver Program**

The participant’s and LAR’s choice to receive services through either an institutional program or through the Waiver program must be documented on the Freedom of Choice form as part of the Enrollment Packet. The Freedom of Choice form must be maintained in the participant’s file in accordance with [POLICY 0 3700 Record Keeping].

The Freedom of Choice form is available at:

https://hhs.texas.gov/laws-regulations/forms/search-results?field_form_number_range_tid=All&title_1=2809&title=&body_value=&=Apply.

**Comprehensive Waiver Provider**

The participant and LAR have the freedom to choose an HHSC approved CWP within their county from which to receive YES Waiver services. The participant and LAR may choose among qualified CWPs within their county at any time.
The LMHA/LBHA or WPO assists the participant and LAR in the initial selection of a CWP by:

- providing a list of all approved CWPs serving the participant’s county of residence that must include location, contact information, and phone number; and
- providing appropriate descriptions of and standardized materials for each CWP.

The participant’s and LARs choice of CWP must be documented on the Provider Selection Form, as part of the Enrollment Packet in accordance with [POLICY 0 3700 Record Keeping].

The Provider Selection Form is available at:


**Wraparound Provider Organization**

The participant and LAR have the freedom to choose a qualified WPO within their county from which to receive Wraparound services. The participant and LAR may choose among qualified WPOs within their county at any time.

The LMHA/LBHA assists the participant and LAR in the initial selection of a WPO by:

- providing a list of all approved WPOs serving the participant’s county of residence that must include location, contact information, and phone number;
- providing appropriate descriptions of and standardized materials for each WPO; and
- assisting the participant or LAR to contact the correct Managed Care Organization (MCO), if necessary.

The participant’s and LAR’s choice of WPO must be documented on the Provider Selection Form and maintained in the participant’s file any time a change in WPO is made in accordance with [POLICY 0 3700 Record Keeping].

The Provider Selection Form is available at:

If the participant and LAR have selected a WPO other than the LMHA/LBHA and the participant is in substitute care, the LMHA/LBHA will share the DFPS Caseworker information and the DFPS Enrollment Process Form with the selected WPO.

**Direct Service Providers**

To the extent possible, the participant and LAR have the freedom to choose the individuals providing direct services.

**Participant Agreement**

Prior to receiving Waiver services, the LMHA/LBHA and WPO shall review the Participant Agreement form with the participant and LAR to explain the expectations and responsibilities they must fulfill during participation in the Waiver. The participant and LAR must sign the form to convey agreement with the expectations. This must be completed at initial enrollment, annual renewal, and during the transfer process.

The Participant Agreement Form must be maintained in the participant’s file in accordance with [POLICY 0 3700 Record Keeping].

The Participant Agreement Form is available at:


**Release of Information**

The participant, LAR, Wraparound Facilitator, and all direct services providers from a CWP must sign a Release of Information form to permit the exchange of information regarding the participant’s services, progress, and other information deemed necessary prior to delivering services to the participant.

The Wraparound Facilitator must send signed copies of the completed Enrollment Packet to the DFPS Managing Conservator at the time of initial enrollment, annual renewal, and the transfer process.

**Coordination with Managing Conservators**

The WPO shall ensure coordination and exchange of information with the DFPS Managing Conservator to assist in duties and responsibilities towards participants in
substitute care. The Managing Conservator should be involved in the Wraparound process in the same manner as an LAR would be involved in the process.

These responsibilities include:

- the right to Fair Hearing Requests [POLICY 0 1100 Complaints and Fair Hearings];
- to be informed of the right to a choice of providers [POLICY 0 2600 Participant Rights and Responsibilities];
- participation in the Wraparound Plan development and monitoring of Waiver services [POLICY 0 5000 Wraparound Provider Organization Responsibilities]; and
- participation in transition planning for the participant [POLICY 0 5300 Transition Plan].
YES Waiver Providers, including subcontracted providers, are responsible for meeting the following YES Waiver requirements:

- provider credentialing;
- criminal history and background checks;
- reporting critical incidents;
- reporting abuse, neglect, and exploitation;
- medication management;
- use of restrictive interventions;
- general training and technical assistance; and
- YES Waiver program visibility.

In addition, YES Waiver Providers must assume role-specific responsibilities as conveyed in YES Waiver policies and must adhere to all YES contract stipulations.
Policy Statement

In addition to Provider Credentialing, YES Waiver Providers must conduct thorough criminal background checks prior to employment and thereafter as required. YES Waiver Providers must assure the following pre-employment registry checks are completed for all employees, interns, volunteers, and contracted or subcontracted providers prior to employment or assignment regardless of the activities the person will be performing:

- criminal history and abuse registry checks (performed annually);
- List of Excluded Individuals/Entities (LEIE) state and federal registry check (performed monthly);
- Nurse Aide state registry check (performed annually); and
- Employee Misconduct Registry (EMR) state registry check (performed annually).

Any person who is listed as having a finding in any of the registry checks listed above concerning abuse, neglect, exploitation, or misconduct of a consumer or misappropriation of property may not be employed or serve as a volunteer or intern.

If an employee, intern, volunteer, and contracted or subcontracted provider is listed as having a finding in any of the registry checks listed above then the employer must immediately discharge the employee, intern, volunteer, and contracted or subcontracted provider. If any exclusion is found it must also be reported immediately.

Procedure

Pre-employment criminal history and background checks must be conducted annually and in accordance with 25 TAC 414, Subchapter K. If the person lived outside the state of Texas at any time during the previous two years, then the criminal history check must include submission of fingerprints to the Federal Bureau of Investigation (FBI). A person who has been convicted of any of the criminal
offenses delineated in 25 TAC 414, Subchapter K may not be employed or serve as a volunteer or intern.

**Nurse Aide Registry**

HHSC reviews and investigates allegations of abuse, neglect, or misappropriation of property by nurse aides. If there is a finding of an act of abuse, neglect, or misappropriation, the nurse aide must not be employed by, or serve as an intern or volunteer with, an entity providing Waiver services.

Consolidated results for both the Nurse Aide Registry and the Employee Misconduct Registry are available at:

[https://emr.dads.state.tx.us/DadsEMRWeb/emrRegistrySearch.jsp](https://emr.dads.state.tx.us/DadsEMRWeb/emrRegistrySearch.jsp)

**Employee Misconduct Registry**

The Employee Misconduct Registry (EMR) is used to determine whether an individual has committed an act of abuse, neglect, exploitation, misappropriation, or misconduct. Individuals who have engaged in misconduct are listed in the registry and are unemployable and disallowed from providing any type of Waiver services through employment or as an intern or volunteer.

**Federal Registries**

Any entity providing Waiver services must run monthly LEIE checks on each service provider in accordance with the Code of Federal Regulations (CFR), section §455.436.

**Reporting Background and Registry Checks**

Any WPO and CWP contracted providers serving YES Waiver participants are responsible for adhering to [POLICY 0 3100 Criminal History and Federal and State Registry Checks]. YES Waiver Providers are responsible for tracking dates the background and registry checks were conducted for each employee, intern, volunteer, and contracted or subcontracted provider. YES Waiver Providers are responsible for establishing a formal and internal process on how this information exchange will be managed and documented in order to ensure the safety of YES Waiver participants.
Additionally, all background and registry check documentation for employees, interns, volunteers, and contracted providers and their service providers must be both readily available and accessible for the YES Quality Management team to review during desk and onsite reviews.

Results of criminal history and registry checks must be documented and stored as part of the YES Waiver Providers’ personnel files in accordance with [POLICY 0 3700 Record Keeping]. The process and documentation must occur in accordance with 25 TAC 414, Subchapter K.

**Documentation**

WPOs and CWPs providing services to YES Waiver participants are required to maintain a formal documented process for keeping pre-employment criminal history background checks, Nurse Aide registry, Employee Misconduct registry, and LEIE findings, as well as all annual Nurse Aide registry, annual Employee Misconduct registry, and monthly LEIE findings after the date of hire, up to date on all individuals providing Waiver services including subcontractors. A criminal background and registry check of the owner of the contracted provider that employs multiple service providers does not satisfy this requirement. Each service provider employed by the contracted provider must have a unique date for when their background and registry checks were conducted. WPOs and CWPs will need to have this information documented in their personnel files for every provider that is providing a Waiver service to participants in their program.

**Notification of Change in Criminal History**

Any entity providing YES Waiver services must notify the HHSC YES Waiver Department and the WPO of any changes to the criminal history and/or abuse registry check for any individual who has been involved in providing Waiver services, in writing to the YES Waiver inbox (YESWaiver@hhsc.state.tx.us), within three business days of discovering the change in the criminal history or abuse registry. Notification to other administrative bodies must be conducted in accordance with national, state, local, and agency policy.
The first employee of a YES Waiver Provider with knowledge of an incident are required to submit a Critical Incident Report (CIR) for all critical incidents that result in substantial disruption of program operation involving or potentially affecting a YES Waiver participant to the Wraparound Facilitator within **one business day**.

Wraparound Facilitators must report all incidents involving Waiver participants secure email to the HHSC YES Waiver Inbox (**YESWaiver@hhsc.state.tx.us**) within **72 hours** or **three business days**, by completing a Critical Incident Reporting form.

The Wraparound Facilitator is responsible for notifying all CFT members of the critical incident and documentation about the critical incident must be included in the updated Wraparound Plan and Crisis and Safety Plan. CFT members should work together to review and update strategies, needs, and services in order to properly address the participant’s current situation.

Depending on the type of incident, HHSC may need additional information about the incident and will call the provider to obtain this information. Providers are expected to answer and return all calls from HHSC within **24 business hours or one business day**.

HHSC monitors critical incidents during every Quality Management (QM) review and is responsible for overseeing the reporting of, and response to, critical incidents, and reserves the right to conduct onsite reviews with or without prior notice.

The Critical Incident Report template is available at:


Examples of incidents required to be reported include, but are not limited to:

- medical injuries that result in emergency room visits;
- hospitalization admissions;
- behavioral or psychiatric emergencies that result in admission to a psychiatric facility;
- allegations of violation(s) of participant rights;
allegations of abuse, neglect, or exploitation;
CPS Custody;
criminal activity that results in arrest or charges being filed;
applied restraint or seclusion of participant;
medication errors;
participant departure (e.g. running away) that will result in disruption of planned services;
property or vehicle loss or damage;
legal/juvenile justice involvement; or
death.

**Temporary Inpatient Services**

In the event a Waiver participant must be placed in temporary inpatient services for a maximum of **90 calendar days**, the participant will not receive Waiver services while hospitalized; however, the participant’s eligibility to remain in the Waiver will not be affected, as long as the WPO monitors the participant on a monthly basis and concludes that the participant will continue to be eligible and chooses to receive Waiver services upon discharge from the hospital.

Wraparound services may continue to be available to those participants that reside in communities that have System of Care resources.

**Crisis Situations**

If and when a participant experiences a crisis, a CFT meeting should occur within **72 business hours**, as recommended by The National Wraparound Implementation Center (NWIC), but no later than **seven business days** following the crisis event. At a minimum, the Wraparound Facilitator is expected to make contact with the participant and LAR within **72 hours** of the crisis event. The Wraparound Facilitator should also coordinate an immediate CFT meeting, if needed and at the request of the participant and LAR, or plan on discussing the following topics during the next regularly scheduled CFT meeting:

- the circumstances regarding the crisis;
- update and edit the Crisis and Safety Plan, as needed;
- review, discuss, and edit the needs, strategies, and services on the Wraparound Plan;
- review, discuss, and edit the IPC, as needed;
- discuss and update the roles of the CFT members; and
• discuss any other contributing factors or information that could prevent another crisis, as needed.

If the participant’s crisis situation involves an admission to a hospital or institution, the Wraparound Facilitator must meet with the participant and LAR to review and update the Crisis and Safety Plan within **seven business days** of the participant’s discharge. The Wraparound Facilitator will have **30 calendar days** to schedule a CFT meeting upon the participant’s discharge from the hospital or institution, unless the participant and LAR request an immediate CFT meeting, to discuss the topics listed above during the next regularly scheduled CFT meeting.

**Critical Incidents Related to Abuse, Neglect, or Exploitation**

Critical incidents related to abuse, neglect, or exploitation are handled in accordance with [POLICY 0 3300 Reporting Abuse, Neglect, or Exploitation].

**Risk Assessment**

HHSC will conduct a risk assessment of LMHA/LBHAs, WPOs, and CWPs on a quarterly basis. The assessment includes a review of any reported critical incidents and/or events.

Data gathered from risk assessments is reported to the HHSC Policy Development and Support Department annually.

**Training**

All entities providing YES Waiver services will assure that all staff, subcontractors, and individuals in contact with YES Waiver participants will be trained in reporting Critical Incidents.
Policy Statement

YES Waiver Providers must develop, implement, and enforce a written policy for training all direct service staff members, including subcontractors and their direct service staff on the requirements for reporting abuse, neglect, or exploitation.

At a minimum, the policy must comply with all child abuse reporting guidelines and requirements seen in Chapter 261 of the Texas Family Code, available at:


Procedure: Filing a Report

Reports of abuse or indecency with a youth should be made immediately, but no later than one hour after having knowledge or suspicion that a Waiver participant has been or is being abused, neglected, or exploited, to:

- The Texas Department of Family and Protective Services via:
  - Texas Abuse Hotline, 1-800-252-5400, 24 hours a day, seven days a week;
  - fax at 1-800-647-7410; or
  - website at https://www.txabusehotline.org/Login/;
- any local or state law enforcement agency;
- the state agency that operates, licenses, certifies, or registers the facility in which the alleged abuse occurred; or
- the agency designated by the court to be responsible for the protection of youth.

When the alleged or suspected abuse involves a person responsible for the care, custody, or welfare of the youth, the report must be made to DFPS.

Emergencies

All emergency situations must be reported by calling 9-1-1 or contacting the local law enforcement agency.
The DFPS online reporting website is only for reporting situations that do not require an emergency response, as it may take up to **24 hours** for a report made through the website to be processed.

### Allegations of Abuse, Neglect, or Exploitation

Allegations of abuse, neglect, or exploitation must be reported by YES Waiver Providers and direct service providers to the appropriate investigative authority **immediately**, but no later than **one hour** after having knowledge or suspicion, that a Waiver participant has been or is being abused, neglected, or exploited.

Within **one business day** following an allegation of abuse, neglect, and exploitation the YES Waiver Providers must submit the Client Abuse and Neglect Reporting form to DFPS. The form is available at:


Waiver participants are given the contact information verbally and in writing for the local client’s rights officer, the Department of Family and Protective Services, and the Office of the Ombudsman at intake, when requested, at annual renewal, and when a need is identified or thought to exist.

If the perpetrator is an employee or agent of the Waiver Provider entity, the director shall ensure that the employee or agent is removed as a provider of services. While allegations against an employee or agent of the Waiver Provider entity are being investigated, the individual may be assigned duties that do not require direct client contact or placed on administrative leave.

YES Waiver Providers may not change a confirmed finding made by a DFPS investigator but may request a review of the finding or the methodology used to conduct the investigation.

### Investigative Authority

All allegations are reported to DFPS Statewide Intake. DFPS will determine whether they or HHSC Provider Investigations has jurisdiction over investigative authority of abuse, neglect, and exploitation involving Waiver participants when the alleged perpetrator(s) is:

- an employee of the LMHA/LBHA, WPO, or CWP;
• an employee of an agent of the LMHA/LBHA, WPO, or CWP;
• an employee of a subcontractor of the LMHA/LBHA, WPO, or CWP; or
• a parent or primary caregiver.

**Law Enforcement**

Law enforcement has investigative authority of allegations of abuse, neglect, and exploitation involving Waiver participants when the alleged perpetrator is any other entity or any other person not under DFPS’ investigative authority.
Personal Restraint

25 TAC §415.253 defines personal restraint as "any manual method by which a person holds or otherwise bodily applies physical pressure that immobilizes or reduces the ability of the individual to move his or her body or a portion of his or her body". Personal restraint is used only as a last resort after less restrictive measures have been found to be ineffective or are judged unlikely to protect the waiver participant or others from harm. The intervention is used for the shortest period possible and terminated as soon as the waiver participant demonstrates the release behaviors specified by the ordering physician.

Limited Use of Physical Restraints

The limited use of physical restraints is permitted in the delivery of YES Waiver services only when:

- necessary to prevent imminent death or substantial physical harm to the Waiver participant; or
- necessary to prevent imminent death or substantial physical harm to another; and
- less restrictive methods have been attempted and failed. Use of restraints must be used in accordance with 25 TAC 415, Subchapter F.

Providers shall not use more force than is necessary to prevent imminent harm and shall ensure the safety, well-being, and dignity of Waiver participants who are personally restrained, including attention for personal needs. The effects of the intervention in relation to the participant's health and welfare must always be considered. When applied, interventions and/or restraints must be used for the shortest period of time necessary and terminated upon the participant demonstrating release behaviors specified by the ordering physician.

The provider must take into consideration information that could contraindicate or otherwise affect the use of personal restraint, including information obtained during the initial assessment of each Waiver participant at the time of enrollment or intake. This information includes, but is not limited to:
● pre-existing medical conditions or any physical disabilities and limitations, including, without limitation, cognitive functioning, substance use disorders, obesity, or pregnancy, that would place the participant at greater risk during restraint;
● any history of sexual abuse, physical abuse, neglect, trauma, or previous restraint that would place the participant at greater psychological risk during restraint;
● cultural factors; and
● information contained in a declaration for mental health treatment, if available.

A Waiver participant held in restraint shall be under continuous direct observation. The provider shall ensure adequate breathing and circulation during restraint. An acceptable hold is one that engages one or more limbs close to the body to limit or prevent movement.

The provider shall document the following information in the Waiver participant's file within 24 hours:

● the circumstances leading to the use of personal restraint;
● the specific behavior necessitating the restraint and the behavior required for release;
● less restrictive interventions that were attempted before restraint began;
● the names of the providers who implemented the restraint;
● the date and time the procedure began and ended; and the Waiver participant's response to the restraint.

The Waiver participant’s LAR must be notified within the same day the restraint was administered. The HHSC Ombudsman’s office is staffed to receive allegations of any violations or perceived violations of a client’s rights. The Waiver participant and LAR shall be made aware of their right to file complaints through the HHSC Ombudsman’s office. HHSC must investigate all complaints made to the Ombudsman. Suspicion of abuse, neglect, or exploitation in relation to the use of a restraint is reported to the Department of Family and Protective Services for investigation.
Reporting Physical Restraints as Critical Incidents

Providers must report the use of physical restraints on a participant to HHSC as a critical incident [see POLICY 0 3200 Critical Incident Reporting].

Prohibited Restraints

In accordance with 25 TAC §415.254 and §415.256, the use of chemical and mechanical restraints and seclusion are prohibited.

Limited Use of Other Restrictive Interventions

Restrictive interventions include, but are not limited to, home accessibility/safety adaptations such as alarm systems, monitoring devices, door locks, and other devices.

The limited use of restrictive interventions is permitted in the delivery of YES Waiver services only when:

- the participant is determined to be a danger to self or others and adequate safety cannot be assured in the community;
- the intervention is necessary to ensure the health, welfare and safety of the participant
- the intervention is identified and requested by the CFT; and
  - the intervention is identified as a strategy in the Wraparound Plan and/or Crisis and Safety Plan. Wraparound The restrictive intervention must be clearly documented in the Wraparound Plan and/or Crisis and Safety Plan, including under what circumstances and what type of intervention is to be used, and how and when intervention will be used.
  - The CFT must be in agreement with the Wraparound Plan and the Crisis and Safety Plan.

Verbal and written notification to the participant and LAR must be provided describing the right to discontinue use of the restrictive intervention at any time, and written consent of the participant or LAR must be documented in the participant’s file.

Allowance for a revised Crisis and Safety Plan must be made when the restrictive intervention is not working.
The CFT must review the need for the use of restrictive intervention at least annually, and whenever the participant’s needs change, in order to determine the need to continue the restrictive intervention throughout the program.

**Training**

All YES Waiver Providers providing YES Waiver services will assure that all staff, including contracted and subcontracted providers receive annual behavior management and safe use of personal restraint training.
Policy Statement

HHSC requires adequate training and education for YES Waiver Providers that serve YES participants. For this reason, YES Waiver Providers must ensure that all staff providing any type of direct service to YES participants, as well as subcontracted providers and their YES Waiver Provider staff, receive the following required trainings prior to delivering Waiver services and/or participating in CFT meetings.

Training requirements are applicable to staff at all levels, including individuals in leadership roles. Requirements specified by HHSC are supplemental to requirements associated with licensures as well as other onboarding and ongoing professional development required by each organization. YES Waiver Providers may use HHSC suggested training resources or may utilize other training sources that include required training components as outlined in this section.

All required trainings must be completed within the time frames specified below. It is the responsibility of YES Waiver Providers to comply with all applicable state and federal abuse and other reporting laws. YES Waiver Providers must also understand and comply with professional and legal requirements within the State of Texas.

Both web-based and in-person trainings will require a certificate or other documentation that states the training title, staff name, and date of completion to indicate the training was completed. Waiver Provider agencies must maintain all training documentation in personnel files which must be both readily available and accessible for the HHSC QM team to review during both desk and onsite reviews.

YES Waiver Providers are also required to submit their policies and procedures to HHSC for review and approval in accordance with contract requirements. HHSC may ask to review an agency’s training materials upon request.

First Aid and CPR Certification

All staff members providing any type of direct service to YES participants must be certified in First Aid and CPR prior to service delivery and are required to maintain current certification throughout their time at the agency.
Onboarding Provider Training

All staff members providing any type of direct service to YES participants must review available resources including the YES Waiver Policy Manual, YES Waiver User Guide, and other materials in order to become knowledgeable and familiar with the YES Waiver program.

Required Trainings

All staff including direct service staff as well as all layers of leadership with oversight of the YES Waiver program at a WPO, CWP, or subcontractor agency must complete the trainings listed below:

- YES Waiver 101;
- NWIC What is This Thing Called Wraparound Video (required for anyone who is not a Wraparound Facilitator and did not attend an in-person Wraparound training);
- Team Roles in Wraparound (required for anyone who is not a Wraparound Facilitator and did not attend an in-person Wraparound training);
- Advancing Wraparound Practice: Supervision and Managing to Quality (in-person training for YES Program Managers/Supervisors)
- Critical Incident Training;
- Reporting of Abuse, Neglect, or Exploitation;
- Restraint and Restrictive Interventions;
- HIPAA Training;
- DFPS Trauma Informed Care;
- CANS (required for CANS Assessors, recommended for staff in other roles); and
- Crisis and Safety Planning.

In addition to the trainings above, Wraparound Supervisors and Wraparound Facilitators must also complete the following trainings:

- Introduction to Wraparound (in-person training);
- Engagement Training (in-person training); and
- Intermediate Wraparound (in-person training).

In addition to required training, all organizations should provide adequate, role specific, foundational orientation to their staff in order to ensure competency in the following areas:
Recommended Trainings

YES Waiver Providers are also responsible for implementing and maintaining a plan for continuous training of all staff members providing direct services to YES participants. The trainings below are recommended for staff at all levels:

- Cultural Competency (Administrator Track);
- Cultural Competency (Provider Track);
- Suicide Prevention (in-person or online training);
- Mental Health First Aid (MHFA);
- Mental Health Wellness for Individuals with Intellectual and Developmental Disabilities (MHW-IDD) Parts 1 – 6;
- Harm Reduction Training;
- Assessing Trauma in Individuals with ID; and
- Psychotropic Medication Training.

Online Training Links

- What is This Thing Called Wraparound?
- Team Roles in Wraparound
- DFPS Reporting Suspected Abuse or Neglect of a Child: A Guide for Professionals
  ‣ [https://www.dfps.state.tx.us/Training/Reporting/default.asp](https://www.dfps.state.tx.us/Training/Reporting/default.asp)
- CMS Restraint Training Requirements Handbook
- Department of Aging and Disability Services (DADS) HIPAA Privacy Training for Contractors and Volunteers
  - https://apps.hhs.texas.gov/providers/hipaa/privacy/index.cfm
- DFPS Trauma Informed Care Training
  - https://www.dfps.state.tx.us/Training/Trauma_Informed_Care/default.aspx
- The Institute for Innovation and Implementation – Wraparound Training calendar
  - https://theinstitute.ummeryland.edu/our-work/texas-center/wraparound/wraparound-training/wraparound-training-calendar/
- The John Praed Foundation – CANS Training and Certification
- Think Cultural Health
- Suicide Prevention
- Mental Health First Aid
- Mental Health Wellness for Individuals with Intellectual and Developmental Disabilities (MHW-IDD) Parts 1 – 6
  - https://training.mhw-idd.uthscsa.edu/index.html
- Assessing Trauma in Individuals with ID
  - https://www.aucd.org/docs/Assessing%20Trauma%20in%20Individuals%20With%20ID%20(compressed).pdf
- Psychotropic Medication Training
  - https://www.dfps.state.tx.us/Training/Psychotropic_Medication/default.aspx
- HHSC Advancing Health Equity in Texas Through Culturally Responsive Care
- Staying Safe in the Community
  - https://register.gotowebinar.com/register/1749007835979830273
- Professional Boundaries, Inc.
Required Training Descriptions

Wraparound In-person Trainings

The YES Waiver utilizes the National Wraparound Implementation Center (NWIC) evidence-based model of Wraparound for Waiver service coordination and development of the person-centered plan for Waiver participants. YES Waiver Providers are required to send direct service staff to complete Wraparound trainings in accordance with the Medicaid service identified for the provision of Wraparound for Waiver participants. Within the first three months of hire, direct service staff must attend the first of three Wraparound in-person trainings:

1. Introduction to Wraparound;
2. Engagement Training; and

The Wraparound Facilitator should sign up for Engagement Training within one month from completing Introduction to Wraparound and Intermediate Wraparound training should be completed no more than six months from the date the Introduction to Wraparound training was completed. Wraparound Facilitators must attend the three in-person Wraparound Trainings and receive, at a minimum, monthly one-on-one coaching and group supervision with their Wraparound Supervisor.

Wraparound Supervisor Requirements

Supervisors play a multidimensional role in Wraparound. They must not only know the practice model for quality Wraparound but be able to communicate and coach the practices with Wraparound Facilitators. They must also work with the broader community to ensure local systems collaborate and support high quality, high-fidelity Wraparound.

As such, all Supervisors of Wraparound Facilitators are required to adhere to the Wraparound training timelines listed above and must complete all three in-person Wraparound trainings as well as the NWIC Advancing Wraparound Practice:
Supervision and Managing to Quality training. YES Managers/Supervisors must also participate in onsite, telephonic, and/or virtual support delivered by the entity contracted with HHSC to provide Wraparound coaching, support, and training.

**Critical Incident Training**

Through this training, staff at all levels must understand the following core competencies related to critical incidents:

- events and circumstances that qualify as critical incidents;
- responding to critical incidents; and
- reporting critical incidents.

All staff, including direct service staff, as well as all layers of leadership with oversight of the YES Waiver program at a WPO, CWP, or subcontractor agency are required to complete Critical Incident training upon hire. Completion of this training must be documented in personnel files and is required annually.

**Reporting Abuse, Neglect, and Exploitation Training**

All staff providing direct services to YES participants, including layers of leadership with oversight of the YES Waiver program at a WPO, CWP, or subcontractor agency, must complete training on and demonstrate a thorough understanding of the policies and procedures in regard to reporting child abuse, including sexual abuse, neglect and exploitation, before contact with persons served. New staff must receive this training as part of their initial training/orientation.

Relevant elements of reporting, investigating, and preventing abuse, neglect, and exploitation include, but are not limited to:

- the acts and signs of possible abuse, neglect, and exploitation;
- the prohibition of abuse, neglect, and exploitation of persons served;
- the disciplinary consequences for:
  - committing abuse, neglect, and exploitation;
  - failing to report abuse, neglect, or exploitation; and
  - failing to cooperate with an investigation;
  - the procedures for reporting allegations of abuse, neglect, and exploitation;
- the prohibition of retaliatory action and the consequences for engaging in retaliatory action;
- the methods for preventing abuse, neglect, and exploitation; and
• memoranda of understanding and rules of investigatory agencies.

Completion of this training must be documented in personnel files and is required annually.

**Restraint and Restrictive Interventions Training**

All staff providing direct services to YES participants, including layers of leadership with oversight of the YES Waiver program at a WPO, CWP, or subcontractor agency, must be trained upon hire in the safe use of physical restraints. Training must focus on maintaining the safety, well-being, and dignity of participants who are physically restrained. Training must be documented in personnel files and is required annually.

**Health Insurance Portability and Accountability Act (HIPAA) Training**

After this training, providers must be able to protect the rights of persons receiving YES services, responsibly handle Protected Health Information (PHI), identify what information needs protection, display an understanding of HIPAA, and eliminate the potential for penalties from misuse of PHI. This training will help providers understand the basic information about the federal HIPAA rules that protect the privacy of an individual's health information.

All staff providing direct services to YES participants, including layers of leadership with oversight of the YES Waiver program at a WPO, CWP, or subcontractor agency, must complete HIPAA training upon hire. Completion of this training must be documented in personnel files and is required annually.

**DFPS Trauma Informed Care**

HHSC recognizes the long-term effects of adverse childhood experiences such as child abuse and neglect. The need to address trauma is increasingly viewed as an important component of effective service delivery. The impact of trauma is experienced by children, families, caregivers, and the social service providers who serve them. This training will assist families, caregivers, and other social service providers in fostering greater understanding of trauma informed care and child traumatic stress. It will also help providers understand the effects that trauma can have on child development, behaviors, and functioning, as well as recognize, prevent and cope with compassion fatigue.
All staff providing direct services to YES participants, including layers of leadership with oversight of the YES Waiver program at a WPO, CWP, or subcontractor agency, must receive Trauma Informed Care training upon hire. Completion of this training must be documented in personnel files and is required every two years.

**CANS Training**

YES Waiver Providers will assure that all staff providing direct services to YES participants acquire a working knowledge of the CANS assessment tool, the Transformational Collaborative Outcomes Management (TCOM) model, and the use of CANS to support the Wraparound planning process, inform the YES participants’ IPC, and measure and track progress over time.

Staff involved in conducting the YES Assessment (CANS) must be trained and certified in the use of the CANS assessment tool. CANS administrators must re-certify in accordance with requirements specified by the Praed Foundation.

In addition, each organization involved in conducting the YES Assessment (CANS) must have at least one staff person certified as a Super User for the CANS. Super Users must perform quality assurance training activity in accordance with contract requirements. Super Users will maintain the Super User status in accordance with Praed Foundation requirements. Completion of CANS training must be documented in personnel files and is required every two years.

**Recommended Training Descriptions**

**Cultural Competency Training**

Culturally and linguistically appropriate services are increasingly recognized as effective in improving the quality of care and services. This training will help providers become better able to respond to the changing demographics in their services area, not only in regard to racial and ethnic differences, but also to their linguistically and culturally diverse population.

All staff providing direct services to YES participants, including layers of leadership with oversight of the YES Waiver program at a WPO, CWP, or subcontractor agency, are encouraged to complete Cultural Competency training. Completion of this training should be documented in personnel files.
Suicide Prevention Training

“ASK About Suicide to Save A Life” training provides an overview of the basic epidemiology of suicide and suicidal behavior, including risk and protective factors. Through this five-part video series, participants are trained to recognize warning signs—behaviors and characteristics that might indicate elevated risk for suicidal behavior—and how to intervene with a person they think might be at risk for suicide.

All staff providing direct services to YES participants, including layers of leadership with oversight of the YES Waiver program at a WPO, CWP, or subcontractor agency, are encouraged to complete Suicide Prevention training. Completion of this training should be documented in personnel files.

Mental Health First Aid (MHFA) Training

This training helps equip providers with the basic tools to help someone showing signs of mental illness or substance use disorder or experiencing a mental health crisis. MHFA can save a life, just like CPR can save someone who can’t breathe or is having a heart attack.

All staff providing direct services to YES participants, including layers of leadership with oversight of the YES Waiver program at a WPO, CWP, or subcontractor agency, are encouraged to complete Mental Health First Aid training. Completion of this training should be documented in personnel files.

Mental Health Wellness for Individuals with Intellectual and Developmental Disabilities (MHW-IDD) Training

This 6-part e-learning training series was developed by legacy Department of Aging and Disability Services (DADS) and DSHS to educate direct service workers and others about behavioral health needs of people who have an IDD and a co-occurring behavioral health condition. This training looks at challenging behavior in a new way and emphasizes the importance of supporting mental wellness in individuals with an IDD.

Through the modules in this course, viewers will learn to recognize the "whole person," and to gain a better understanding of different factors that influence the way people with IDD think, feel, and behave. Viewers will also learn how to positively impact their quality of life.
The course consists of six modules:

2. Trauma Informed Care for Individuals with IDD;
3. Functional Behavior Assessment and Behavior Support;
4. Overview of Genetic Syndromes Associated with IDD;
5. Overview of other Medical Diagnoses Associated with IDD; and
6. Putting it all Together

All staff providing direct services to YES participants, including layers of leadership with oversight of the YES Waiver program at a WPO, CWP, or subcontractor agency, are encouraged to complete Mental Health Wellness for Individuals with Intellectual and Developmental Disabilities training.

Completion of this training should be documented in personnel files.

**Harm Reduction Training**

Harm Reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs. Harm reduction incorporates a spectrum of strategies from safer use, to managed use to abstinence to meet drug users “where they’re at,” addressing conditions of use along with the use itself.

All staff providing direct services to YES participants, including layers of leadership with oversight of the YES Waiver program at a WPO, CWP, or subcontractor agency, are encouraged to complete Harm Reduction training. Completion of this training should be documented in personnel files.

**Assessing Trauma in Individuals with ID Training**

This training highlights the prevalence and severity of abuse and neglect for people who have intellectual disabilities, diagnostic overshadowing of trauma symptoms, sources of particular vulnerability, and tools that are used to assess trauma in individuals with IDD.

All staff providing direct services to YES participants, including layers of leadership with oversight of the YES Waiver program at a WPO, CWP, or subcontractor agency, are encouraged to complete Assessing Trauma in Individuals with ID training. Completion of this training should be documented in personnel files.
Psychotropic Medication Training

Psychotropic medication is a medication that is prescribed for the treatment of symptoms of psychosis or another mental, emotional, or behavioral disorder and that is used to exercise an effect on the central nervous system to influence and modify behavior, cognition, or affective state. This training explains the State’s expectations for the safe and effective use of psychotropic medications by children in Texas Department of Family and Protective Services (DFPS) conservatorship. Always discuss specific questions about the medications with the child's doctor. The following goals and objectives will be discussed in this training:

- understanding that other interventions should be considered along with psychotropic medications;
- understanding the need for a complete psychiatric evaluation (including physical examination) before making a decision about psychotropic medications and treatments;
- understanding the responsibility of the Medical Consenter to decide whether or not to give informed consent for each psychotropic medication prescribed for a child; and
- understanding how psychotropic medications are used.

All staff providing direct services to YES participants, including layers of leadership with oversight of the YES Waiver program at a WPO, CWP, or subcontractor agency, are encouraged to complete Psychotropic Medication training. Completion of this training should be documented in personnel files.

Staying Safe in the Community

This training will cover the basics on staying safe while providing services in the community. The training discusses how to be proactive, prepared, alert/aware, and how to use intuition when working with families in the community. Staff should be aware of the safety and risk management policies and procedures at their agency. Completion of this training should be documented in personnel files.

Professional Boundaries Training

Maintaining professional boundaries is vital and necessary for all staff providing direct services to YES participants. Examples of professional boundaries include, but are not limited to the following:
• clearly established limits that allow for safe connections between service providers and their clients;
• “being with” the client, not becoming the client;
• being friendly, not friends;
• the ability to know where you end, and the client begins; and
• a clear understanding of the limits and responsibilities of a direct service provider role.

Completion of this training should be documented in personnel files.

**Technical Assistance**

**Monthly State Liaison Calls**

YES Waiver Providers are required to participate in a monthly call with their YES Waiver state liaison. Topics discussed during this call may include, but are not limited to:

• issues the YES Waiver Provider may be experiencing;
• challenges that are hindering successful implementation of the YES Waiver program and/or its policies and procedures;
• successes the program is experiencing;
• information exchanges between the YES Waiver Provider and state liaison; and
• other technical assistance.

**YES Waiver Conference Calls**

Providers should participate in HHSC YES Waiver Department conference calls which address topics that may impact all providers, including program updates, data trends and analysis, and other pertinent information regarding the YES Waiver program.

**Quarterly Best Practices Meeting**

Providers should have at least one program representative attend the YES Waiver Best Practices Meeting, which takes place quarterly, in Austin, Texas. A variety of topics will be discussed during these meetings, which may include, but are not limited to:

• best practices within the mental health field;
● YES policy and guidance;
● trainings based on provider feedback and provider data; and
● facilitated discussions.

**NWIC Coaching**

YES Waiver Providers are also required to participate in monthly coaching sessions with NWIC coaches to discuss at a minimum:

● YES Waiver program implementation;
● Wraparound implementation;
● supervision and staffing of Wraparound Facilitators;
● organizational infrastructure and support; and
● any other questions or topics about Wraparound requiring clarification and/or support.
3600 Confidentiality

Protected Health Information

YES Waiver Providers must act in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and any other applicable federal or state laws.

Sharing or Exchanging Confidential Information

To comply with the HHSC Quality Management review in protecting confidential information, YES Waiver Providers must:

- establish and implement appropriate administrative, technical, and physical safeguards to protect the privacy, and prevent unauthorized disclosure of, PHI or sensitive personal information (SPI);
- take necessary precautions when transmitting PHI or SPI so that a participant could not be identified (e.g., remove the name(s) of relatives, household members, and/or employers);
- secure and encrypt email when transmitting PHI or SPI;
- transmit all PHI or SPI via a HIPAA-compliant method;
- include a cover sheet when faxing items that include PHI or SPI;
- report violations of privacy or privacy concerns to a Supervisor and HHSC;
- take immediate and corrective action following the discovery of a privacy violation; and
- refer complaints or allegations of breaches of confidentiality to HHSC.

Information Management System

YES Waiver Providers must maintain a secure information management system to protect information such as:

- who the participant wishes to be informed about services, supports, and treatment while in the Waiver program;
- collateral information provided by someone about the participant;
- protected health information;
- sensitive personal information;
- billing information; and
all service-related information.

**Release of Confidential Information Related to the Waiver**

The LMHA/LBHA and/or Wraparound Facilitator must inform the participant and LAR of the participant’s confidentiality rights and the reasons associated with the Waiver requiring release of confidential information.

The LMHA/LBHA and/or Wraparound Facilitator must obtain permission, through a signed release, from the participant and LAR in order to release personal or program information for administrative purposes.

**Release Form**

The release form must grant permission to the YES Waiver Provider to release participant information, billing and claims information, information needed for quality assurance and Waiver claims monitoring, and audits.

The release form must:

- be signed by the participant and/or the participant’s LAR;
- include the date of signature;
- include a specific termination date, which shall be no longer than one year from the date of signature; and
- be renewed as necessary.

**Release of Confidential Information Not Related to the Waiver**

In the event the YES Waiver Provider must disclose confidential information for purposes other than those related to Waiver administration, the entity or direct service provider must obtain separate permission from the participant and LAR prior to the release of any information.

A release granting permission to disclose information for a non-Waiver related purpose is not a blanket release of information. The entity must obtain a release of information for each separate non-Waiver related purpose.
Confidentiality in Service Delivery

Staff must consider the participant’s privacy and confidentiality rights and preferences to the greatest extent possible when determining locations for services.

To accommodate service delivery in various environments such as homes, schools, homeless shelters, or street locations, the entity must have policies and procedures addressing confidentiality and safety considerations when services are provided in a community-based setting.

Official Agencies

Acting in their official capacity, staff of HHSC and/or CMS are permitted to access information or files related to participants in accordance with applicable law, rule, or regulation.

Staff of official agencies are required to follow all applicable confidentiality laws, rules, and regulations regarding the transmission, sharing, or exchange of confidential information.

Transfer of Files

HHSC has the authority to require YES Waiver Providers to transfer original and/or copies of participant files to another entity without consent from the participant and LAR:

- upon termination of the contract between the entity and HHSC; or
- when the care and treatment of the participant is transferred to another entity.

Fees

YES Waiver Providers cannot charge fees to any official agency requesting information or participant files.
3700 Record Keeping

Retention of Waiver Information

Record retention practices must be in compliance with current federal or state law, rule, or regulation.

Service Data

All files, reports, and source documentation related to service data for Waiver participants must be retained by YES Waiver Provider for six years following either the date of expiration, termination of the entity’s contract with HHSC, or termination of services, whichever is later.

Pending Litigation, Quality Management Review or Audit

Documents pertaining to pending litigation, QM review, or a pending audit must be retained until all inquiries and/or actions of the litigation or audit are resolved.

Required by Contract

The entity must retain the following documents, as required by its contract with HHSC, for a period of at least six years:

- the contract with HHSC;
- internal monitoring records of the quality and appropriateness of Medicaid program participation and compliance;
- all plans required by the contract;
- all accounting and other financial records;
- real estate and personal property leases;
- policies, manuals, and standard operating procedures;
- provider credentialing records;
- records relating to insurance policies;
- employee records;
- licenses and certifications;
- subcontracts;
● audit records and working papers;
● claim payments; and
● any records required by HHSC.

Security of Participant Records

An entity must ensure the security of participant files in retention and destruction, in accordance with all applicable federal and state laws, rules, and regulations by establishing an effective and efficient record keeping system. All active files must be maintained in an organized system located in a secure, locked area. An effective and efficient record keeping system must:

● protect against unauthorized access, disclosure, modification, or destruction of medical records or participant files;
● ensure availability, integrity, utility, authenticity, and confidentiality of information with a participant’s file;
● adhere to good professional practice;
● permit clinical review and audit activities; and
● facilitate prompt and systematic retrieval of information.

Participant Files

All clinical and participant files must be current and complete, and maintained in an organized and concise manner. Participant files must be retained for a minimum of six years following either the date of the participant’s termination from the Waiver, or the termination of the entity’s contract with HHSC, whichever is later.

YES Waiver Providers must maintain a clinical file for every individual assessed on the Inquiry List and each Waiver participant. A participant’s file must:

● include participant name and contact information;
● identify an emergency contact with contact information;
● include participant diagnosis;
● include detail regarding any medication(s) used by participant;
● include information regarding previously received services, if applicable;
● identify whether the participant has allergies, and if so, the specific allergies;
● demonstrate medical necessity of the service(s); and
● include financial and insurance information.

In addition, the LMHA/LBHA will maintain all records included in the Enrollment Packet.
**LMHA/LBHA**

The participant file maintained by the LMHA/LBHA must include:

- CE document authorized in CMBHS;
- Enrollment Packet Forms
- all service authorizations;
- all Crisis and Safety Plans, Wraparound Plans/IPC;
- summaries of all meetings regarding the participant;
- Denial of Eligibility form, if applicable;
- other Waiver documentation.

**Participant Assessments**

Participant assessments and re-assessments of Level of Care must be maintained by the LMHA/LBHA WPO and HHSC.

**Audits of Claims**

In accordance with 45 CFR §92.42, all documents associated with an audit of claims are maintained by HHSC, the WPO, and the CWP for at least three years following the date of the audit.

**Disaster Recovery Plan**

The entity must develop and maintain a written disaster recovery plan for information resources to ensure continuity of Waiver services.
**4000 Local Mental/Behavioral Health Authority Responsibilities: Inquiry List**

**Policy Statement**

The LMHA/LBHA shall maintain an Inquiry List of all individuals interested in YES Waiver services in its service area.

**Procedure**

LMHA/LBHAs will maintain an up-to-date Inquiry List, in accordance with 26 TAC §307.13. HHSC approves the Inquiry List management policy for each service area in the Waiver.

LMHA/LBHAs shall submit a copy of the up-to-date Inquiry List using the Inquiry List Template provided by HHSC YES Waiver staff to the HHSC YES Waiver Inbox (YESWaiver@hhsc.state.tx.us) and Contracts Management Inbox (performance.contracts@dshs.state.tx.us) by the **fifth business day of each month**. All fields must be completed for each individual on the list.

In accordance with contract requirements, LMHA/LBHAs must formally notify HHSC YES Waiver staff if the program is unable to meet the demands of their Inquiry Line. Additionally, formal notification is needed any time a program experiences any technical issue(s) that impede the functionality and purpose of the Inquiry Line.

**Phone Line**

In accordance with contract requirements, LMHA/LBHAs shall establish and maintain a toll-free phone line which must be visible and easily identified on the LMHA/LBHAs website. This phone line should operate as either:

- a direct Waiver Inquiry phone line with voice messaging capabilities; or
- an agency-wide phone number equipped with an operating system which provides a Waiver Inquiry option for callers that includes all required information on a recorded phone message. For more details and suggested script, [see YES Waiver Use Guide].
Phone messages received on the Waiver Inquiry Line must be returned within 24 hours, or one business day.

When an individual is in substitute care through the Department of Family and Protective Services (DFPS), LMHA/LBHAs will accept the DFPS Managing Conservator as the LAR and add the individual to the Inquiry List. LMHA/LBHAs must also obtain the DFPS Managing Conservator’s name and phone number and ensure they are notified of assessments and appointments for the individual just as an LAR would be notified.

Waiver vacancies are filled on a first-come, first-serve basis in chronological date and time the phone call or voice message is received.

Municipal and family courts can mandate an individual be referred for assessment for possible YES Waiver participation; however, a court cannot override YES Waiver eligibility criteria or court order participation.

**Inquiry Line Process**

In accordance with 26 TAC §307.13, an individual is added to the Inquiry List only through direct contact with the LMHA/LBHA. Waiver vacancies are filled on a first-come, first-serve basis in chronological date and time the phone call or voice message is received. Only an individual or the individual’s LAR/DFPS Conservator can add name(s) to the Inquiry List. An individual will not be placed on the Inquiry List if contact to the LMHA/LBHA is from any other source than those stated above.

The LMHA/LBHA must assign the individual a registration date on the Inquiry List that is based on the chronological date and time the phone call or voice message requesting YES Waiver program services was received.

**Policy Statement: Reserved Capacity**

A percentage of statewide Waiver capacity is reserved for individuals who are at imminent risk of being relinquished to state custody.

**Procedure: Reserved Capacity Requests**

If the LMHA/LBHA is at the maximum enrollment capacity or experiencing delays in scheduling eligibility assessments for YES Waiver services, the LMHA/LBHA shall utilize the YES Waiver Reserved Capacity Screening Form found at:
LMHA/LBHAs shall screen all individuals for imminent risk of relinquishment at the time their name is added to the Inquiry List. If a child or youth whose name has been added to an LMHA’s Inquiry List must wait to be assessed, then the LMHA must screen the child or youth for imminent risk of relinquishment.

If the LMHA/LBHA considers an individual to be at imminent risk of relinquishment, the LMHA/LBHA shall immediately submit the completed Reserved Capacity Screening form to HHSC for review at: YESWaiver@hhsc.state.tx.us.

HHSC shall review the YES Waiver Reserved Capacity Screening Form within three business days. If the department determines that the individual is at imminent risk of relinquishment, HHSC must authorize the LMHA to complete the clinical eligibility assessment within three business days from the date the determination was made by HHSC.

If the individual is determined clinically eligible, HHSC will allocate an available reserved capacity vacancy.

**Denial of Reserved Capacity Vacancy**

If an individual is denied a reserved capacity vacancy, the LMHA/LBHA will assign the individual a registration date on the Inquiry List that is based on the chronological date and time of the original phone call or voice message request for YES Waiver services in accordance with 26 TAC §307.13.

**Program Information**

LMHA/LBHAs must provide general information about the YES Waiver to an interested individual and LAR, including, but not limited to:

- description of YES Waiver services;
- demographic eligibility criteria;
- clinical eligibility criteria; and
- Medicaid eligibility criteria

LMHA/LBHAs must provide all required information when answering and returning calls to individuals [see User Guide - Inquiry Line Script].
LMHAs/LBHAs must never discourage an individual from adding their name to the Inquiry List due to:

- limited availability of Wraparound Facilitators at the LMHA/LBHA;
- limited availability of employed or contracted providers of the CWP service array;
- a dual diagnosis such as Autism, Intellectual and Developmental Disabilities (IDD), and Substance Use.

LMHA/LBHAs are required to assure that their program has enough staff to maintain their Inquiry List, assessment, and enrollment process in order to assure sufficient access to Waiver services.

The LMHA/LBHA must also inform the individual and LAR that if the individual is enrolled in the YES Waiver program, they will no longer be eligible to participate in another Medicaid home and community-based 1915(c) waiver or 1915(i) state plan benefit program at the same time.

If the individual is already enrolled in another 1915(c) or 1915(i) program, then the choice between remaining in the current waiver or choosing to enroll in the YES Waiver program must be made as YES participants are not allowed to be dually enrolled in these programs.

It is the responsibility of the LMHA/LBHA to adequately inform individuals and LARs of this choice and to provide them with more information about the variety of home and community-based option.

**Maximum Enrollment**

HHSC allocates YES Waiver vacancies at least annually, and when necessary, as well as in response to:

- geographic service demand;
- service needs;
- community infrastructure;
- LMHA/LBHA service region; and
- within the limits of the approved YES Waiver vacancies.

HHSC also reserves the right to increase or decrease the maximum enrollment numbers for each program based on a variety of factors, some of which include adequacy and safety of a program providing YES services and in response to the
needs of the service region. LMHA/LBHAs shall not schedule or perform clinical eligibility assessments if their program has met maximum capacity without prior written approval from HHSC.

**Notification of Vacancy Availability**

When a YES Waiver vacancy becomes available or is projected to be available within 30 calendar days, the LMHA/LBHA – who has not exceeded maximum enrollment capacity – must notify the next individual and LAR on the Inquiry List of the vacancy, (including an individual in a non-community setting), no later than seven business days after the vacancy has become available and schedule an appointment to complete the assessment for clinical eligibility.

**Removal from Inquiry List**

The LMHA/LBHA will not remove an individual’s name from the Inquiry List. The LMHA/LBHA will remove the individual from active status in accordance with 26 TAC §307.13 if it is documented that:

- the individual, LAR, or DFPS Managing Conservator has requested verbally or in writing that the child or youth’s name be removed from the Inquiry List;
- the individual, LAR, or DFPS Managing Conservator has declined, verbally or in writing, YES Waiver program services;
- the individual, LAR, or DFPS Managing Conservator has not responded to the LMHA/LBHA notification of a Waiver vacancy within 30 calendar days of the notification of the vacancy;
- the individual has moved out of Texas; or
- the individual is deceased.

Exceptions are granted to individuals with LARs who are active or former military service members, or the spouse of an active or former military service member, who declare and maintain Texas as their home state of record, even if temporarily residing out of state.

- An individual may maintain a placement-hold on the Inquiry List due to this exception in accordance with the following time frames:
  - indefinite until services are provided; or
  - the one-year anniversary date from when:
    - the member's active duty ends;
    - the member was killed in action; or
◊ the member died while in service.

The LMHA/LBHA will call the individual or LAR and will follow the procedures listed on the YES Waiver Inquiry Line Script [see User Guide - Inquiry Line Script]. If there is no answer, the LMHA/LBHA will leave a voicemail to inform the individual and LAR that they have **seven business days** to return their call. A good faith effort must be made prior to removing an individual from active status on the from the Inquiry List. A good faith effort is considered to be:

- a minimum of two phone call attempts at least a week apart from each other and made at different times throughout the day;
- at least one letter should be mailed to the individual and LAR, if their address is known, notifying them of:
  - the dates of the two previous attempts made by phone;
  - the **seven business day** deadline to return the call before the LMHA/LBHA moves on to the next individual on the Inquiry List;
  - their right to remain on the inquiry list and to be assessed based on the chronological order of their name on the Inquiry List at the time they return the call from the LMHA/LBHA; and
  - the **30 calendar day** deadline to prevent removal from active status from the Inquiry List.

If the individual and LAR does not return the LMHA/LBHA’s phone call within **seven business days** and after good faith efforts have been made, the LMHA/LBHA shall send the individual/LAR the Letter of Withdrawal, which must include the reason for withdrawal, via certified mail. A copy of this letter and the certified mail documentation will be kept in the individual’s file.

If contacting multiple individuals on the Inquiry List at the same time, the LMHA/LBHA will try to schedule assessments in the order inquiries were received.

**Request for Reinstatement**

In accordance with 26 TAC §307.13 if an individual’s name is removed from active status from the Inquiry List, the individual, LAR, Managing Conservator, or LMHA/LBHA may request that HHSC review the decision.

**Reinstatement Approved**

At its discretion, HHSC may:
● reinstate the individual’s name on the Inquiry List according to the original date the individual or LAR requested the individual’s name be added to the Inquiry List; or
● add the individual’s name to the Inquiry List according to the date the individual or LAR requested that HHSC review the circumstances under which the child or youth’s name was removed.

Reinstatement Denied

An individual’s name will remain in inactive status if HHSC upholds the original decision by the LMHA/LBHA. The individual and LAR may continue to have the opportunity to exercise their right to appeal the decision in accordance with 26 TAC §307.15.

Responsibility for Quality Service Delivery

Because YES Waiver participants are some of the state’s most vulnerable children and youth, HHSC has identified the need to ensure that quality services are delivered to participants. For this reason, YES Waiver Providers are required to adhere to the following guidelines regarding quality services delivery in accordance to 25 TAC §412.62.

● Monitoring. The local authority must maintain a contracts management system that ensures each community services contractor performs in accordance with the provisions of the contract. The WPO and CWP shall monitor each community services contractor’s compliance with the contract and evaluate the contractor’s provision of services, including:
   competency of the contractor to provide care;
   consumers’ access to services;
   safety of the environment in which services are provided;
   continuity of care;
   compliance with the performance expectations;
   satisfaction of consumers and family members with services provided; and
   utilization of resources.

● Enforcing. The WPO and CWP shall enforce each community services contract. The WPO and CWP will develop policies and procedures regarding contract enforcement that address the use of at least the following enforcement actions:
   training;
• technical assistance for contractors;
• a Corrective Action Plan (CAP); and
• sanctions, which may include:
  ◊ withholding or recouping funds;
  ◊ imposing financial penalties;
  ◊ requiring service delivery at no additional cost to the WPO and CWP;
  ◊ suspending participation in the provider network;
  ◊ contract amendment; and
  ◊ contract termination.
Policy Statement

The LMHA/LBHA shall be responsible for serving as a WPO and CWP provider of last resort.

In accordance with 25 TAC §412.61, the local authority must allow consumers to choose freely, without influence by any local authority staff or representative, any contractor participating in the provider network that provides the type of community service which the local authority has authorized for the consumer.

In areas where additional WPOs and CWPs are available to provide services, the LMHA/LBHA shall assure that materials are available and presented to YES Waiver participants at the time of WPO and service provider selection to assure participants are informed of the available providers in their service area.

Dual Roles for the Same Participant

As the provider of last resort, only LMHA/LBHAs may serve as both the WPO and CWP for the same participant. When this occurs, HHSC requires a clear separation of service provider and Wraparound functions. The distinct individual staff member providing Wraparound must be administratively separate from other provider functions and any related utilization review units and functions.

HHSC closely monitors arrangements where the same entity develops the service plans (Wraparound Plan and IPC) and provides services. HHSC reviews the administrative structure of the entity to ensure that there is a clear administrative separation of Wraparound and YES Waiver Provider staff/functions before approving this arrangement. In addition, HHSC reviews the individuals who are performing Wraparound to ensure that they are not also providing YES services and are not under the administrative control of units providing YES Waiver services. HHSC also reviews every IPC to ensure that there is no evidence of conflict of interest prior to approval of the IPC.
5000 Wraparound Provider Organization Responsibilities

Wraparound Facilitation

Policy Statement

The YES Waiver utilizes the National Wraparound Implementation Center (NWIC) Wraparound model as the care coordination model for Waiver participants [see POLICY 0 3500 General Training and Technical Assistance].

According to NWIC, Wraparound is an evidence-based care coordination model targeting children, youth, and families with severe emotional or behavioral needs. Based in an ecological model, Wraparound draws upon the strengths and resources of a committed group of family, friends, professionals, and community members. Wraparound mobilizes resources and talents from a variety of sources, resulting in the creation of a Wraparound Plan that is the best fit between the family vision and story, team mission, strengths, needs, and strategies.

During the Wraparound process, the Child and Family Team (CFT) works collaboratively, utilizing the strengths of the youth and the family, to develop an individualized Wraparound Plan for the youth and the caregiver(s). The CFT meets over time to implement this plan, monitor its effectiveness, and work toward success. Providing comprehensive care through the Wraparound process requires a high degree of collaboration and coordination among the child and family service agencies and organizations in a community.

Wraparound Facilitators are responsible for, but not limited to, the following duties:

- facilitating communication with the individual and LAR;
- scheduling and facilitating CFT meetings;
- developing and updating the Wraparound Plan and submitting IPCs;
- monitoring the day to day implementation of the Wraparound Plan;
- monitoring and assessing the participant’s health and welfare;
- facilitating and collectively assessing how well services are meeting a participant’s need(s) during CFT meetings;
• tracking and documenting the progress the participant and LAR are making towards achieving their stated goals and measurable target outcomes in their Wraparound Plan;
• meeting with the participant in person and CFT at least once every 30 calendar days;
• having contact with the LAR at least once every 30 calendar days in order to verify:
  ‣ the Safety and Crisis Plan is working as intended;
  ‣ services and supports are being implemented and provided in accordance with the Wraparound Plan and continue to meet the participant's reason for referral, needs, goals, and preferences;
  ‣ the Waiver participant and LAR are satisfied with the implementation of services;
  ‣ the participant's health and welfare are reasonably assured; and
  ‣ the Waiver participant and LAR exercise free choice of providers and accesses to non-Waiver services including health services.

Wraparound Facilitators are also responsible for coordinating and facilitating the Wraparound process throughout the four Wraparound phases which include:

• **Engagement and Team Preparation.** During this phase, the groundwork for trust and shared vision among the family and CFT members is established, so people are prepared to come to meetings and collaborate. During this phase, the tone is set for teamwork and team interactions that are consistent with the Wraparound principles, particularly through the initial conversations about strengths, needs, and culture. In addition, this phase provides an opportunity to begin to shift the family’s orientation to one in which they understand they are an integral part of the process and their preferences are prioritized. The activities of this phase should be completed relatively quickly (within one to two weeks if possible) so that the CFT can begin meeting and establish ownership of the process as quickly as possible.

• **Initial Plan Development.** During this phase, team trust and mutual respect are built while the CFT creates a Wraparound Plan using a high-quality planning process that reflects the Wraparound principles. In particular, the participant and their LAR should feel that they are heard, that the needs chosen are ones they want to work on, and that the options chosen have a reasonable chance of helping them meet these needs. This phase should be completed during one or two meetings that take place within one to two weeks, a rapid time frame intended to promote team cohesion.
and shared responsibility toward achieving the team’s mission or overarching goal.

- **Plan Implementation.** During this phase, the initial Wraparound Plan is implemented, progress and successes are continually reviewed, and changes are made to the plan and then implemented all while maintaining or building team cohesiveness and mutual respect. The activities of this phase are repeated until the team’s mission is achieved and formal Wraparound is no longer needed.

- **Transition.** While the focus on transition is continual during the Wraparound process and the preparation for transition is apparent even during the initial engagement activities, it is during this phase that transition plans are finalized for a successful transition out of formal Wraparound to a mix of formal and natural supports in the community and, if appropriate, to services and supports in a lower Level of Care or to Transition Age Youth services or adult services.

**Wraparound Intake with Participant and LAR**

The intake between the Wraparound Facilitator, participant, LAR, and DFPS Medical Consenter – if the participant is in substitute care – must occur within seven business days of the HHSC authorization of the CE document in CMBHS. This intake will take place prior to the first CFT Meeting and will be held at the home or a location that the participant and LAR find most comfortable and should seem more like a conversation than a formal meeting. The following topics will be discussed during this meeting:

- The participant and LAR will describe what things have worked in the past to help the family and what they would like to see happen in the Wraparound process.
- The Wraparound Facilitator, participant and LAR will create a Crisis and Safety Plan.
  - A Crisis and Safety Plan focuses on planning for, predicting, and preventing the occurrence of a crisis. The participant and LAR’s needs, strengths, and preferences are taken into consideration. Crisis and Safety Plans are incorporated into the Wraparound Plan with all CFT members knowing the roles they will play if and when a crisis arises. This helps to prevent crises and ensures that they are addressed immediately.
- The participant and LAR will talk about people who care about them, as well as who has been helpful for each family member.
● The Wraparound Facilitator will listen closely as the participant and LAR describe the family’s beliefs and traditions as well as family members’ strengths – things that they are good at and that help them succeed.
● The Wraparound Facilitator, participant, and LAR will develop the IPC that best meets the needs of the participant;
● The participant and LAR will also describe what they believe family members need the most help with – what their needs are.

This intake should last from **one to three hours** and can take place with the Wraparound Facilitator and LAR first and then with the participant, or everyone can meet together, depending on the family’s preference. The participant and LAR will also be given:

● the YES Waiver Enrollment Packet available at: https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers;
● the YES Waiver Family Guide;
● a copy of the Department of State Health Services/Health and Human Services Handbook of Consumer Rights: Mental Health Services, available at: https://hhs.texas.gov/sites/default/files/documents/about-hhs/your-rights/office-ombudsman/mh-consumer-rights-handbook.pdf; and
● the Authorization of Services letter.

**Procedure: Child and Family Team Meetings**

The Child and Family Team (CFT) is a group of people – chosen with the family and connected to them through natural and formal support relationships – who develop and implement the family’s plan, address unmet needs, and work toward the family’s vision. In accordance with NWIC requirements, Wraparound Facilitators are responsible for coordinating and leading the development of the CFT, including the recruitment of CFT members. In order to be considered a CFT, members of the team must include natural and formal supports in addition to the Wraparound Facilitator, participant, and LAR. Once team members have been identified and agreed upon by the participant and LAR, the Wraparound Facilitator will begin contacting each member in order to schedule and facilitate the first CFT meeting. All members will document their attendance by signing the Sign in Sheet provided by the Wraparound Facilitator. A Sign in Sheet is required at every CFT meeting and must be attached to or included in the Wraparound Plan and kept in the participant’s file.
The first official CFT meeting must occur within **30 calendar days** of the HHSC authorization of the CE document in CMBHS. Required attendance for the initial CFT meeting are the:

- Wraparound Facilitator;
- participant;
- LAR;
- natural supports;
- formal supports; and
- DFPS Caseworker (if participant is in substitute care).

If the participant is involved with the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI), then the TCOOMMI case manager should be engaged as a member of the CFT. The participant’s TCOOMMI plan of care will align with what the CFT agrees on and develops for the participant’s YES Waiver Wraparound Plan.

The Wraparound Facilitator is responsible for facilitating a discussion with the CFT and for monitoring progress, services, and outcomes at every CFT meeting. CFT members will work together to ensure that the strategies and services in place are working, while simultaneously crafting new ideas and strategies when they are not.

Discharge and transition planning should begin during the first CFT and continue throughout the Wraparound process in order to better prepare the participant and other team members for transitioning out of the YES Waiver program. Transition plans should be reviewed and revised as needed at every monthly CFT meeting in order to reflect the progress the participant has made. The final transition plan will be submitted to CMBHS, along with their CE, prior to the CE end date.

**Initial Wraparound Plan Development**

During the first CFT meeting, the team will work to:

- review and update the Crisis and Safety Plan;
- review and add to the strengths list;
- identify additional natural and formal supports;
- create a Family Vision and/or Team Mission Statement;
- discuss, agree on, and document needs statements for the participant and LAR;
• brainstorm, agree on, and document strategies with measurable target outcomes for each documented needs statement for both the participant and LAR;
• agree on, assign, and document the roles for each CFT member;
• agree on how the CFT will measure and document the participant’s progress every month;
• review and update IPC services;
• develop a transition plan;
• update the Wraparound Plan; and
• discuss, agree on, and document the participant’s services, including the type, scope, frequency, duration, and location of each service in the Wraparound Plan.

The Wraparound Facilitator is responsible for updating all CFT members with any changes made to the Wraparound Plan within **five business days**.

If a service provider is unable to attend a scheduled CFT meeting in person or over the phone, they must submit a detailed summary of their interactions with the participant since the last CFT meeting no later than **seven business days** prior to the upcoming CFT meeting. This summary must include updates and issues the CFT should be aware of in regard to the participant’s strengths, needs, and progress, as well as recommendations regarding their service type, scope, frequency, and duration. Any changes to existing services on the Wraparound Plan should be immediately communicated to the CWP if the CWP is not present at the meeting.

**Wraparound Plan Implementation**

In the beginning, meetings are likely to occur at least every two to four weeks until the CFT identifies that they are making fewer adjustments. At that point, team meetings should continue, at a minimum, on a monthly basis.

**Monthly Child and Family Team Meetings**

The CFT members are expected to meet at least monthly. The Waiver requires a review of each participant’s Wraparound Plan and IPC during each CFT monthly meeting in order to ensure that the participant’s Safety and Crisis Plan continues to be effective and for Wraparound fidelity. The Wraparound Facilitator is responsible for determining if any existing situations may jeopardize the participant’s health and welfare. Revisions to the Crisis and Safety Plan may be made at any time by the CFT or the Wraparound Facilitator.
CFT members required to be in attendance for monthly meetings are the:

- Wraparound Facilitator;
- participant;
- LAR;
- CWP, or designee;
- any natural or formal supports; and
- if the participant is involved with the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI), the TCOOMMI case manager should be engaged as a member of the CFT. The participant’s TCOOMMI plan of care will also need to align with the participant’s Wraparound Plan.

If the participant and LAR are not able to meet for a scheduled CFT meeting, the reason must be documented in both their Wraparound Plan and participant file.

During each monthly CFT meeting, the Wraparound Facilitator must review and address, at a minimum, the following topics with the CFT members:

- document members in attendance;
- Crisis and Safety Plan;
- needs, strategies, and roles of every CFT member;
- measure and document progress and/or lack of progress towards the family vision, needs, and outcomes;
- IPC services;
- transition plan;
- the satisfaction and effectiveness of services;
- natural and formal supports;
- any other topics that the CFT determines is important; and
- obtain signatures on the Services Page to verify agreement to services from all members present at the CFT meeting.

If any changes are made to the Crisis and Safety Plan or to the needs, strategies, or services on the Wraparound Plan the Wraparound Facilitator must assure that all members of the CFT are notified.

Every 90 calendar days, the CFT is required to review the IPC for the participant. The following members required to be in attendance for every 90 calendar day CFT meetings are:

- Wraparound Facilitator;
● participant;
● LAR;
● CWP or designee;
● any natural family supports; and
● if the participant is involved with the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI), the TCOOMMI case manager should be engaged as a member of the CFT.

Other Attendees

Other attendees who should attend CFT meetings are other formal supports, such as professional therapists and additional natural supports such as other family members or friends.

Oversight of Wraparound Activities

The WPO oversees the Wraparound Facilitator’s efforts to ensure that:

● CFT meetings are occurring as required;
● the IPC is aligned with the Wraparound Plan and developed using the Wraparound process;
● revisions to the Wraparound Plan, the Crisis and Safety Plan, and the IPC occur as necessary; the participant is receiving at least one billable Waiver service per month; and
● the Wraparound Facilitator’s documentation demonstrates compliance
● with applicable law, rule, and policy.

Monitoring Progress

The WPO is responsible for maintaining an LOC-YES authorization from the participant’s MCO which requires that a CANS assessment be completed every 90 calendar days and verify that their MEV status is active.

The participant and LAR will determine whether or not they would like to invite any members of the CFT to this assessment or may choose to have the CANS administered during the 90 calendar day CFT meeting. The Wraparound Facilitator will document the participant’s and LARs choice in the Wraparound Plan and will list all CFT members present during the CANS assessment in the participant’s file.
Annual Assessment and Renewal

The clinical eligibility evaluation for continued YES Waiver services is completed annually [see POLICY 0 2200 Clinical Criteria and Assessment].

To avoid a lapse in service authorization and program eligibility, the CE annual renewal assessment can be scheduled up to 30 calendar days prior to, but no later than, 10 business days before the CE expiration date. Early scheduling and submission of annual renewal documentation will ensure that there is not a lapse in services and that adequate time is given for the HHSC review and approval process, electronic data transmission, and notification to the participant for their right to a fair hearing.
**5100 Individual Plan of Care Requests**

**Initial Service Authorization Request**

The initial IPC is based on the Crisis and Safety Plan and the Wraparound Plan which can be completed without every member of the CFT present, or in the absence of the CWP.

After development of the initial IPC, the CWP, or designee is required to be present at all subsequent CFT meetings in which the Wraparound Plan will be revised. IPCs will be revised in accordance with changes to the Wraparound Plan.

**Procedure: IPC Development**

Development of the IPC includes:

- identifying the types of Waiver services;
- identifying annual quantity of Waiver services;
- calculating annual cost of proposed services;
- identifying State Plan services;
- identifying non-Waiver services (i.e., community resources, volunteers, nonprofit organizations, etc.).

**IPC Request**

After the IPC is discussed with the participant, LAR, and Wraparound Facilitator, the WPO is required to submit the IPC request in CMBHS in order to obtain authorization for YES Waiver services from HHSC.

**IPC Dates**

The effective date of the IPC will correspond with the date that the IPC is authorized by TMHP. The end date of the IPC is the end date of the CE document in CMBHS.

**Changes to IPC Request**

The IPC should be reviewed and/or revised and submitted to CMBHS at least every **90 calendar days** and when warranted by changes in the participants’ needs.
Changes to the request must be communicated to HHSC prior to authorization or denial of the request. Any changes made by the WPO must be placed back in ‘Ready for Review’ status within five business days of the request being placed into ‘Draft’ status by HHSC.

**Monitoring**

The WPO is responsible for monitoring the status of the IPC request in CMHBS.

**Clinical Eligibility Annual Renewal**

Prior to completing an Annual Renewal IPC, an annual clinical eligibility assessment must be performed in accordance with [POLICY 0 2200 Clinical Criteria and Assessment]. Within 10 business days of the annual CE document being authorized by HHSC, the WPO must submit the annual renewal IPC based on the Wraparound Plan developed during the CFT meeting.

**Preventing Lapse in Services**

The provision of services without an active IPC (not expired) is not reimbursable. The annual renewal IPC must be entered into CMBHS in a timely manner to allow for those services to be authorized without a lapse between an expired IPC and an annual IPC.

**Effective Date**

The effective date of the annual IPC corresponds with the participant’s annual clinical eligibility determination.

**End Date**

The end date of the IPC is the end date of the authorized CE document.

**Health and Human Services Review and Approval**

All IPC types (initial, revision, and annual renewal) must be entered into CMBHS and placed in ‘Ready for Review’ status no later than five business days after completing or updating the Wraparound Plan with the CFT.
Within **five business days** of the IPC being entered into CMBHS, HHSC must authorize or deny the request. Clarification or questions regarding the IPC from the HHSC authorizer are placed in the ‘Note’ section and the request is placed into ‘Draft’ status (not authorized).

**Comprehensive Waiver Provider Copy**

Within **three business days** of the HHSC authorization date of the service authorization, the WPO must provide a copy of the authorized IPC to the CWP.

**Denial and Appeal**

If an IPC is denied for any reason, HHSC must provide a reason for the denial in the ‘Reviewer Notes’ section CMBHS. The WPO shall provide the participant and LAR the Fair Hearing Request form in accordance with 26 TAC §307.15.

**Billable Services**

Waiver services are provided and billed according to the units specified in the service authorization, and in accordance with the billing policies for each specific Waiver service. Only one Waiver service is permitted to be provided at a time except as otherwise indicated by HHSC in YES Waiver policy [see POLICY 0 9000 Billing].
Policy Statement

YES Waiver services are designed to meet needs associated with SED and are not sufficient to meet the needs associated with intellectual or developmental disability (IDD), Autism Spectrum Disorder, and Substance Use Disorder. The WPO must ensure that a YES Waiver participant with a co-occurring IDD, Autism diagnosis, or substance use disorder is offered services which address both their co-occurring diagnosis.

Assessment

Additional assessment and planning of appropriate services and service delivery is required for a participant with a co-occurring diagnosis of:

- IDD – developmental disability (mild, moderate, severe, profound, or unspecified);
- Autism Spectrum Disorder – Rett’s Disorder, Childhood Disintegrative Disorder, Asperger’s Disorder, and PDD Not Otherwise Specified; or
- Substance Use Disorder.

Waiver Services

Community-based services and supports received through YES Waiver address the participant’s needs that arise as a result of and are specific to the SED.

As YES Waiver services do not meet the needs that arise as a result of a single diagnosis of IDD, Autism diagnoses, or substance use disorders. In these cases, families should be informed of programs and resources, including 1915(c) waivers that address the needs associated with a single diagnosis of primary IDD, Autism diagnosis, or Substance Use Disorder.

Procedure: Service Authorization for Co-Occurring Diagnosis

The IPC for a participant with a co-occurring IDD diagnosis must identify non-Waiver services the participant needs in relation to their IDD diagnosis. These must
be documented in CMBHS at ‘Other Non-Waiver Medicaid State Plan Services’ or ‘Non-Waiver Services–Services Provided by Other Funding Sources’.


**5300 Transition Plan**

### Level of Care

WPOs are responsible for facilitating changes in a participant’s services. Changes in services are needed when a participant is transitioning to a different Level of Care, transitioning to adult services upon aging out of the YES Waiver, transferring to a different WPO or CWP, and when services are terminating. All changes should be coordinated in accordance with YES policies specific to the type of change needed.

### Policy Statement

Transition planning for the participant should begin during the first CFT meeting and should be revised and edited at every meeting there after until the participant discharges from the program. In doing so, the CFT is able to edit the plan as strategies are determined effective or non-effective and natural and formal supports are added or removed from the Wraparound Plan. Transition planning will also ensure that all CFT members are reminded of, and actively thinking and working towards, the participant’s transition out of Waiver services or deviating to a lower Level of Care and less-intensive service array. The WPO must oversee the development of a transition plan for each participant in the Waiver program.

### Notification of Transition

The Wraparound Facilitator must notify all collaborating partners when the CFT determines that it is in the best interest of a YES Waiver participant to transition out of Waiver services to a less-intensive service array, and/or can utilize natural and community supports to achieve their goals and objectives.

### Termination of Services

A copy of the transition plan should be attached to the most recent IPC and submitted in CMBHS at least **30 calendar days** prior to the date of the participant’s termination from the Waiver program.

A termination CE must be entered at least **five business days** prior to the termination date. A CE termination auto-generates an IPC termination once the CE Termination is authorized by HHSC.
Policy Statement: Aging Out

In accordance to 26 TAC §307.11, the WPO must begin to establish a transition plan to adult services at least six months before the participant ages out of the YES Waiver program. The last day of clinical eligibility for 18-year-olds is the day before their 19th birthday. The WPO is also responsible for assisting the participant in applying for Medicaid a minimum of three months before they age out of the YES Waiver program. This will ensure that the participant can continue with adult services, if needed, without a disruption in services due to Medicaid ineligibility.

Procedure

A copy of the transition plan should be submitted through CMBHS 30 calendar days prior to the participant’s 19th birthday. This plan should be attached to the most recent IPC or the Termination CE. The WPO must share the transition plan with the CWP, and all members of the CFT.

Notification of Transition

The development of a transition plan must begin at least 6 months prior to the participant’s 19th birthday. The transition plan should be developed in coordination with the CFT and future providers.

Participants interested in continuing to receive Medicaid State Plan Services, yet are aging out of YES Waiver, may be appropriately served in another TRR Level of Care.

Plan Development

The transition plan must be developed in consultation with the CFT and future providers over the course of multiple Wraparound meetings.

The transition plan must include:

- a summary of the mental health community services and treatment the youth received as a Waiver participant;
- the participant’s current status (e.g., diagnosis, medications, level of functioning) and unmet needs;
- information from the participant and the LAR regarding the participant’s strengths, preferences for mental health community services, and responsiveness to past interventions;
• a service plan that indicates the mental health and other community services the participant shall receive; and
• adequate time for both current and future providers to transition natural supports and/or community-based services without a disruption in services.

Submission of the transition plan to HHSC at least one month prior to the date of transition.

Refer to the User Guide for more information on Transition Planning.

**Termination of Services**

The participant’s termination from the Waiver must be entered into CMBHS at least **one business day** prior to the participant’s 19th birthday.

HHSC must receive a copy of the transition plan from the WPO at least **30 calendar days** prior to the participant’s date of from the Waiver. The transition plan must be attached to the most recent IPC revision of the CE termination.

**Termination IPC Request**

A termination IPC is automatically generated once the clinical eligibility termination is entered.
Policy Statement: Transfers to a New Service Area or WPO

Because YES Waiver participants are some of the state’s most vulnerable children and youth, HHSC has identified the need to ensure that strong policies and procedures are in place for participants needing to transfer services. The WPO that is serving the participant is responsible for transferring and coordinating changes in YES Waiver services for the participant and LAR. The following scenarios are considered transfers and the procedures outlined in this section must be implemented in order to ensure appropriate continuity of care:

- participant and LAR relocate to a new service area within the state;
- participant and LAR request a change in their WPO provider; or
- the LAR’s parental rights have been terminated and the participant is removed from the home and DFPS or another adult is now the participant’s Managing Conservator or LAR.

Participants in the transfer process should:

- never be placed on the receiving LMHA’s Inquiry List;
- never be made to wait longer than **seven business days** for YES Waiver services;
- never be automatically terminated because the LAR lost parental rights; and
- never be transferred to the receiving WPO without the required coordination of services that must take place prior to transferring a participant to a new WPO.

Coordination between the transferring and receiving WPO is necessary and vital to the Wraparound process as the receiving Wraparound Facilitator needs to know what services the participant was receiving and have access to the Wraparound Plan. This will ensure a more seamless transition experience and avoid a disruption in services to the participant and LAR.
Policy Statement: Changes in CWP

Transfers and changes in CWPs are processed differently than terminations and are necessary under different circumstances [see POLICY 0 5400 Participant Transfers].

Procedure: Processing CWP Transfers

In order to better prepare the participant and LAR that are transferring to a new CWP, the Wraparound Facilitator must:

- coordinate a CFT meeting to discuss requested changes and implications;
- communicate critical issues or family needs with the new CWP who should participate in the team meeting;
- communicate with the team about any services that may not be available through the new CWP;
- facilitate a discussion with the CFT about what to expect while changes are being processed;
- communicate critical information via fax or email with the receiving CWP such as LAR contact information, Crisis and Safety Plan, last dates of service, continuity of care issues, and any other relevant information;
- inform the participant’s direct service providers about pending changes and service transfer dates to the receiving CWP, transferring CWPs cannot be paid for services provided after the service end/transfer date;
- work with the transferring CWP to determine service usage and remaining dollar or unit balances to provide an anticipated usage summary to the receiving CWP;
- process an ‘Outgoing Estimate IPC’ through CMBHS in accordance with the YES Waiver User Guide;
- inform the receiving CWP of the adaptive aids and supports and/or minor home modifications that have been purchased (both outstanding and already billed); and
- submit and process ‘Transfer CE’ and ‘IPC Transfer Out’ for participants transferring to a different service area and WPO.

Procedure: Processing Incoming Participants

The WPO receiving a new participant or coordinating a change in CWP must assign a Wraparound Facilitator to:

- review information provided by the transferring CWP;
• contact the participant, LAR, and DFPS Caseworker – if the participant is in substitute care – to schedule a face-to-face meeting within **seven business days**. At the initial meeting, the Wraparound Facilitator must work with the family to:
  ‣ identify the CFT members;
  ‣ review and revise the participant’s IPC, as needed;
  ‣ review and revise the participant’s Crisis and Safety Plan, as needed; and
• submit and process incoming documents in CMBHS according to the YES Waiver User Guide.

**CMBHS: Transfers**

For more information regarding the process for completing participant transfers to a new WPO in CMBHS, see the Yes Waiver User Guide.

**Incoming Documents in CMBHS**

When a participant relocates to a new service area, the receiving WPO will enter a diagnosis and the YES assessment in CMBHS. In addition, a ‘Transfer In IPC’ must be submitted within **10 business days**. The start date should be the date immediately following the end date from the transferring WPO, with no breaks in service.

**CMBHS: Change in CWP**

For more information regarding the process for transitioning participants to a new CWP in CMBHS, see the Yes Waiver User Guide.

**Outgoing Documents in CMBHS**

When a participant is transitioning to a new CWP, an ‘IPC Outgoing Estimate’ in CMBHS is required. The ‘IPC Transfer Out’ entered in CMBHS must include:

• reason(s) for transfer;
• date of transfer; and
• name and location of receiving CWP.

**Incoming Documents in CMBHS**

When a participant has chosen a new CWP, the Wraparound Facilitator must create an ‘Incoming Estimate’ in CMBHS and include:
- the start date, which will be one day later than the CFT meeting. Indicate the reason in the ‘Note’ section as ‘Changing Comprehensive Waiver Provider’;
and
- the end date of the original IPC in the ‘Note’ section.
5500 Termination of Waiver Services

Reasons for Termination

A participant should be terminated from the YES Waiver in the event:

- **Graduated/Adequate progress addressing reason(s) for referral**: CFT agreed that the identified need(s) in the Wraparound Plan have been adequately met and the participant no longer requires a YES Level of Care;
- **Moved out of state**: participant and LAR’s permanent residence is no longer in the state of Texas;
- **Participant no longer resides with LAR**: participant moved out of the LAR’s home and is permanently living with someone else. Temporary living arrangements should not be included in this category;
- **Unable to Locate**: Wraparound Facilitator was unable to locate participant and LAR;
- **Withdrawal**: participant and LAR chose not to continue with YES Waiver services;
- **Non-engagement**: participant and LAR not engaged in YES Waiver services for **60 consecutive calendar days** and good faith efforts were attempted by the Wraparound Facilitator;
- **Out-of-Home Placement**: participant entered an out of home placement for up to **90 consecutive calendar days**;
- **Detention/Incarceration**: participant was detained or incarcerated for more than **90 consecutive calendar days**;
- **Foster care placement**: participant was placed in DFPS conservatorship and the new guardian chose not to continue YES Waiver services;
- **Participant does not maintain active Medicaid eligibility**: participant cannot obtain or loses Medicaid coverage due to lapse in renewal or ineligibility;
- **Participant aged out**: participant turned 19 years of age while receiving YES services;
- **Cost Neutrality**: the cost of services and supports provided in the home or community exceeds the cost neutrality guidelines of the Waiver; or
- **Participant is deceased**.

If a participant and LAR do not participate in Waiver services for a period of 60 days, the WPO may consider denying, reducing, suspending, or terminating Waiver
services if there is no form of contact from the participant and LAR and the good faith efforts attempted by the Wraparound Facilitator are documented in the participant’s file.

Prior to termination, the WPO must complete and document good faith efforts to engage the participant and LAR. A minimum of two phone calls and one certified letter within a 60-day period that allows the participant and LAR to respond within two weeks constitutes a good faith effort.

The same efforts must be made for participants in substitute care. All phone calls and correspondence shall be directed to the DFPS Conservator. If the DFPS Conservator is not engaging in the process, the WPO may contact the DFPS Regional Program Director for support.

A participant who moves out of the state is no longer eligible to participate in the Waiver and must be terminated from the Waiver program. The WPO must inform the participant and LAR that Waiver services will be terminated.

**Procedure: Termination CE Request**

A Termination CE is submitted when a participant discontinues Waiver participation prior to **365 calendar days** of eligibility. The Termination CE must be entered into CMBHS prior to the participants CE termination date, allotting enough time for the HHSC approval process of **five business days** and electronic data submission.

A termination CE will automatically generate an IPC termination. The WPO should document the reason for termination and the effective date of the termination.

The WPO must document the reason for termination given by the Wraparound Facilitator, in the ‘Notes on IPC Type’ section of the Termination IPC.

After a Termination CE has been authorized by the Health and Human Services Commission, the WPO should send the Denial of Eligibility letter and Fair Hearing Request form so that the participant and LAR can inquire to reinstate services at a later date. However, the participant and LAR must follow the initial Inquiry List and initial enrollment process as described and in accordance with [POLICY 0 2400 Medicaid Benefits, 02500 Enrollment Process, and 0 4000 Local Mental/Behavioral Health Authority Responsibilities: Inquiry List].
5600 Temporary Out-of-Home Living Arrangement

**Definition**

A temporary out-of-home living arrangement is defined as a temporary living arrangement, that is not funded through YES Waiver Respite or Supportive Family-Based Alternatives services, in which a participant is residing on a daily basis, away from the LAR, or outside of their own apartment or home, if a legally emancipated minor.

Examples of temporary out-of-home living arrangements include, but are not limited to: shelter, group home, residential treatment center, or other facility-based setting.

**Duration**

A temporary out-of-home living arrangement is permitted to last up to **90 consecutive or cumulative calendar days** per CE year.

**Policy Statement: Temporary Out-of-Home Waiver Status**

During the time a participant is in a temporary out-of-home living arrangement, the participant will remain enrolled in the Waiver but cannot receive funding through the Waiver for services while residing in an institutional setting. Funding for Wraparound, transportation, and other services are available to those participants that reside in a community with System of Care funding from HHSC.

**Procedure: Wraparound Facilitation**

In the case of temporary out-of-home living arrangements, Waiver participants should not be terminated from the Waiver and therefore should maintain an authorization for LOC-YES.

The provision of intensive case management (ICM) is allowable within **180 calendar days** of discharge from a private residential setting (note: ICM cannot be
provided in Waco Center for Youth). Therefore, ICM may continue in order to coordinate and document the participant’s plan to transition back to residing with the LAR or back to the participant’s home or apartment, if legally emancipated.

**Reporting to Health and Human Services Commission**

Temporary out-of-home living arrangements in an institutional setting or treatment facility must be reported to HHSC as a critical incident [see POLICY 0 3200 Critical Incident Reporting].

If the participant has not received Waiver services for at least 90 calendar days, the WPO must submit an updated IPC to HHSC, within 30 calendar days of the day the participant stopped residing in the temporary out-of-home living arrangement.

**Medicaid Policy for State Plan Benefits**

Per the Texas Medicaid Provider Procedures Manual - Behavioral Health, Rehabilitation, and Case Management Services Handbook states: Texas Medicaid must not be billed for case management services provided to people who are residents or inpatients of:

- nursing facilities (for people not mandated by the Omnibus Budget Reconciliation Act [OBRA] of 1987);
- an Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID);
- state-supported living centers;
- state mental health (MH) facilities;
- Title XIX participating hospitals, including general medical hospitals;
- private psychiatric hospitals;
- a Texas Medicaid-certified residence not already specified;
- an institution for mental diseases, such as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing the diagnosis, treatment, or care of people with mental diseases, including medical attention, nursing care, and related services; and
- a jail or public institution.
Notice of Open Enrollment

HHSC must post a Notice of Open Enrollment to request applications for entities interested in providing all services covered under the YES Waiver.

The Notice of Open Enrollment must describe the eligibility requirements for an entity to become a credentialed CWP. An interested entity must meet, and maintain, the eligibility requirements contained in the Notice of Open Enrollment throughout the application and selection process.

The interested entity must submit the application in accordance with the instructions provided in the Notice of Open Enrollment.

HHSC may request items from the original Open Enrollment for any providers interested in expanding services to other locations. See HHSC’s Procurement and Contract Services Open Enrollment Opportunity website for more information:

https://apps.hhs.texas.gov/PCS/HHS0000065/.

Procedure: Credentialing

CWPs are credentialed by HHSC through a desk review and an on-site review. The LMHA/LBHA is not responsible for, nor has a role in, credentialing CWPs.

Desk Review

Upon receiving the application and other required documents, HHSC must complete a review of all submitted materials within 10 business days.

HHSC notifies the entity via email when the desk review is complete and then schedules the on-site review.
On-Site Review

HHSC will conduct the on-site review after completion of the desk review. The on-site review includes, but is not limited to, a tour of the facility, interviews with pertinent staff, and the review and verification of:

- facility and staff availability;
- staff credentialing and privilege;
- quality assurance/management;
- clinical operations;
- treatment records;
- facility safety;
- facility appearance;
- record keeping;
- confidentiality practices;
- utilization program;
- organization of administration;
- staffing plan; and
- medication safety.

Approval

Provider Agreement

Following successful completion of the desk review and on-site review, HHSC will execute a Medicaid Provider Agreement with the approved CWP.

Texas Medicaid Healthcare Partnership

The approved CWP will receive an approval letter from HHSC, to enable the CWP to apply for and obtain its YES Waiver-specific provider type. Upon receipt of the approval letter from HHSC, the CWP must contact TMHP to enroll as a Waiver provider; however, Waiver services must not begin until the Waiver provider type has been determined by TMHP [see POLICY 0 9000 Billing].

The CWP is responsible for maintaining enrollment with TMHP and adhering to all TMHP provider enrollment and reenrollment requirements as indicated in the Texas Medicaid Provider Procedures Manual, including but not limited to establishing appropriate unique suffixes for each physical location where
services are delivered. HHSC is not responsible for rejected claims for services that were provided by an entity not properly enrolled with TMHP.

**Program Training**

Prior to providing Waiver services and/or participating in a CFT meeting, a CWP staff member must receive program training in accordance with [POLICY 0 3500 General Training and Technical Assistance].

**Credentialing**

Once all program training requirements are met, the CWP credentialing process is considered complete by HHSC and the approved CWP is permitted to begin Waiver services.

**Licensing and Compliance**

HHSC monitors CWPs for compliance with licensing requirements. Any time harmful or non-compliant practices are identified, corrective action will be taken to bring the CWP back into compliance.

Failure to comply with corrective action plans may result in contract action up to and including possible contract termination.

**Overview**

A CWP will ensure staffing, service delivery, training, documentation, policies, billing, and operations that promote quality care and high-fidelity services for YES Waiver participants. The CWP must ensure availability, accessibility and continuity of care for participants enrolled in the program as required by this manual and the executed contract with HHSC.

**Staffing**

The CWP is responsible for:

- recruiting an adequate number of qualified staff and/or subcontractors to assure the provision of all services in the YES service array, access to services that are convenient for the family, and choice of individual service providers;
● ensuring adequate coverage is available when individual providers are unavailable, and the lack of immediate care would pose a serious threat to the participant’s health or welfare;
● maintaining current information regarding staff qualifications and training records and direct service employee attendance/time records for HHSC review upon request and in accordance with law; and
● immediately terminating the employment of a direct service provider for any confirmed ANE incident involving a participant [see POLICY 0 3100 Criminal History and Federal and State Registry Checks].

Service Delivery

The CWP is responsible for:

● training and supervising all staff and/or subcontractors in the provision of YES Waiver services;
● attending CFT meetings and/or in situations where attendance is not possible, submit a progress update to the Wraparound Facilitator in advance in order to inform the discussion of the progress the participant is making with the service provided;
● providing services and supports, by staff or subcontractors, in appropriate locations that are in the best interest of the participant;
● appropriately matching the skill set of a direct service staff member with the most recent assessment of a participant;
● implementing services that are authorized in the participant’s YES Waiver service authorization;
● monitoring services for consistency with the participant’s IPC and verifying authorization prior to the provision of services;
● monitoring proper implementation and provision of Waiver services in accordance with the participant’s service authorization;
● training staff and/or subcontractors on the Wraparound process;
● notifying the Wraparound Facilitator of significant changes in the participant’s situation or needs;
● approving and providing ongoing oversight of respite settings to ensure the safety and appropriateness of the setting including provider qualifications; and
● verifying the qualifications of all employees and subcontractors for all services.
Training
The CWP is responsible for:

- training all direct service staff on the CWP policies and procedures; and
- developing training interventions and/or strategies for achieving objectives with the CFT.

Documentation
The CWP is responsible for:

- monitoring service notes entered into CMBHS;
- reviewing and maintaining adequate documentation of services; and
- making documentation of services available to participating entities and/or others, at all CFT meetings if not in attendance and as needed throughout the Wraparound process.

Billing
The CWP is responsible for:

- monitoring billing to ensure integrity of all claims submitted to TMHP for payment; and
- refunding to TMHP any overpayment, as defined by 42 CFR §433.304, within 60 calendar days, following the CWP’s discovery of the overpayment.

Operations
The CWP is responsible for:

- complying with all rules and regulations of the HHSC;
- complying with all licensure rules and regulations and maintaining current licenses;
- communicating routinely and maintaining a professional relationship with the WPO in order to help ensure that services provided are adequate, accessible, and meet the needs and expectations of the participant and CFT;
- responding to information requests within three business days to the WPO or HHSC;
- reporting suspected fraudulent practices in accordance with HHSC rules;
- completing and submitting critical incident reports;
● reporting allegations of abuse, neglect, and exploitation;
● implementing a procedure for reporting a complaint against the CWP or its staff and/or subcontractors; and
● maintaining policies, contracts, or other written agreements between the organization and all employees or subcontracted providers which specify:
  ‣ that the employee, entity, contractor, or subcontractor must comply with all applicable YES Waiver policies, Medicaid laws and regulations related to the Waiver, and CMS instructions;
  ‣ a prompt payment provision that stipulates the terms agreed to by both organization and the provider; and
  ‣ that HHSC may audit or inspect any books, record, devices or systems used to transmit participant data of the organization, or its subcontractors, related to delivery of YES Waiver services to determine if the organization or subcontractors are complying with the terms of the contract and the YES Waiver Policy Manual.

Subcontracted Services

Agreement

A CWP is permitted to enter into an agreement with individuals or agencies to subcontract for YES Waiver services. A separate agreement is required for each individual or agency providing Waiver services.

The agreement must include the following:

● role and responsibilities of the CWP;
● role and responsibilities of the subcontractor;
● staff qualifications;
● criminal history and state and federal registry checks; and
● rate and payment information.

The CWP must provide a copy of its standard agreement to HHSC.

Verification of Qualifications

The CWP must verify the qualifications of an individual or agency interested in providing subcontracted Waiver services. The CWP must verify that a subcontractor:
is in good standing with all federal and state funding and regulatory agencies;
- is not debarred, suspended, or otherwise excluded from participation in any federal grant program;
- is not delinquent on any repayment agreement associated with the business;
- has not had a required license or certification revoked;
- has not voluntarily surrendered any license issued by HHSC within the previous three years of the date of the agreement; and
- has not had a contract terminated by HHSC.

**Document Retention**

The CWP must retain a copy of all current, amended, or revised subcontractor agreements [see POLICY 0 3700 Record Keeping].

**Subcontractor Responsibilities**

An individual or agency entering into a subcontractor agreement to provide Waiver services is responsible for:

- maintaining a list of current personnel providing Waiver services or performing related activities;
- maintaining a list of the service(s) provided by personnel;
- conducting criminal history checks of all staff members;
- verifying staff licensures and credentials are current;
- verifying staff have completed all YES Waiver required trainings and are maintaining appropriate documentation for services delivered to YES participants;
- identifying staff performing dual roles; and
- providing documentation to the CWP of the procedures for:
  - record keeping;
  - verifying staff qualifications and training; and
  - criminal history and abuse registry checks.

**Medication Management**

**Scope**

The LMHA and CWP will ensure that medications are administered only by individuals with authority to do so by the nature and scope of their license, certification, and/or practice.
Administration

YES Waiver Providers are responsible for administering prescription medication to a Waiver participant who is unable to self-administer medication. To administer prescription medication to a YES Waiver participant, the WPO and CWP shall:

- obtain a signed authorization from the participant’s LAR;
- ensure medication is in its closed, original container, and includes the:
  - participant’s full name;
  - participant’s date of birth;
  - name of the prescribing physician or other licensed health professional; and
  - expiration date;
- ensure medication is administered in accordance with a physician or other licensed health professional’s instructions and label directions;
- ensure expired medications are not administered to the participant;
- administer the medication only to the participant for whom it is intended; and
- notify the LAR of any expired prescription medication.

Self-Administration

A participant is permitted to self-administer prescription medication under the supervision of a WPO and CWP direct service staff member. To permit a participant to self-administer medication, the WPO and CWP must:

- obtain a signed authorization from the participant’s LAR;
- ensure medication is in its closed, original container, and includes the:
  - participant’s full name;
  - participant’s date of birth;
  - name of the prescribing physician or other licensed health professional; and
  - expiration date.
- ensure medication is administered in accordance with a physician or other licensed health professional’s instructions and label directions;
- ensure the participant is not self-administering expired medication;
- ensure the participant is administering only to them self; and
- notify the LAR of any expired prescription medication.
Documentation

When prescription medication is administered to a participant or self-administered by a participant, the WPO and CWP must document the:

- full name of the participant taking the medication;
- name of the medication;
- date, time, and amount of medication given or taken; and
- full name and signature of the direct service staff member administering the medication or supervising the participant’s self-administration.

The WPO and CWP must retain records of medication administration for three months following the date of the administration [see POLICY 0 3700 Record Keeping].

Unused Medication

Any unused medication must be returned to the participant’s LAR. The WPO and CWP must document the name of the medication returned and the date and amount of medication returned to the LAR in the participant’s file.

Nonprescription Medication

The WPO and CWP are permitted to administer nonprescription medication after obtaining permission from the LAR and in accordance with the LMHA/LBHA and CWP policies and procedures.

Administration Errors

The WPO and CWP are required to report any medication administration errors to HHSC as a critical incident [see POLICY 0 3200 Critical Incident Reporting].

Medication errors that must be reported to HHSC include but are not limited to:

- administering medication to the wrong person;
- administering the wrong medication;
- administering the wrong dosage;
- failing to administer medication at the prescribed time;
- failing to follow administration instructions properly; or
- failing to accurately document the administration.
**Storage**

Medication must be placed in an individual container that has the participant’s name and current picture displayed and clearly visible for staff to see. All containers must be placed in a locked storage container and kept out of the reach of participants. Medication that requires refrigeration must be stored separately, in a manner that does not contaminate food, and must also be placed in a locked container.
Website Information

YES Waiver Providers are required to add information regarding the YES Waiver program to their organizational website, as well as any other social media platforms that advertise any type of services related to the YES Waiver program the provider offers, in a place that is clearly visible and easy to locate. The following information is required, at a minimum, for LMHA/LBHAs, WPOs, and CWPs:

- use HHSC approved online content and information about the YES Waiver program;
- list YES Waiver service array;
- provide information describing the Wraparound process; and
- use any HHSC approved multimedia content directed and intended for individuals and providers.

Inquiry Line

As LMHA/LBHAs are the only YES Waiver Providers able to perform the initial assessment and submit initial clinical eligibility determinations for individuals interested in the YES Waiver program, LMHAs/LBHAs are required to post the YES Waiver Inquiry Line on their website in addition to the required information above. The Inquiry Line must also be visible and easy to locate on the LMHA/LBHAs website.

Marketing and Outreach Materials

Any information developed by YES Waiver Providers and intended for distribution in accordance with their outreach and marketing plan, must be submitted to, and approved by, HHSC prior to dissemination. All outreach material templates must be submitted electronically to HHSC at the beginning of the Waiver year and any new or updated outreach material that is created thereafter must be submitted to, and approved by, HHSC prior to dissemination. Outreach material should be available in both English and Spanish.
Outreach Material Approval

Any tools or information developed by the WPO or CWP for use must be submitted to HHSC during:

- the first contract issuance;
- at contract renewal; and
- any time changes/updates are made to the marketing material.

HHSC must first approve the material and will notify the WPO and/or CWP of this approval in writing before the WPO and/or CWP disseminates the material to the public.
A CWP is required to develop and maintain an adequate provider network. An adequate provider network consists of:

- contracted qualified providers for the full YES Waiver service array;
- services on the IPC are provided free of conflict of interest (i.e. services are not provided by the individual/agency developing the IPC, except as the provider of last resort);
- access to all services on an authorized IPC within **10 business days** of the date of authorization;
- a participant choice of qualified provider of individual Waiver services; and
- access to providers within 30 miles of their residence (within 75 miles if the participant lives in a rural area).

In the absence of alternate WPO or CWP, the LMHA/LBHA can serve in both roles for the same participant as the WPO and CWP of last resort.

Provider network information will be submitted to HHSC through the Quarterly Provider Report. Failure to submit reports or verify availability of all services in the YES service array may result in a required Strategic Outreach Plan.
**Policy Statement**

When the agreement between HHSC and a CWP is terminated, all participants served by the CWP must choose a different CWP. Participants must be transitioned to the CWP of their choice prior to the date of the termination of the agreement.

The CWP must notify the participant, LAR, and DFPS Caseworker if the participant is in substitute care, that the provider agreement with HHSC is being terminated.

**Procedure: Coordination of Transfer of Participant**

HHSC will notify the WPO of an agreement termination. At least 30 calendar days prior to the date of termination, the CWP must provide notice to the participant, LAR, and DFPS Conservator – if the child is in substitute care – that the CWP agreement with HHSC is being terminated. The WPO will then facilitate the transfer in accordance with [POLICY 0 5400 Participant Transfers].
Individual Plans of Care

A YES Waiver initial IPC must be reviewed and updated according to the participant’s needs, agreed upon by the CFT, and a revised IPC must be uploaded into CMBHS every 90 calendar days. The IPC must be entered into CMBHS even if there are no changes to the plan [see POLICY 0 5100 Individual Plan of Care Requests].

All services must be provided in accordance with the Wraparound Plan and associated IPC. The Wraparound Facilitator must meet with the CFT at least every 30 calendar days to determine response and effectiveness of services and to measure progress throughout the Wraparound process.

Service Documentation

Documentation requirements for the IPC, the Wraparound Plan, progress notes, and provision of services, are described in each individual service policy [see POLICY 0 6100 YES Waiver Service Array]. All service documentation must include how strategies and treatment provided directly support the reason for referral and the identified need(s) of the participant and the LAR. The provider must document the provision of service by maintaining up-to-date progress notes, which are reviewed by HHSC. All service documentation must be submitted within two business days after service delivery.

For more information on documentation requirements for billing, [see POLICY 0 9000 Billing].

Monitoring of Progress Notes

Wraparound Facilitators are required to monitor all of the services a participant receives throughout the Wraparound process. This should be done in a variety of ways, some of which include speaking to providers, participants, and/or their LARs outside of CFT meetings, reviewing progress notes, and discussing services and progress during CFT meetings.
Group Setting Services

Certain Waiver services are permitted to be provided in a group setting, if identified as clinically appropriate by the CFT and must consist of no more than six individuals, excluding service providers.

The following Waiver services are permitted to be provided in a group setting:

- Community Living Supports (CLS);
- Family Supports;
- Paraprofessional Services; and
- Specialized Therapies.

Billing

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. For information on billing for group setting services, refer to specific policies and billing sections for each of the four services above see POLICY 0 9000 Billing].
Service Description

YES Waiver Adaptive Aids and Supports (AA&S) are goods and/or services that are intended to support the underlying mental health need of the participant and are determined to be medically necessary to help the participant remain in the home and community and avoid an out-of-home placement.

AA&S are provided in combination with other YES Waiver services to help decrease or eliminate barriers to services and to increase participants’ access to their community. AA&S are not applicable for use by anyone other than the YES participant.

AA&S Request Determination

All Waiver services, including AA&S, are requested on an IPC throughout the Wraparound process and directly related to the participant’s mental health need and reason for referral. A request for AA&S should be determined only after natural supports, community resources, formal supports, and other strategies have been documented and attempted, but have proven unable to meet the needs of the participant. Natural supports or resources provided by the community should be prioritized over formal supports and services through the Waiver. Once all of these supports and resources have been exhausted and documented in the Wraparound Plan, the CFT may determine that an AA&S request should be pursued.

The request should be reviewed by the YES Program Manager/Supervisor and other appropriate parties prior to submission HHSC.

The CFT is required to meet and review the participant’s continued need for authorized services at least every **90 calendar days** from the date of the delivery of the AA&S. The review should assess whether or not the purchased AA&S were:

- effective in meeting the identified needs;
- purchased in a timely manner;
- utilized for the intended purpose.

This review should be documented and placed in the participant’s file. AA&S must be requested in 90-day increments.
AAS should only be developed through the brainstorming process of the CFT meeting and must be reflected on the Wraparound Plan. The brainstorming process identifies multiple strategies to meet an identified need which may include formal and natural supports and services.

After brainstorming, tasks are assigned to each CFT member to explore ways in which the family, team, and community will help to meet this identified need, including the use of natural supports and community resources. Natural supports or resources provided by the community should be prioritized over formal services through the Waiver.

**Request Prior to First Team Meeting**

AA&S can only be requested prior to the first CFT meeting if the request is tied to a Crisis and Safety Plan and is medically necessary.

**Adherence to Waiver Restrictions**

AA&S must not circumvent other restrictions of Waiver services, including the prohibition against claiming for the costs of room and board.

**Reviews and Verifications**

HHSC reviews all AA&S requests and verifies all requirements are met prior to IPC approval and may ask for additional information, at any time. HHSC authorizes AA&S based on the needs of each participant. HHSC will deny AA&S requests if requirements are not met.

**Recoupment**

HHSC may pursue recoupment of funds if it is determined a CWP has billed for AA&S inappropriately, if the service provided was not approved, or if the service was not provided as described to HHSC in the AA&S Request Form.

An AA&S Request Form and associated documentation must be submitted and approved by HHSC for an AA&S to be approved on the IPC.
Heightened Scrutiny

Some AA&S requests may require heightened scrutiny in order to be approved. The Adaptive Aids and Supports Heightened Scrutiny List [Appendix D:] includes goods and services that may require additional evidence of medical necessity in order to be approved on an IPC. These requests are typically not medically necessary and may not qualify as adaptive aids and supports. The YES Waiver program staff will consider these requests per the review process outlined below to determine if the request is necessary to meet a participant’s underlying mental health needs and reason for referral.

As with all Waiver services, it is expected that the CFT will meet the identified need(s) using Waiver services as a last resort. AA&S should not be requested if there are other available family and/or community resources or if there is a Waiver service within the CWP service array that could meet the participant’s identified need(s). When it is determined by the CFT that all possible services and strategies have been exhausted and no other means or strategies exist, the CFT may decide to submit an AA&S request.

Heightened Scrutiny Review Process

The heightened scrutiny review process, which is conducted by a team of three HHSC YES Waiver staff, will require additional information and documentation which will be determined and requested by HHSC after the AA&S request has been submitted to HHSC for review. Communication between HHSC and the YES Program Manager/Supervisor may be required before an approval or denial of the AA&S in question can be made in order to gather additional information or to clarify medical necessity.

Non-Billable List

Some categories of goods and services are not billable adaptive aids and supports [See Appendix C:].

Adaptive Aids & Supports Criteria

An AA&S request must meet and provide the following criteria on the request form prior to approval by HHSC:
• be directly and specifically relate the participant’s SED and reason for referral for mental health services;
• be medically necessary to prevent institutionalization and out-of-home placement;
• be directly tied to an identified need on the CANS assessment;
• be determined during the Wraparound process as either:
  ‣ a strategy of last resort after all natural and formal supports, as well as community resources have been documented, exhausted, and proved unsuccessful in the Wraparound Plan, and tied to a strategy associated with an underlying mental health need, or
  ‣ a critical component and last resort strategy within a Crisis and Safety Plan that is absolutely necessary prior to the first CFT meeting taking place;
• be used to supplement and affect services under the approved service plan to decrease or eliminate barriers to services and increase participants’ access to their community;
• be cost effective, according to current market prices, for the type of adaptive aid and:
  ‣ be the lowest cost, unless contraindicated by specific written justification for using a higher bid; and
  ‣ for requests exceeding $500, be compared to at least three solicited bids;
• must not duplicate any service offered under a YES Waiver service category;
• must not duplicate services covered under the Medicaid State Plan;
• cannot be used for purposes that are intended as a diversion and do not have a therapeutic objective;
• cannot be used for goods or services that supplant normal family obligations;
• may not circumvent other restrictions of Waiver services, including the prohibition against claiming for the costs of room and board;
• cannot be used to replace deficits in YES Waiver provider networks;
• have been reviewed and accepted by the YES Program Supervisor/Manager and any other appropriate parties;
• comply with 26 TAC §307.9;
• must be requested as a “last resort,” after the CFT has gone through each stage of the Wraparound process and the CFT has determined that the family, team, and community cannot meet the specific mental health need being addressed through any other means;
• be requested in accordance with YES Waiver policy and procedures; and
• must not be on the AA&S Non-Billable List [see Appendix C:].
Wraparound Plan

The Wraparound Plan may be requested by HHSC when reviewing an AA&S request. The Wraparound Plan must include all components required to be documented in the plan, with a specific focus on the following:

- how the AA&S is tied to the participant’s identified mental health need and reason for referral;
- how the AA&S will be used by the participant, including strategies or action steps;
- outline of the strategies and tasks assigned to each team member, and the outcomes of each task;
- how the AA&S will assist participants in achieving their identified needs; and
- if the request is recurring, the participant progress or lack of progress in relation to the AA&S and why the AA&S is still needed to meet participants’ identified need(s).

Adaptive Aids and Supports Requests

The Adaptive Aids & Supports Request Form is available on the YES Waiver website at:


The form must be completed and submitted to HHSC for approval. Instruction for completing the form can be found on the form itself and additional support can be found in the YES Waiver User Guide.

HHSC approval of an AA&S Request Form is required prior to the Wraparound Facilitator submitting AA&S services on an IPC. The AA&S description should be included in the IPC AA&S justification box, and the AA&S Request Form should be attached to the IPC. AA&S are not officially authorized until approved in CMBHS by HHSC. If the AA&S request is denied by HHSC, the Wraparound Facilitator must send the Denial of Eligibility Letter, including the reason for denial and Fair Hearing Request Form to the participant, LAR and/or DFPS Caseworker, if the participant is in substitute care.
Progress Notes

Documentation of the provision of service, which is reviewed by HHSC, must include:

- participant name;
- Medicaid ID #;
- start and stop time of the service, if applicable;
- service name and description, if applicable;
- service location, if applicable;
- specific skill(s) received and method used to train participant in skill(s), and participant’s response to use of Adaptive Aid and Service, as well as how the AA&S addresses the mental health needs and reason for referral;
- verified use of the AA&S;
- an invoice or receipt for the purchase of the material(s), which is in compliance with Waiver policies and procedures;
- proof that at least three bids or prices were solicited for goods costing $500 or more;
- proof of completed health and safety and background checks; and
- a copy of the AA&S request form and supporting documents must be retained in the participant’s file.

Failure to show appropriate documentation regarding the purchase of AA&S may result in recoupment of funds. Only one service note can be entered into CMBHS for each adaptive aid request.

Staff Training

Wraparound Facilitators and service providers must be knowledgeable regarding the purpose, policy, and requirements involving the purchase of AA&S. The Wraparound Facilitator must also ensure that CFT members understand their role in the Wraparound process and the policy requirements for an approved AA&S. This includes the connection between the requested AA&S, the underlying mental health need, reason for referral, and the strategies outlined in the Wraparound Plan.

IPC Revisions and Annual Renewals

When completing a 90 calendar day IPC revision or an annual renewal IPC, the Wraparound Facilitator must complete a new AA&S Request Form that includes a
description of the benefits of continuing the AA&S to meet the participant's identified need(s) and goal(s); if applicable.

**Billing**

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Adaptive Aids and Supports and Minor Home Modifications will be limited to an annual maximum combined amount of $5,000. For information regarding billable and non-billable services, payment rate, and required documentation for submitting a claim for AA&S [see POLICY 0 9000.1 Billing: Adaptive Aids and Supports].

**Adaptive Aids and Supports – Health and Safety Requirements**

**Policy Statement**

Ensuring the health and safety of a YES Waiver participant is a top priority. YES Waiver Providers must take reasonable measures to protect a participant from abuse, neglect, and exploitation and to ensure the safety of the physical location of AA&S.

Decisions regarding the participant’s activities will be based on a reasonable and prudent parent standard, in accordance with the DFPS Minimum Standards for Child-Placing Agencies.

**Places of Public Use**

Locations for AA&S that are public places must be safe for human use. A LAR, LAR’s designee, or an LMHA/LBHA, WPO or CWP staff member will be held to a reasonable and prudent parent standard when accompanying the participant to places of public use. According to DFPS, the reasonable and prudent parent standard is the standard of care that a parent of reasonable judgment, skill, and caution would use to maintain the health, safety, and best interest of the child and encourage the emotional and social growth and development of the child. Additional information about the reasonable and prudent parent standard can be found in 26 TAC §748.705.
Short-Term Activities

A participant engaging in a short-term activity or one-time event must be accompanied by, and under the constant supervision of, the LAR, LAR designee, and/or CWP staff members.

Ongoing Activities

When a participant is engaging in an ongoing activity for a specific service, lesson, or encounter, for a limited number of hours per week or month, the CWP must:

- complete a pre-employment criminal history and background check, in accordance with YES Waiver Policy, of any person who will have any contact with the participant; and
- conduct a pre-employment and monthly check, thereafter, of the HHSC Nurse Aide Registry and the Employee Misconduct Registry, of any person who will have any contact with the participant. Consolidated results for the Nurse Aide Registry and the Employee Misconduct Registry are available at: https://emr.dads.state.tx.us/DadsEMRWeb/emrRegistrySearch.jsp.

Businesses within City Limits

The LMHA/LBHA, WPO, or CWP must obtain and document a copy of the certificate of occupancy of a business providing a Waiver service that is located within city limits.

If for any reason a business within a city limit does not have a certificate of occupancy, the CWP must provide justification to HHSC in the IPC for choosing that particular service provider and why the business does not have a certificate of occupancy. The CWP must also complete the Building Safety and Environmental Health Checklist, which can be found on the YES Waiver Website under YES Provider Resources and Forms and Templates.

Link to Forms and Templates page of YES Waiver Website:

Businesses Outside of City Limits

The LMHA/LBHA, WPO, or CWP must complete the Building Safety and Environmental Health Checklist when a business located outside of city limits is chosen as a Waiver service provider.

Notification of Change in Criminal History

The CWP must notify HHSC of any changes to the criminal history and/or abuse registry check for any individual who has been involved in providing Waiver services, via secure email, within three business days of the CWP discovering the change in the criminal history or abuse registry.
Community Living Supports

Service Description

Community living supports are provided to the Waiver participant and family to facilitate the Waiver participant's achievement of documented goals for community inclusion and remaining in their home. The supports may be provided in the Waiver participant's residence or in community settings (including but not limited to libraries, city pools, camps, etc.) Community living supports provide assistance to the family caregiver in the disability-related care of the Waiver participant, while facilitating the Waiver participant's independence and integration into the community. The training in skills related to activities of daily living, such as personal hygiene, household chores, and socialization may be included, if these skills are affected by the Waiver participant's SED.

Community living supports may also promote communication, relationship-building skills, and integration into community activities. These supports must be targeted at enabling the Waiver participant to attain or maintain their maximum potential. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. Training may be provided to both the caregiver and the Waiver participant, dependent upon the Waiver participant's age, on the nature of the emotional disorder, the role of medications, and self-administration of medications.

Training can also be provided to the Waiver participant's primary caregivers to assist the caregivers in coping with and managing the Waiver participant's emotional disturbance. This includes instruction on basic parenting skills and other forms of guidance. Basic parenting skills for this population are those practices and techniques that are intended to help natural or adoptive parents who may also be experiencing personal stress and family difficulties with a child who is having difficulty with behavior, friendships, emotional regulation, or school performance.

Limitation

CLS cannot be provided at the same time as:

- Employment Assistance;
- Non-Medical Transportation;
- Respite Services;
For Family Caregiver(s)

In addition to developing skills for the participant, CLS may also provide curriculum-based skills training to the family caregiver(s). Training topics for family caregivers receiving CLS will vary as these trainings are tailored to each family and their unique need based on the participant’s age, the nature of the SED, the role of medications, and the self-administration of medications, and any other applicable information.

Instructions on basic parenting skills and other forms of guidance can be provided to the participant’s primary caregivers to assist in coping with and managing the participant’s SED.

Provider Qualifications

CLS services must be provided by a credentialed QMHP–CS, defined as an individual who:

- has a bachelor’s degree from an accredited college or university with a minimum number of hours that is equivalent to a major, in accordance with 26 TAC §301.331, in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; or
- is a registered nurse (RN); or
- has completed an alternative credentialing process identified by the Department of State Health Services; or
- has a master’s degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; and
- in addition to passing a criminal history and background check [see POLICY 0 3100 Criminal History and Federal and State Registry Checks].
Information regarding competency and credentialing can be found in 26 TAC §301.331.

CWPs are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of Waiver Provider agencies to ensure compliance with the Waiver Provider agreement. During these reviews, HHSC also verifies the qualifications of Waiver Provider agency employees and subcontractors.

**Wraparound Plan**

The Wraparound Plan must:

- include the description and documentation of the type, scope, duration, and frequency of the service;
- identify the need in the Wraparound Plan that the service will address;
- describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
- identify natural and/or non-traditional and community support systems.

**Progress Notes**

Progress notes are required for the provision of CLS services and must include all of the applicable details outlined below:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- service name and description;
- service location;
- training methods used (e.g. instructions, modeling, role play, feedback, repetition);
- skills training curriculum used;
- need identified in the Wraparound Plan that the service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant’s response to the service provided;
- progress or lack of progress with service;
summary of activities and behaviors observed during the service and how these activities directly impact the identified need that the service addresses; and

direct service provider’s printed name, signature, and credentials.

The provider must document the provision of service by maintaining up-to-date progress notes, which are reviewed by HHSC. All service documentation must be submitted within **two business days** after service delivery.

### Non-Face-to-Face Contact with Participants

There are times when CLS services provided to a participant may not be face-to-face. While these contacts are not billable and should be limited, when they do occur, the provider must document in the progress notes:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- description of the contact;
- service name and description;
- type of contact;
- training methods used (e.g. instructions, modeling, role play, feedback, repetition);
- skills training curriculum used;
- need identified in the Wraparound Plan that the CLS service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant and/or Family Caregiver(s)’ response to CLS service provided;
- progress or lack of progress with CLS service;
- summary of activities, meals, and behaviors during the service and how these activities directly impact the identified need that the CLS service addresses; and
- direct service provider’s printed name, signature, and credentials.

### Contact with Other Parties

When CLS services are provided face-to-face or over the phone with someone other than the participant, such as, but not limited to, LAR, the provider must document in the progress notes:
• participant name;
• Medicaid ID #;
• date of the contact;
• service name and description;
• person with whom the contact was made;
• start and stop time of contact;
• reason for the contact;
• description of the contact;
• outcome(s) of the contact; and
• direct service provider’s printed name, signature, and credentials.

**Program Training**

Prior to providing Waiver services and/or participating in a CFT meeting, a CLS provider must receive program training in accordance with [POLICY 0 3500 General Training and Technical Assistance] as applicable.

**Billing**

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for CLS is detailed in [POLICY 0 9000.2 Billing: Community Living Supports].
7000.3 Employment Assistance

Service Description

Employment assistance is assistance provided to an individual as identified during the person-centered planning process to help the individual locate paid employment at or above minimum wage in an integrated employment setting in the community and meet the individual’s personal and career goals. Transporting the individual to help the individual locate paid employment in the community is a billable activity within the service.

Employment assistance includes:

- identifying the participant’s employment preferences, job skills, and requirements for a work setting and work conditions;
- locating prospective employers offering employment compatible with the participant’s identified preferences, skills, and requirements; and
- contacting a prospective employer on behalf of the participant and negotiating their employment.

Limitations

Employment assistance cannot be provided at the same time as:

- Community Living Supports;
- Non-Medical Transportation;
- Paraprofessional Services;
- Respite; or
- Supported Employment.

Transportation

Transporting the participant to help them locate paid employment in the community is a billable activity within this service.

Incentives, Subsidies, and Certain Expenses

This service does not include incentive payments, subsidies, or unrelated vocational training expenses such as:
• incentive payments made to an employer to encourage hiring the participant;
• payments that are passed through to the participant;
• payment for supervision, training, support, and adaptations typically available to other workers without disabilities filling similar positions in the business; or
• payments used to defray the expenses associated with starting up.

Provider Qualifications

A provider of employment assistance must:

• be at least 18 years of age;
• maintain a current driver’s license, and insurance if transporting the participant;
• pass a criminal history and background check [see POLICY 0 3100 Criminal History and Federal and State Registry Checks]; and
• have one of the following:
  ‣ 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; or
  ‣ 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; or
  ‣ 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.

CWPs are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of Waiver Provider agencies to ensure compliance with the Waiver Provider agreement. During these reviews, HHSC also verifies the qualifications of Waiver Provider agency employees and subcontractors.

Wraparound Plan

The Wraparound Plan must:

• include the description and documentation of the type, scope, duration, and frequency of the service;
• identify the need in the Wraparound Plan that the service will address;
• describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
• identify natural and/or non-traditional and community support systems.

**Progress Notes**

Documentation of employment assistance must include:

• participant name;
• Medicaid ID #;
• date of contact with the participant;
• start and stop time of contact with the participant;
• service name and description;
• service location;
• training methods used (e.g. instructions, modeling, role play, feedback, repetition);
• title of evidence-based or best practice curriculum used;
• need identified in the Wraparound Plan that the service will address;
• use of adaptive aids and supports, if applicable;
• transportation services, if applicable;
• participant’s response to the service provided;
• progress or lack of progress with service;
• summary of activities and behaviors observed during the service and how these activities directly impact the identified need that the service addresses; and
• direct service provider’s printed name, signature, and credentials.

The provider must document the provision of employment assistance by maintaining progress notes detailing the activity the participant engaged in with the service provider, which will be reviewed by HHSC. All documentation must be made within **two business days** after service delivery.

**Program Training**

Prior to providing Waiver services and/or participating in a CFT meeting, an employment assistance provider must receive program training in accordance with [POLICY 0 3500 General Training and Technical Assistance].
Billing

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for employment assistance is detailed in [POLICY 0 9000.3 Billing: Employment Assistance].
7000.4 Family Supports

Service Description

Family supports provides peer mentoring and support to the primary caregivers; engages the family in the treatment process; models self-advocacy skills; provides information, referral and non-clinical skills training; maintains engagement; and assists in the identification of natural/non-traditional and community support systems. Family Supports are peer-to-peer mentoring services and are not clinical skills training.

Provider Qualifications

A family support provider must:

- have a high school diploma, or a high school equivalency certificate issued in accordance with the law of the issuing state; and
- pass a criminal history and background check [see POLICY 0 3100 Criminal History and Federal and State Registry Checks].

In addition to at least one of the following:

- one cumulative year of receiving mental health community services for a mental health disorder; or
- one cumulative year of experience navigating the mental health system as the parent or primary caregiver of a child/youth receiving mental health community services; and
- be under the direct clinical supervision of a master's level therapist and receive, at a minimum, an hour of monthly supervision. The supervisor must document and maintain all supervision notes in the family support provider file.

CWPs are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of Waiver Provider agencies to ensure compliance with the Waiver Provider agreement. During these reviews, HHSC also verifies the qualifications of Waiver Provider agency employees and subcontractors.
Wraparound Plan

The Wraparound Plan must:

- include the description and documentation of the type, scope, duration, and frequency of the service;
- identify the need in the Wraparound Plan that the service will address;
- describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
- identify natural and/or non-traditional and community support systems.

Progress Notes

Progress notes are required for the provision of family support services and must include:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- service name and description;
- service location;
- training methods used (e.g. instructions, modeling, role play, feedback, repetition);
- title of evidence-based or best practice curriculum used;
- need identified in the Wraparound Plan that the service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant’s response to the service provided;
- progress or lack of progress with service;
- summary of activities and behaviors observed during the service and how these activities directly impact the identified need that the service addresses; and
- direct service provider’s printed name, signature, and credentials.

The provider must document the provision of service by maintaining up-to-date progress notes, which are reviewed by HHSC. All service documentation must be submitted within **two business days** after service delivery.
Non-Face-to-Face Contact with Participant

When Family Support Services provided to a participant are not face-to-face, the service is not billable, but the provider must document in the progress notes:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- description of the contact;
- service name and description;
- type of contact;
- training methods used (e.g. instructions, modeling, role play, feedback, repetition);
- need identified in the Wraparound Plan that the Family Supports service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant and/or Family Caregiver(s) response to Family Supports service provided;
- progress or lack of progress with Family Supports service;
- summary of activities, meals, and behaviors during the service and how these activities directly impact the identified need that the Family Supports service addresses; and
- direct service provider’s printed name, signature, and credentials.

Contact with Other Parties

When Family Support Services are provided face-to-face or provided over the phone with someone other than the participant, such as, but not limited to, the LAR, the provider must document in the progress notes:

- participant name;
- Medicaid ID #;
- date of the contact;
- service name and description;
- person with whom the contact was made;
- start and stop time of contact;
- reason for the contact;
- description of the contact;
● outcome(s) of the contact; and
● direct service provider’s printed name, signature, and credentials.

**Program Training**

Prior to providing Waiver services and/or participating in a CFT meeting, a family support provider shall receive program training in accordance with [POLICY 0 3500 General Training and Technical Assistance].

**Billing**

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for family supports is detailed in [POLICY 0 9000.4 Billing: Family Supports].
Service Description

Minor Home Modifications are services related to addressing the Waiver participant’s need(s) that arise as a result of their SED and are medically necessary. These services contribute to the functioning of the Waiver participants in the community and thereby assist Waiver participants in avoiding institutionalization. These services include home accessibility/safety adaptations physical adaptations to the Waiver participant’s residence, required by the Waiver participant's service plan, that are necessary to ensure the health, welfare and safety of the participant. Minor home modifications must be age appropriate and related to specific therapeutic goals. The provider agency will be required to maintain written documentation of reasonable cost for services.

Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of Waiver services. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair. Minor home modifications include, but are not limited to:

- alarm systems;
- alert systems; and
- other safety devices.

Wraparound Plan

The Wraparound Plan must describe how the chosen modification:

- addresses the participant’s identified need and is linked to their SED;
- will be used, including strategies or action steps; and
- will assist the participant in achieving their identified goal(s).
Procedure: Minor Home Modification Request Form

Prior to submitting an IPC for a minor home modification, a Minor Home Modification Request Form must be submitted to HHSC and must include:

- the type and description of the modification;
- a description for how the modification will be used and the expected duration;
- an estimated maximum dollar cost that adequately pays for the requested modification;
- verification of soliciting at least three bids or prices for a modification costing $500 or more;
- a link between the use of the requested modification and the participant’s identified mental health need as documented in the Wraparound Plan;
- an assurance that the requested home modification meets any required standards and/or codes, if applicable;
- a statement that the requested modification is being purchased through Medicaid as a last resort; and
- documented strategies and attempts made and exhausted prior to the minor home modification request.

HHSC approval of a Minor Home Modification Request Form is required prior to the Wraparound Facilitator submitting a Minor Home Modification on an IPC. The Minor Home Modification description should be included in the IPC Minor Home Modification justification box, and the Minor Home Modification Request Form should be attached to the IPC. Minor Home Modifications are not officially authorized until approved in CMBHS by HHSC. If the Minor Home Modification request is denied by HHSC, the Wraparound Facilitator must send the Denial of Eligibility Letter, including the reason for denial and Fair Hearing Request Form to the participant, LAR and/or DFPS Caseworker, if the participant is in substitute care.

Provision of Service Documentation

Documentation of the provision of service, which is reviewed by HHSC, must include:

- the receipt of purchase, a copy of which must be in the participant’s file [see POLICY 0 3700 Record Keeping];
- verification of soliciting at least three bids or prices for a modification costing $500 or more;
- a brief explanation of any home modification which falls outside of the scope of an existing warranty;
- a copy of the warranty information for the modification, if available; and
- proof that the requested home modification meets required standards and/or codes, if applicable.

**Billing**

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Minor Home Modifications and Adaptive Aids and Supports will be limited to an annual maximum combined amount of $5,000. Information regarding payment rate, requisition fees, and required documentation for submitting a claim for Minor Home Modifications is detailed in [POLICY 0 9000.5 Billing: Minor Home Modification].
**Service Description**

Non-medical transportation enables Waiver participants to gain access to Waiver and other community services, activities and resources, as specified by the Wraparound Plan. This service is in addition to, not instead of, medical transportation required under 42 CFR §431.53 and transportation services under the State Plan. Transportation services under the Waiver are offered in accordance with the Waiver participant's service plan. This service shall be made available after other transportsations already available through formal and natural supports have been exhausted.

**Provider Qualifications**

A provider of non-medical transportation must:

- be over the age of 18;
- have a valid Texas driver’s license and insurance appropriate to the vehicle used to provide the transportation; and be a:
  - member of the Waiver Provider agency staff; or
  - direct service provider subcontracted with the Waiver Provider agency; and
- pass a criminal history and background check [see POLICY 0 3100 Criminal History and Federal and State Registry Checks].

CWPs are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of Waiver Provider agencies to ensure compliance with the Waiver Provider agreement. During these reviews, HHSC also verifies the qualifications of Waiver Provider agency employees and subcontractors.

**Relatives as Providers**

A participant’s LAR is not permitted to be reimbursed by Medicaid for the provision of non-medical transportation.

A relative of a Waiver participant must meet all provider qualifications above in order to be reimbursed by Medicaid for the provision of non-medical transportation.
Wraparound Plan

The Wraparound Plan must describe how the use of non-medical transportation will assist the participant in achieving their identified need(s), as linked to their SED.

Progress Notes

Documentation of non-medical transportation in a transportation log or alternative mileage log must include:

- participant name;
- Medicaid ID #;
- date of contact;
- start and stop time of contact;
- need identified in the Wraparound Plan that the non-medical transportation service will address;
- start and end location name;
- start address and end address;
- number of miles driven each way;
- total number of miles driven per page and final collective total; name of service provider; and
- direct service provider’s signature and credentials.

A sample transportation log is available on the YES Waiver web site at:

https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers/yes-waiver-resources.

Billing

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for non-medical transportation is detailed in [POLICY 0 9000.6 Billing: Non-Medical Transportation].
7000.7 Paraprofessional Services

Service Description

Services related to addressing the Waiver participant's needs that arise as a result of their SED. These services contribute to the functioning of the Waiver participants in the community and thereby assist Waiver participants in avoiding institutionalization. The services are essential to promote community inclusion in typical child/youth activities and exceed what would normally be available for children in the community. The paraprofessional is a behavioral aide supporting the Waiver participant to meet the behavioral goals outlined in their plan. The paraprofessional may model and coach appropriate behaviors. Paraprofessional services are provided under the direction of a licensed behavioral health professional. There are three types of paraprofessional services:

1. **Skilled mentoring and coaching**: mentoring is provided by a person who has had additional training/experience working with children/youth with mental health problems. For example, a teenager with severe behavior problems may require mentoring from a person with behavioral management expertise.

2. **Paraprofessional aide**: this service may be reimbursed if delivered in a setting where provision of such support is not already required or included as a matter of practice. The aide assists the Waiver participant in preventing and managing behaviors stemming from SED that create barriers to inclusion in integrated community activities such as after-school care or day care.

3. **Job placement**: assistance in finding employment. Job placement can be provided by the paraprofessional to assist the Waiver participant with developing a resume and completing applications. Job placement is not supported employment or employment assistance.

Limitations

Paraprofessional services cannot be provided at the same time as:

- Respite;
- Supported Employment;
- Employment Assistance;
- Community Living Supports; and
• Non-Medical Transportation.

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver.

**Skilled Mentoring and Coaching**

Skilled mentoring and coaching:

- addresses participant’s symptom-related problems that may interfere with the individual’s functioning and living, working, and learning environment;
- provides opportunities for the participant to acquire and improve skills needed to function as appropriately and independently as possible;
- facilitates the participant’s community integration; and
- increases the participant’s community tenure.

Examples of skilled mentoring and coaching include training in symptom management, personal hygiene, nutrition, food preparation, exercise, money management, and community.

**Paraprofessional Aide**

Paraprofessional services consist of training the participant in:

- The importance of taking medications as prescribed;
- Self-administration of medication;
- Determining the effectiveness of the medication(s);
- Identifying side-effects of medication(s); and
- Contraindications for medications that are prescribed.

**Job Placement**

Employment related services provide support and skills training that are not job-specific and focus on developing skills to reduce or manage the symptoms of the participant’s SED that interfere with their ability to make vocational choices or obtain or retain employment.

Examples of job placement services include instruction in dress, grooming, socially and culturally appropriate behaviors, and etiquette necessary to obtain and retain employment; and training in task focus, maintaining concentration, task completion, and planning and managing activities to achieve participant’s goals.
Provider Qualifications

A provider of paraprofessional services must:

- be at least 18 years of age;
- have received:
  - a high school diploma; or
  - a high school equivalency certificate issued in accordance with the law of the issuing state;
- have a minimum of one year of documented full-time experience working with the SED population. Experience may be considered if the documented experience includes activities that are comparable to services specified under the service description;
- demonstrate competency in the provision and documentation of the specified or comparable service. Competency is assessed and documented by the Waiver Provider agency and reviewed by HHSC;
- pass a criminal history and background check [see POLICY 0 3100 Criminal History and Federal and State Registry Checks]; and
- be under the direct clinical supervision of a master’s level therapist and receive, at a minimum, one hour of monthly supervision. The supervisor must document and maintain all supervision notes in the paraprofessional’s file.

CWPs are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of Waiver Provider agencies to ensure compliance with the Waiver Provider agreement. During these reviews, HHSC also verifies the qualifications of Waiver Provider agency employees and subcontractors.

Settings

Paraprofessional services may be provided in the participant’s residence or in community settings, including, but not limited to:

- libraries;
- parks; and
- museums.
Wraparound Plan

The Wraparound Plan must:

- include the description and documentation of the type, scope, duration, and frequency of the service;
- identify the need in the Wraparound Plan that the service will address;
- describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
- identify natural and/or non-traditional and community support systems.

Progress Notes

Progress notes are required for the provision of paraprofessional services and must include:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- service name and description;
- service location;
- training methods used (e.g. instructions, modeling, role play, feedback, repetition);
- title of evidence-based or best practice curriculum used;
- need identified in the Wraparound Plan that the service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant’s response to the service provided;
- progress or lack of progress with service;
- summary of activities and behaviors observed during the service and how these activities directly impact the identified need that the service addresses; and
- direct service provider’s printed name, signature, and credentials.

The provider must document the provision of paraprofessional services by maintaining up-to-date progress notes, which are reviewed by HHSC. All service documentation must be submitted within two business days after each contact that occurs to provide services to the individual and LAR in the YES Waiver program.
Non-Face-to-Face Contact with Participant

When paraprofessional services provided to a participant are not face-to-face, the provider must document in the progress notes:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- description of the contact;
- service name and description;
- type of contact;
- training methods used (e.g. instructions, modeling, role play, feedback, repetition);
- need identified in the Wraparound Plan that the Family Supports service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant and/or Family Caregiver(s)response to Family Supports service provided;
- progress or lack of progress with Family Supports service;
- summary of activities, meals, and behaviors during the service and how these activities directly impact the identified need that the paraprofessional services address; and
- direct service provider’s printed name, signature, and credentials.

Contact with Other Parties

When paraprofessional services are provided face-to-face, or provided over the phone with someone other than the participant, such as, but not limited to, the LAR, the provider must document in the progress notes:

- participant name;
- Medicaid ID #;
- date of the contact;
- service name and description;
- person with whom the contact was made;
- start and stop time of contact;
- reason for the contact;
- description of the contact;
• outcome(s) of the contact; and
• direct service provider’s printed name, signature, and credentials.

**Program Training**

Prior to providing Waiver services and/or participating in a CFT meeting, a provider of paraprofessional services must receive program training prior to delivering services to YES Waiver participants and in accordance with [POLICY 0 3500 General Training and Technical Assistance].

**Billing**

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for paraprofessional services is detailed in [POLICY 9000.7 BILLING: PARAPROFESSIONAL SERVICES].
7000.8 Pre-Engagement Services

Service Description

An LMHA/LBHA may bill YES Pre-engagement, one time through a manual process, for reimbursement for administrative activities provided in an effort to enroll an individual into the YES Waiver, when another Medicaid service cannot be billed for these activities.

Administrative activities refer to assessments, youth and family contacts, assistance obtaining paperwork necessary for determining Medicaid eligibility, and any other services necessary for Waiver eligibility and enrollment.

Individual Enrolls in Waiver

If the individual enrolls in the YES Waiver, the pre-engagement service begin date will be the date enrollment activities began. The pre-engagement service end date will be the date on which the individual enrolls in the Waiver.

Individual Does Not Enroll in Waiver

If the individual does not enroll in the Waiver, the final pre-engagement service date will be the date on which the individual notifies the LMHA/LBHA of the decision not to enroll.

Provider Qualifications

Pre-engagement services must be provided by a credentialed QMHP-CS or QMHP-CS equivalent, defined as an individual who:

- has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major, as determined by the LMHA/LBHA, in accordance with 26 TAC §301.331, in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; or
- is a registered nurse (RN); or
- has completed an alternative credentialing process identified by HHSC; or
• has a master's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; and
• must pass a criminal history and background check [see POLICY 0 3100 Criminal History and Federal and State Registry Checks].

Information regarding competency and credentialing in 26 TAC §301.331.

**Progress Notes**

Progress notes are required for the provision of pre-engagement services and must include:

• participant name;
• date of contact with the participant;
• start and stop time of contact with the participant;
• service name and description;
• service location; and
• summary of activities.

The provider must document the provision of pre-engagement services by maintaining up-to-date progress notes, which will be reviewed by HHSC.

**Billing**

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for pre-engagement services is detailed in [POLICY 9000.8 BILLING: PRE-ENGAGEMENT SERVICES].
Respite – In Home

Service Description
In-home respite service is provided on a short-term basis because of the absence of, or need for relief for, the LAR or other primary caregiver of a Waiver participant.

Limitations
A maximum of 720 consecutive or cumulative hours (30 calendar days) of respite service of any type, or combination of any type, can be provided to a participant each service plan year.

In-home respite cannot be provided at the same time as:

- Supportive Family-Based Alternatives;
- Community Living Supports;
- Supported Employment;
- Employment Assistance;
- Non-Medical Transportation; or
- Paraprofessional Services.

In-home respite cannot be provided in a group setting. This service is intended as a one-to-one respite service for a single Waiver participant during a specific time period.

Federal financial participation is not to be claimed for the cost of room and board, except when provided as part of respite care furnished in a facility approved by the state that is not a private residence.

Settings
In-home respite service is provided:

- within the State of Texas; and
- in the private residence of:
  - the participant; or
a relative of the participant other than the parents, spouse, legal guardian, or LAR.

**Safety Checklist**

The Waiver Provider agency must complete a Building Safety and Environmental Health Checklist prior to the provision of in-home respite service. The checklist is available under Forms and Templates section at:


**Crisis and Safety Plan**

The Waiver Provider agency must provide a copy of the participant’s Crisis and Safety Plan to the respite provider.

**Provider Qualifications**

An in-home respite provider:

- must be at least 18 years of age;
- must have a current Texas driver’s license;
- must pass a criminal history and abuse registry checks [see POLICY 0 3100 Criminal History and Federal and State Registry Checks] and
- may be a relative of the participant other than the natural or adoptive parents, spouse, legal guardian, or LAR.

**Wraparound Plan**

The Wraparound Plan must:

- include the description and documentation of the type, scope, duration, and frequency of the service;
- identify the need in the Wraparound Plan that the service will address;
- describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
- identify natural and/or non-traditional and community support systems.
Progress Notes

Progress notes are required for the provision of in-home respite service and must include:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- service name and description;
- service location;
- need identified in the Wraparound Plan that the service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant’s response to the service provided;
- progress or lack of progress with service;
- summary of activities, meals, and behaviors during the service and how these activities directly impact the identified need that the service addresses; and
- direct service provider’s printed name, signature, and credentials.

The provider must document the provision of in-home respite service by maintaining up-to-date progress notes, which will be reviewed by the Health and Human Services Commission. All service documentation must be submitted within two business days after each contact that occurs to provide services to the individual and LAR in the YES Waiver program.

Program Training

Prior to providing respite services, an in-home respite provider must:

- receive program training in accordance with [POLICY 0 3500 General Training and Technical Assistance]; and

Billing

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment
rate, and required documentation for submitting a claim for in-home respite is
detailed in [POLICY 9000.10 BILLING: RESPITE, IN-HOME].

Respite – Out-of-Home Camp

Service Description
Out-of-home respite service at a camp is provided on a short-term basis because of
the absence of or need for relief for the LAR or other primary caregiver of a YES
Waiver participant.

Limitations
A maximum of 720 consecutive or cumulative hours (30 calendar days) of
respite service of any type, or combination of any type, can be provided to a
participant each service plan year.

Respite at a camp cannot be provided at the same time as:

- Supportive Family-Based Alternatives; or
- Community Living Supports;
- Supported Employment;
- Employment Assistance;
- Non-Medical Transportation; or
- Paraprofessional Services.

Federal financial participation is not to be claimed for the cost of room and board,
except when provided as part of respite care furnished in a facility approved by the
state that is not a private residence.

Provider Qualifications
Day or overnight camp respite service is provided only by camps that are licensed
by the state of Texas or accredited by the American Camp Association (ACA).

An out-of-home camp provider:

- must be at least 18 years of age;
- must have a current Texas driver’s license;
- must pass a criminal history and abuse registry checks [see POLICY 0 3100
  Criminal History and Federal and State Registry Checks].
Department of State Health Services

Out-of-home respite service is provided by camps that are licensed and adhere to 25 TAC 265, Subchapter B.

American Camp Association

Out-of-home respite service is also provided by camps that are accredited by the American Camp Association. Accreditation requirements and standards for the American Camp Association are available at:

http://www.acacamps.org/accreditation.

Crisis and Safety Plan

The Waiver Provider agency must provide a copy of the participant’s Crisis and Safety Plan to the respite provider.

Wraparound Plan

The Wraparound Plan must:

- include the description and documentation of the type, scope, duration, and frequency of the service;
- identify the need in the Wraparound Plan that the service will address;
- describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
- identify natural and/or non-traditional and community support systems.

Progress Notes

Progress notes are required for the provision of respite service provided by a camp and must include:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- service name and description;
- service location;
- need identified in the Wraparound Plan that the service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
● participant’s response to the service provided;
● progress or lack of progress with service;
● summary of activities, meals, and behaviors during the service and how these activities directly impact the identified need that the service addresses; and
● direct service provider’s printed name, signature, and credentials.

The provider must document the provision of respite service by maintaining up-to-date progress notes, which will be reviewed by HHSC. All service documentation must be submitted within **two business days** after each contact that occurs to provide services to the individual and LAR in the YES Waiver program.

**Program Training**

Prior to providing respite services, an out-of-home respite provider must receive program training in accordance with [POLICY 0 3500 General Training and Technical Assistance].

**Billing**

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for respite provided by a camp is detailed in [POLICY 9000.11 BILLING: RESPITE, OUT-OF-HOME: CAMP].

**Respite – Out-of-Home Licensed Childcare Center**

**Service Description**

Out-of-home respite service at a Licensed Child Care Center (LCCC) is provided on a short-term basis because of the absence of or need for relief for the LAR or other primary caregiver of a YES Waiver participant.

Respite provided by a LCCC is divided into preschool age and school age groups, in accordance with the following:

**Preschool Age**

Preschool age respite is provided for youth ages 3 to 5 years old.
School Age

School age respite is provided for youth who are 6 through 18 years of age.

Provider Qualifications

An out-of-home licensed childcare center provider:

- must be at least 18 years of age;
- must have a current Texas driver’s license;
- must pass a criminal history and abuse registry checks [see POLICY 0 3100 Criminal History and Federal and State Registry Checks].

Limitations

A maximum of **720 consecutive or cumulative hours (30 calendar days)** of respite services of any type, or combination of any type, can be provided to a participant each service plan year.

Respite at a LCCC cannot be provided at the same time as supportive family-based alternatives or community living supports.

Provider Qualifications

A respite service provider must be a childcare center licensed by the DFPS, in accordance with 26 TAC 746.

Wraparound Plan

The Wraparound Plan must:

- include the description and documentation of the type, scope, duration, and frequency of the service;
- identify the need in the Wraparound Plan that the service will address;
- describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
- identify natural and/or non-traditional and community support systems.

Progress Notes

Progress notes are required for the provision of respite service provided by a LCCC and must include:
● participant name;
● Medicaid ID #;
● date of contact with the participant;
● start and stop time of contact with the participant;
● service name and description;
● service location;
● need identified in the Wraparound Plan that the service will address;
● use of adaptive aids and supports, if applicable;
● transportation services, if applicable;
● participant’s response to the service provided;
● progress or lack of progress with service;
● summary of activities, meals, and behaviors during the service and how these activities directly impact the identified need that the service addresses; and
● direct service provider’s printed name, signature, and credentials.

The provider must document the provision of respite service by maintaining up-to-date progress notes, which will be reviewed by HHSC. All service documentation must be submitted within two business days after each contact that occurs to provide services to the individual and LAR in the YES Waiver program.

**Program Training**

Prior to providing respite services, a LCCC respite provider must receive program training in accordance with [POLICY 0 3500 General Training and Technical Assistance].

**Billing**

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for respite service provided by a LCCC is detailed in [POLICY 9000.12 BILLING: RESPITE – OUT-OF-HOME LICENSED CHILDCARE CENTER].
Respite – Out-of-Home Licensed Childcare Center – Texas Rising Star Provider

Service Description
Out-of-home respite service at a licensed childcare center, Texas Rising Star (TRS) Provider, is provided on a short-term basis because of the absence of or need for relief for the LAR or other primary caregiver of a YES Waiver participant.

Respite provided by a TRS Provider is divided into preschool age and school age groups, in accordance with the following:

Preschool Age
Preschool age respite is provided for youth ages 3 to 5 years old.

School Age
School age respite is provided for youth who are 6 through 18 years of age.

Limitations
A maximum of **720 consecutive or cumulative hours (30 calendar days)** of respite service of any type, or combination of any type, can be provided to a participant each service plan year.

Respite provided by a TRS Provider cannot be provided at the same time as supportive family-based alternatives or community living supports.

Provider Qualifications
A TRS respite provider must be:

- licensed as a childcare center by DFPS, in accordance with 26 TAC 746; and
- must be at least 18 years of age;
- must have a current Texas driver’s license; and
must pass a criminal history and abuse registry checks [see POLICY 0 3100 Criminal History and Federal and State Registry Checks].

Wraparound Plan

The Wraparound Plan must:

- include the description and documentation of the type, scope, duration, and frequency of the service;
- identify the need in the Wraparound Plan that the service will address;
- describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
- identify natural and/or non-traditional and community support systems.

Progress Notes

Progress notes are required for the provision of TRS Provider respite services and must include:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- service name and description;
- service location;
- need identified in the Wraparound Plan that the service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant’s response to the service provided;
- progress or lack of progress with service;
- summary of activities, meals, and behaviors during the service and how these activities directly impact the identified need that the service addresses; and
- direct service provider’s printed name, signature, and credentials.

The provider must document the provision of respite service by maintaining up-to-date progress notes, which will be reviewed by HHSC. All service documentation must be submitted within two business days after each contact that occurs to provide services to the individual and LAR in the YES Waiver program.
Program Training

Prior to providing respite services, a TRS respite provider must receive program training in accordance with [POLICY 0 3500 General Training and Technical Assistance].

Billing

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for TRS Provider respite is detailed in [POLICY 9000.13 BILLING: RESpite – OUT-OF-HOME LICENSED CHILDCARE CENTER – TEXAS RISING STAR PROVIDER].

Respite – Out-of-Home Licensed Childcare Home

Service Description

Out-of-home respite service at a Licensed Child Care Home (LCCH) is provided on a short-term basis because of the absence of or need for relief for the LAR or other primary caregiver of a YES Waiver participant.

Respite provided by a LCCH is divided into preschool age and school age groups, in accordance with the following:

Preschool Age

Preschool age respite is provided for youth ages 3 to 5 years old.

School Age

School age respite is provided for youth who are 6 through 18 years of age.

Limitations

A maximum of **720 consecutive or cumulative hours (30 calendar days)** of respite service of any type, or combination of any type, can be provided to a participant each service plan year.
Respite at a LCCH cannot be provided at the same time as supportive family-based alternatives or community living supports.

**Provider Qualifications**

A respite service provider must be a childcare home licensed by DFPS, in accordance with 26 TAC 747.

An LCCH provider:

- must be at least 18 years of age;
- must have a current Texas driver’s license; and
- must pass a criminal history and abuse registry checks [see POLICY 0 3100 Criminal History and Federal and State Registry Checks].

**Wraparound Plan**

The Wraparound Plan must:

- include the description and documentation of the type, scope, duration, and frequency of the service;
- identify the need in the Wraparound Plan that the service will address;
- describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
- identify natural and/or non-traditional and community support systems.

**Progress Notes**

Progress notes are required for the provision of respite service provided by a LCCH and must include:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- service name and description;
- service location;
- need identified in the Wraparound Plan that the service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant’s response to the service provided;
- progress or lack of progress with service;
● summary of activities, meals, and behaviors during the service and how these activities directly impact the identified need that the service addresses; and

● direct service provider’s printed name, signature, and credentials.

The provider must document the provision of respite service by maintaining up-to-date progress notes, which will be reviewed by HHSC. All service documentation must be submitted within **two business days** after each contact that occurs to provide services to the individual and LAR in the YES Waiver program.

### Program Training

Prior to providing respite services, a LCCH respite provider must receive program training in accordance with [POLICY 0 3500 General Training and Technical Assistance].

### Billing

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for respite service provided by a LCCH is detailed in [POLICY 9000.14 BILLING: RESPITE – OUT-OF-HOME LICENSED CHILDCARE HOME].

### Respite – Out-of-Home Licensed Childcare Home – Texas Rising Star Provider

### Service Description

Out-of-home respite service at a LCCH, TRS Provider, is provided on a short-term basis because of the absence of or need for relief for the or other primary caregiver of a YES Waiver participant.

Respite provided by a TRS Provider is divided into preschool age and school age groups, in accordance with the following:

**Preschool Age**

Preschool age respite is provided for youth ages 3 to 5 years old.
School Age

School age respite is provided for youth ages who are 6 through 18 years of age.

Limitations

A maximum of **720 consecutive or cumulative hours (30 calendar days)** of respite service of any type, or combination of any type, can be provided to a participant each service plan year.

Respite provided by a TRS Provider cannot be provided at the same time as supportive family-based alternatives or community living supports.

Provider Qualifications

A TRS respite provider must be:

- licensed as a childcare center by DFPS, in accordance with 26 TAC 746; and
- must be at least 18 years of age;
- must have a current Texas driver’s license; and
- must pass a criminal history and abuse registry checks [see POLICY 0 3100 Criminal History and Federal and State Registry Checks].

Wraparound Plan

The Wraparound Plan must:

- include the description and documentation of the type, scope, duration, and frequency of the service;
- identify the need in the Wraparound Plan that the service will address;
- describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
- identify natural and/or non-traditional and community support systems.
Progress Notes

Progress notes are required for the provision of TRS Provider respite services and must include:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- service name and description;
- service location;
- need identified in the Wraparound Plan that the service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant’s response to the service provided;
- progress or lack of progress with service;
- summary of activities, meals, and behaviors during the service and how these activities directly impact the identified need that the service addresses; and
- direct service provider’s printed name, signature, and credentials.

The provider must document the provision of respite service by maintaining up-to-date progress notes, which will be reviewed by HHSC. All service documentation must be submitted within two business days after each contact that occurs to provide services to the individual and LAR in the YES Waiver program.

Program Training

Prior to providing respite services, a TRS respite provider must receive program training in accordance with [POLICY 0 3500 General Training and Technical Assistance].

Billing

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for TRS Provider respite is detailed in [POLICY 9000.15 BILLING: RESPITE, OUT-OF-HOME: LICENSED CHILDCARE HOME, TEXAS RISING STAR PROVIDER].
7000.16 Respite – Out-of-Home Registered Childcare Home

Service Description

Out-of-home respite service at a Registered Child Care Home (RCCH) is provided on a short-term basis because of the absence of or need for relief for the LAR or other primary caregiver of a YES Waiver participant.

Respite provided by a RCCH is divided into preschool age and school age groups, in accordance with the following:

Preschool Age

Preschool age respite is provided for youth ages 3 to 5 years old.

School Age

School age respite is provided for youth who are 6 through 18 years of age.

Limitations

A maximum of **720 consecutive or cumulative hours (30 calendar days)** of respite service of any type, or combination of any type, can be provided to a participant each service plan year.

Respite at a RCCH cannot be provided at the same time as supportive family-based alternatives or community living supports.

Provider Qualifications

Respite service provider must be a childcare home registered with HHSC, in accordance with 26 TAC 747, available at:


Wraparound Plan

The Wraparound Plan must:
● include the description and documentation of the type, scope, duration, and frequency of the service;
● identify the need in the Wraparound Plan that the service will address;
● describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
● identify natural and/or non-traditional and community support systems.

**Progress Notes**

Progress notes are required for the provision of respite service provided by a RCCH and must include:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- service name and description;
- service location;
- need identified in the Wraparound Plan that the service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant’s response to the service provided;
- progress or lack of progress with service;
- summary of activities, meals, and behaviors during the service and how these activities directly impact the identified need that the service addresses; and
- direct service provider’s printed name, signature, and credentials.

The provider must document the provision of respite service by maintaining up-to-date progress notes, which will be reviewed by HHSC. All service documentation must be submitted within **two business days** after each contact that occurs to provide services to the individual and LAR in the YES Waiver program.

**Program Training**

Prior to providing respite services, a RCCH respite provider must receive program training in accordance with [POLICY 0 3500 General Training and Technical Assistance].
Billing
Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for respite service provided by a RCCH is detailed in [POLICY 9000.16 BILLING: RESPITE, OUT-OF-HOME: REGISTERED CHILDCARE HOME].

Respite – Out-of-Home Registered Childcare Home – Texas Rising Star Provider

Service Description
Out-of-home respite service at a RCCH, TRS Provider, is provided on a short-term basis because of the absence of or need for relief for the LAR or other primary caregiver of a YES Waiver participant.

Respite provided by a TRS Provider is divided into preschool age and school age groups, in accordance with the following:

Preschool Age

Respite for the preschool age group serves youth ages 3 to 5 years old.

School Age

Respite for the school age group serves youth who are 6 through 18 years of age.

Limitations
A maximum of 720 consecutive or cumulative hours (30 calendar days) of respite service of any type, or combination of any type, can be provided to a participant each service plan year.

Respite provided by a TRS Provider cannot be provided at the same time as supportive family-based alternatives or community living supports.

Provider Qualifications
A TRS respite provider must be:
registered as a childcare home by DFPS, in accordance with 26 TAC 747; and
● certified as a TRS Provider by the TWC, in accordance with TWC certification
criteria, available at:
https://texasrisingstar.org/wp-content/uploads/2019/03/TRS-Guidelines-
March-2019FINAL.pdf

**Wraparound Plan**

The Wraparound Plan must:

● include the description and documentation of the type, scope, duration, and
frequency of the service;
● identify the need in the Wraparound Plan that the service will address;
● describe the strategies and/or action steps that will be used to encourage
and assist in family and caregiver engagement; and
● identify natural and/or non-traditional and community support systems.

**Progress Notes**

Progress notes are required for the provision of TRS Provider respite services and
must include:

● participant name;
● Medicaid ID #;
● date of contact with the participant;
● start and stop time of contact with the participant;
● service name and description;
● service location;
● need identified in the Wraparound Plan that the service will address;
● use of adaptive aids and supports, if applicable;
● transportation services, if applicable;
● participant’s response to the service provided;
● progress or lack of progress with service;
● summary of activities, meals, and behaviors during the service and how
these activities directly impact the identified need that the service addresses;
and
● direct service provider’s printed name, signature, and credentials.

The provider must document the provision of respite service by maintaining up-to-
date progress notes, which will be reviewed by HHSC. All service documentation
must be submitted within **two business days** after each contact that occurs to provide services to the individual and LAR in the YES Waiver program.

**Program Training**

Prior to providing respite services, a TRS respite provider must receive program training in accordance with [POLICY 0 3500 General Training and Technical Assistance].

**Billing**

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for TRS Provider respite is detailed in [POLICY 9000.17 BILLING: RESPITE, OUT-OF-HOME: REGISTERED CHILDCARE HOME, TEXAS RISING STAR PROVIDER].

**Respite – Out-of-Home Residential Childcare (OTHER)**

**Service Description**

Out-of-home respite service at a residential childcare is provided on a short-term basis because of the absence of or need for relief for the LAR or other primary caregiver of a YES Waiver participant.

Respite at a residential childcare can be provided in the following DFPS-verified or licensed settings:

- foster home;
- child-placing agency; or
- General Residential Operation (GRO).

**Limitations**

A maximum of **720 consecutive or cumulative hours (30 calendar days)** of respite service of any type, or combination of any type, can be provided to a participant, each service plan year.

Respite provided at a residential childcare cannot be provided at the same time as supportive family-based alternatives or community living supports.
Provider Qualifications

- **Foster Family Provider**: a respite service provider must be a foster family verified with the Department of Family and Protective Services, in accordance with 26 TAC 749.
- **Child Placing Agency Provider**: a respite service provider must be a child placing agency licensed with the DFPS, in accordance with 26 TAC 749.
- **GRO Provider**: a respite service provider must be a residential child care operation, in accordance with 26 TAC 748 or a Waiver Provider agency certified by HHSC as a Local Mental Health Authority or a Local Behavioral Health Authority.

Wraparound Plan

The Wraparound Plan must:

- include the description and documentation of the type, scope, duration, and frequency of the service;
- identify the need in the Wraparound Plan that the service will address;
- describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
- identify natural and/or non-traditional and community support systems.

Progress Notes

Progress notes are required for the provision of respite service provided by a foster family and must include:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- service name and description;
- service location;
- need identified in the Wraparound Plan that the service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant’s response to the service provided;
- progress or lack of progress with service;
● summary of activities, meals, and behaviors during the service and how these activities directly impact the identified need that the service addresses; and
● direct service provider’s printed name, signature, and credentials.

The provider must document the provision of respite service by maintaining up-to-date progress notes, which will be reviewed by HHSC. All service documentation must be submitted within **two business days** after each contact that occurs to provide services to the individual and LAR in the YES Waiver program.

**Program Training**

Prior to providing respite services, a residential childcare respite provider must receive program training in accordance with [POLICY 0 3500 General Training and Technical Assistance].

**Billing**

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for residential child care respite is detailed in [POLICY 9000.18 BILLING: RESPITE, OUT-OF-HOME: RESIDENTIAL CHILDCARE].
Specialized Therapies – Animal Assisted Therapy

Service Description
In animal assisted therapy, animals are utilized in goal directed treatment sessions, as a modality, to facilitate optimal physical, cognitive, social and emotional outcomes of a Waiver participant such as increasing self-esteem and motivation and reducing stress. Animal-assisted therapy is delivered in a variety of settings by specifically trained individuals in association with animals that meet specific criteria and in accordance with guidelines established by the American Veterinary Medical Association. Example programs include but are not limited to Therapeutic Horseback Riding and Pet Partners.

Provider Qualifications
An animal-assisted therapy provider must:

- be a licensed professional, with documented training and experience relative to the specific service provided. These may include a: clinical social worker; professional counselor; marriage and family therapist; registered nurse; vocational nurse; physical therapist; occupational therapist; or dietitian; or
- be appropriately trained and obtain certification through a YES Waiver endorsed certification program specific to the type of program and animal(s) involved.

All animals working with an animal-assisted therapy provider must meet specific criteria for the program they are associated with and be trained in accordance with guidelines established by the American Veterinary Medical Association.

Animal Certification Programs
YES Waiver-endorsed certification programs include:

- Pet Partners program;
- Equine Assisted Growth and Learning Association (EAGALA);
● Professional Association of Therapeutic Horsemanship (PATH) International;
and
● Trauma Focused Equine Assisted Psychotherapy (TF-EAP)

Other certification programs are subject to approval by the HHSC YES Waiver Department, upon request by the CWP or the WPO.

CWPs are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of Waiver Provider agencies to ensure compliance with the Waiver Provider agreement. During these reviews, HHSC also verifies the qualifications of Waiver Provider agency employees and subcontractors.

**Wraparound Plan**

The Wraparound Plan must:

- include the description and documentation of the type, scope, duration, and frequency of the service;
- identify the need in the Wraparound Plan that the service will address;
- describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
- identify natural and/or non-traditional and community support systems.

**Progress Notes**

Progress notes are required for the provision of animal-assisted therapy and must include:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- service name and description;
- service location;
- training methods used (e.g. instructions, modeling, role play, feedback, repetition);
- need identified in the Wraparound Plan that the service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant’s response to the service provided;
● progress or lack of progress with service;
● summary of activities and behaviors observed during the service and how these activities directly impact the identified need that the service addresses; and
● direct service provider’s printed name, signature, and credentials.

The provider must document the provision of animal-assisted therapy services by maintaining up-to-date progress notes, which will be reviewed by HHSC. All service documentation must be submitted within two business days after each contact that occurs to provide services to the individual and LAR in the YES Waiver program.

**Program Training**

Prior to providing Waiver services and/or participating in a CFT meeting, an animal-assisted therapy provider must receive program training in accordance with [POLICY 0 3500 General Training and Technical Assistance].

**Billing**

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for animal-assisted services is detailed in [POLICY 9000.19 BILLING: SPECIALIZED THERAPIES].

**Specialized Therapies – Art Therapy**

**Service Description**

Art therapy is a human service profession in which Waiver participants, facilitated by the art therapist, use art media, the creative process, and the resulting artwork to explore their feelings, reconcile emotional conflicts, foster self-awareness, manage behavior, develop social skills, improve reality orientation, reduce anxiety, and increase self-esteem.

**Provider Qualifications**

An art therapy provider must be:

● a licensed professional, with documented training and experience relative to the specific service provided. These may include a clinical social worker; professional counselor; marriage and family therapist; drama therapist;
registered nurse; vocational nurse; physical therapist; occupational therapist; or dietitian; or
• certified by the Art Therapy Credentials Board (ATCB).

CWPs are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of Waiver Provider agencies to ensure compliance with the Waiver Provider agreement. During these reviews, HHSC also verifies the qualifications of Waiver Provider agency employees and subcontractors.

Wraparound Plan

The Wraparound Plan must:

• include the description and documentation of the type, scope, duration, and frequency of the service;
• identify the need in the Wraparound Plan that the service will address;
• describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
• identify natural and/or non-traditional and community support systems.

Progress Notes

Progress notes are required for the provision of art therapy and must include:

• participant name;
• Medicaid ID #;
• date of contact with the participant;
• start and stop time of contact with the participant;
• service name and description;
• service location;
• training methods used (e.g. instructions, modeling, role play, feedback, repetition);
• need identified in the Wraparound Plan that the service will address;
• use of adaptive aids and supports, if applicable;
• transportation services, if applicable;
• participant’s response to the service provided;
• progress or lack of progress with service;
• summary of activities and behaviors observed during the service and how these activities directly impact the identified need that the service addresses; and
direct service provider’s printed name, signature, and credentials.

The provider must document the provision of art therapy services by maintaining up-to-date progress notes, which will be reviewed by HHSC. All service documentation must be submitted within **two business days** after each contact that occurs to provide services to the individual and LAR in the YES Waiver program.

**Program Training**

Prior to providing Waiver services and/or participating in a CFT meeting, an art therapy provider must receive program training in accordance with [POLICY 0 3500 General Training and Technical Assistance].

**Billing**

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for art therapy is detailed in [POLICY 9000.19 BILLING: SPECIALIZED THERAPIES].

**Specialized Therapies – Music Therapy**

**Service Description**

Music therapy utilizes musical or rhythmic interventions specifically selected by a registered music therapist to accomplish the restoration, maintenance, or improvement of social or emotional functioning, mental processing, or physical health. Music therapy is a prescribed use of music to therapeutically address physical, psychological, cognitive, or social functioning to optimize the individual’s quality of life, improve functioning on all levels, enhance well-being and foster independence. Music therapy provides an opportunity to move from isolation into active participation through an increase in verbal and nonverbal communication, social expression, behavioral and social functioning, and self-awareness.

**Provider Qualifications**

A music therapy provider must be:

- a licensed professional, with documented training and experience relative to the specific service provided. These may include a: clinical social worker;
professional counselor; marriage and family therapist; registered nurse; vocational nurse; physical therapist; occupational therapist; or dietitian; or certified by the Certification Board for Music Therapists (CBMT) with documented training and experience relative to the specialized therapy being provided.

CWPs are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of Waiver Provider agencies to ensure compliance with the Waiver Provider agreement. During these reviews, HHSC also verifies the qualifications of Waiver Provider agency employees and subcontractors.

**Wraparound Plan**

The Wraparound Plan must:

- include the description and documentation of the type, scope, duration, and frequency of the service;
- identify the need in the Wraparound Plan that the service will address;
- describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
- identify natural and/or non-traditional and community support systems.

**Progress Notes**

Progress notes are required for the provision of music therapy and must include:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- service name and description;
- service location;
- training methods used (e.g. instructions, modeling, role play, feedback, repetition);
- need identified in the Wraparound Plan that the service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant’s response to the service provided;
- progress or lack of progress with service;
- summary of activities and behaviors observed during the service and how these activities directly impact the identified need that the service addresses; and
- direct service provider’s printed name, signature, and credentials.

The provider must document the provision of music therapy by maintaining up-to-date progress notes, which will be reviewed by HHSC. All service documentation must be submitted within **two business days** after each contact that occurs to provide services to the individual and LAR in the YES Waiver program.

**Program Training**

Prior to providing Waiver services and/or participating in a CFT meeting, a music therapy provider must receive program training in accordance with [POLICY 0 3500 General Training and Technical Assistance].

**Billing**

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for music therapy is detailed in [POLICY 9000.19 BILLING: SPECIALIZED THERAPIES].

**Specialized Therapies – Nutritional Counseling**

**Service Descriptions**

Nutritional counseling assists Waiver participants in meeting their basic and/or special therapeutic nutritional needs. This includes but is not limited to counseling Waiver participants in nutrition principles, dietary plans, and food selection and economics.

**Provider Qualifications**

A nutritional counseling provider must be provided by a person who is a registered, licensed, or provisionally licensed dietitian by the Texas Board of Examiners of Dietitians.

CWPs are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of Waiver Provider
agencies to ensure compliance with the Waiver Provider agreement. During these reviews, HHSC also verifies the qualifications of Waiver Provider agency employees and subcontractors.

**Wraparound Plan**

The Wraparound Plan must:

- include the description and documentation of the type, scope, duration, and frequency of the service;
- identify the need in the Wraparound Plan that the service will address;
- describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
- identify natural and/or non-traditional and community support systems.

**Progress Notes**

Progress notes are required for the provision of art therapy services and must include:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- service name and description;
- service location;
- training methods used (e.g. instructions, modeling, role play, feedback, repetition);
- need identified in the Wraparound Plan that the service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant’s response to the service provided;
- progress or lack of progress with service;
- summary of activities and behaviors observed during the service and how these activities directly impact the identified need that the service addresses; and
- direct service provider’s printed name, signature, and credentials.

The provider must document the provision of nutritional counseling by maintaining up-to-date progress notes, which will be reviewed by the HHSC. All service documentation must be submitted within **two business days** after each contact.
that occurs to provide services to the individual and LAR in the YES Waiver program.

**Program Training**

Prior to providing Waiver services and/or participating in a CFT meeting, a nutritional counselor must receive program training in accordance with [POLICY 0 3500 General Training and Technical Assistance].

**Billing**

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for nutritional counseling is detailed in [POLICY 9000.19 BILLING: SPECIALIZED THERAPIES].

**Specialized Therapies – Recreational Therapy**

**Service Description**

Recreational therapy is an outcome based therapeutic intervention that helps maintain or improve participants physical, social, and emotional well-being. The goal of recreational therapy is to develop self-reliance, resiliency, and improve participant’s functioning and independence in the community, while reducing or eliminating the effects of the participants serious mental, emotional and behavioral difficulties. The goal of recreational therapy is to develop self-reliance, resiliency, and improve participant’s functioning and independence in the community, while reducing or eliminating the effects of the participants serious mental, emotional and behavioral difficulties.

Recreational therapy helps develop leisure time in ways that enhance health, independence, and well-being. It is a prescribed use of recreational and other activities as a treatment intervention to improve the functional living competence of persons with physical, mental, emotional, and/or social disadvantages. Treatment is designed to restore, remediate, or habilitate improvement in functioning and independence while reducing or eliminating the effects of an illness or a disability.

Recreational activities may include, but are not limited to:

- arts and crafts;
- aquatic activities;
- dance and movement;
- drama/theatre;
- experiential interventions;
- games;
- outdoor recreation;
- sensory stimulation and integration;
- sports; and
- yoga.

**Provider Qualifications**

A recreational therapy provider must be:

- a licensed professional, with documented training and experience relative to the specific service provided. These may include: licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, registered nurse, licensed vocational nurses, physical therapists, occupational therapists, or licensed dieticians; or
- certified by the National Council of Therapeutic Recreation Certification (NCTRS); or
- Certified as a Therapeutic Recreation Specialist Texas (TRS/TXC) by Consortium for Therapeutic Recreation/Activities Certification, Inc. (CTRAC).

CWPs are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of Waiver Provider agencies to ensure compliance with the Waiver Provider agreement. During these reviews, HHSC also verifies the qualifications of Waiver Provider agency employees and subcontractors.

**Wraparound Plan**

The Wraparound Plan must:

- include the description and documentation of the type, scope, duration, and frequency of the service;
- identify the need in the Wraparound Plan that the service will address;
- describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
- identify natural and/or non-traditional and community support systems.
Progress Notes

Progress notes are required for the provision of recreational therapy and must include:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- service name and description;
- service location;
- training methods used (e.g. instructions, modeling, role play, feedback, repetition);
- need identified in the Wraparound Plan that the service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant’s response to the service provided;
- progress or lack of progress with service;
- summary of activities and behaviors observed during the service and how these activities directly impact the identified need that the service addresses; and
- direct service provider’s printed name, signature, and credentials.

The provider must document the provision of recreational therapy by maintaining up-to-date progress notes, which will be reviewed by the HHSC. All service documentation must be submitted within two business days after each contact that occurs to provide services to the individual and LAR in the YES Waiver program.

Program Training

Prior to providing Waiver services and/or participating in a CFT meeting, a recreational therapy provider must receive program training in accordance with [POLICY 0 3500 General Training and Technical Assistance].

Billing

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for recreational therapy is detailed in [POLICY 9000.19 BILLING: SPECIALIZED THERAPIES].
Service Description

Supported Employment means assistance provided, in order to sustain competitive and integrated 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). Supported employment includes:

- employment adaptations;
- supervision; and
- training related to a participant’s assessed needs.

Limitations

Supported employment cannot be provided at the same time as:

- Community Living Supports;
- Employment Assistance;
- Non-Medical Transportation;
- Paraprofessional Services; or
- Respite.

Transportation

Transporting an individual to support the individual to be self-employed, work from home, or perform in a work setting is billable within the service. This service is not available to individuals receiving Waiver services under a program funded under section 110 of the Rehabilitation Act of 1973.

Documentation must be maintained in the participant’s file that the service is not available to the participant under a program funded under the Individuals with Disabilities Education Act (20 U.S.C §1401 et seq.).
Personal Assistance

If a participant requires personal assistance with activities of daily living that are necessary to sustain the participant’s work environment and are incidental to the provision of supported employment, the supported employment provider is permitted to deliver personal assistance.

Incentives, Subsidies, and Certain Expenses

This 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:

- incentive payments made to an employer to encourage hiring the participant;
- payments that are passed through to the participant;
- payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business; or
- payments used to defray the expenses associated with starting up or operating a business.

Provider Qualifications

A provider of supported employment must:

- be at least 18 years of age;
- maintain a current driver’s license, and insurance if transporting the participant;
- pass a criminal history and background check [see POLICY 0 3100 Criminal History and Federal and State Registry Checks]; and
- have one of the following:
  - 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;
  - 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; or
  - 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.
CWPs are responsible for verifying the qualifications of all employees and subcontractors. HHSC conducts annual onsite or desk reviews of Waiver Provider agencies to ensure compliance with the Waiver Provider agreement. During these reviews, HHSC also verifies the qualifications of Waiver Provider agency employees and subcontractors.

Wraparound Plan

The Wraparound Plan must:

- include the description and documentation of the type, scope, duration, and frequency of the service;
- identify the need in the Wraparound Plan that the service will address;
- describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
- identify natural and/or non-traditional and community support systems.

Progress Notes

Documentation of supported employment must include:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- service name and description;
- service location;
- training methods used (e.g. instructions, modeling, role play, feedback, repetition);
- title of evidence-based or best practice curriculum used;
- need identified in the Wraparound Plan that the service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant’s response to the service provided;
- progress or lack of progress with service;
- summary of activities and behaviors observed during the service and how these activities directly impact the identified need that the service addresses; and
- direct service provider’s printed name, signature, and credentials.
The provider must document the provision of supported employment by maintaining progress notes detailing the activity the participant engaged in with the service provider, which will be reviewed by the HHSC. All service documentation must be submitted within **two business days** after each contact that occurs to provide services to the individual and LAR in the YES Waiver program.

**Program Training**

Prior to providing Waiver services and/or participating in a CFT meeting, a supported employment provider must receive program training in accordance with [POLICY 0 3500 General Training and Technical Assistance].

**Billing**

Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for employment assistance is detailed in [POLICY 9000.20 BILLING: SUPPORTED EMPLOYMENT].
7000.26 Supportive Family-Based Alternatives

Service Description

Supportive Family-Based Alternatives are designed to provide therapeutic support to the Waiver participant and to model appropriate behaviors for the Waiver participant's family with the objective of enabling the Waiver participant to successfully return to their family and live in the community with their family. Supportive family-based alternatives include services required for a Waiver participant to temporarily reside within a home other than the home of their family.

The support family must include at least one adult living in the home and no more than four non-related individuals may live in the home. The support family must have legal responsibility for the residence and either own or lease the residence. The home must be located in a typical residence in the community and provide an environment that assures community integration, health, safety and welfare of the Waiver participant. The support family must provide services as authorized in the Waiver participant's service plan.

Services may include:

- age and individually appropriate guidance regarding and/or assistance with the activities of daily living and instrumental activities of daily living (ambulating, bathing, dressing, eating, getting in and out of bed, grooming, personal hygiene, money management, toileting, communicating, performing household chores, and managing medications);
- securing and providing transportation;
- reinforcement of counseling, therapy, and related activities;
- assistance with medications and performance of tasks delegated by a registered nurse or physician;
- supervision of the participant for safety and security;
- facilitating inclusion in community activities, social interaction, use of natural supports, participation in leisure activities, and development of socially valued behaviors; or
- assistance in accessing community and school resources.
Limitations

Pre-Authorization
Supportive family-based alternatives (SFA) must be pre-authorized by HHSC and can be authorized for up to **90 consecutive or cumulative calendar days**, per IPC year.

Costs Not Covered
Costs that are not included in the payment of SFA are:

- room and board, as the participant is responsible for costs associated with room and board; and
- transportation, which is included in the provider rate.

Other Services
The participant cannot receive respite or community living support services while receiving SFA. In addition, a participant who is eligible for, or receiving, Title IV-E services cannot receive SFA.

Support Family Requirements
The support family must:

- include at least one adult residing in the home who:
  - is at least 18 years of age;
  - is not the parent, spouse, legal guardian or LAR of the participant;
  - has a current Texas driver’s license;
  - has insurance appropriate to the vehicle used to provide transportation;
  - be CPR and first aid trained and certified; and
  - pass a criminal history and background check [see POLICY 0 3100 Criminal History and Federal and State Registry Checks];
- not have more than four non-related individuals residing in the home;
- have legal responsibility for the residence and either own or lease the residence;
- reside in a home located in a typical residence in the community;
- provide an environment that assures the community integration, health, safety, and welfare of the participant; and
- provide services in accordance with the participant’s service authorization.
Provider Qualifications

SFA services may be provided through one of the following:

- **foster family**: a foster family verified with DFPS in accordance with 26 TAC 749.
- **child placing agency**: a child placing agency licensed with DFPS, in accordance with 26 TAC 749. The child placing agency must recruit, train, and certify the support family and coordinate with the support family.

Wraparound Plan

The Wraparound Plan must:

- include the description and documentation of the type, scope, duration, and frequency of the service;
- identify the need in the Wraparound Plan that the service will address;
- describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
- identify natural and/or non-traditional and community support systems.

Progress Notes

Progress notes are required for the provision of SFA services and must include:

- participant name;
- Medicaid ID #;
- date of contact with the participant;
- start and stop time of contact with the participant;
- service name and description;
- service location;
- training methods used (e.g. instructions, modeling, role play, feedback, repetition);
- title of evidence-based or best practice curriculum used;
- need identified in the Wraparound Plan that the service will address;
- use of adaptive aids and supports, if applicable;
- transportation services, if applicable;
- participant’s response to the service provided;
- progress or lack of progress with service;
● summary of activities and behaviors observed during the service and how these activities directly impact the identified need that the service addresses; and
● direct service provider’s printed name, signature, and credentials.

The provider must document the provision of SFA services by maintaining up-to-date progress notes, which will be reviewed by HHSC. All service documentation must be submitted within two business days after each contact that occurs to provide services to the participant and LAR in the YES Waiver program.

**Program Training**

Prior to providing Waiver services and/or participating in a CFT meeting, a SFA provider must receive program training in accordance with [POLICY 0 3500 General Training and Technical Assistance].

**Billing**

Costs for all Waiver services, including any extended Supportive Family-based Alternatives cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for SFA is detailed in [POLICY 0 9000.21 Billing: Supportive Family-Based Alternative].
7000.27 Transitional Services

Service Description

Transitional services are a one-time, non-recurring allowable expense provided to participants who transition from an institution, provider-operated setting, or family home to their own private community residence.

Assistance may include:

- utility and security deposits for the home or apartment;
- needed household items such as linens and cooking utensils;
- essential furnishings;
- moving expenses; or
- services necessary to ensure health and safety in the home or apartment (e.g. pest eradication, allergen control, or one-time cleaning).

Limitations

Transitional services cannot be used to pay for:

- furnishing living arrangements that are owned or leased by a Waiver Provider where the provision of those items and services are inherent to the service already being provided;
- monthly rental or mortgage expense;
- food;
- regular utility charges; or
- household appliances or items intended for purely diversional or recreational purposes.

Provider Qualifications

Transitional services are provided either directly through the staff members of the CWP or through an outside vendor subcontracted with the CWP (e.g. furniture store, grocery store, or moving company).

The CWP must demonstrate to HHSC that services provided meet the requirements of the participant’s IPC.
Transition Plan

The CFT must develop a transition plan which includes:

- a summary of the mental health community services and treatment the participant received as a Waiver participant;
- the assistance that will be provided to the participant as part of the transition plan;
- strategies for the transition;
- the participant’s current status (e.g., diagnosis, medications, level of functioning) and unmet needs;
- information from the participant and the LAR regarding the participant’s strengths, preferences for mental health community services, and responsiveness to past interventions;
- a service plan that indicates the mental health and other community services the participant will receive as an adult; and
- adequate time for both current and future providers to transition the participant into adult services without a disruption in services.

[See POLICY 0 5300 Transition Plan].

Procedure: Transitional Services Requests

HHSC approval of a Transitional Services Request Form is required prior to the Wraparound Facilitator submitting Transitional Services on an IPC. The Transitional Services description should be included in the IPC Transitional Services justification box, and the Transitional Services Request Form should be attached to the IPC. Transitional Services are not officially authorized until approved in CMBHS by HHSC. If the Transitional Services request is denied by HHSC, the Wraparound Facilitator must send the Denial of Eligibility Letter, including the reason for denial and Fair Hearing Request Form to the participant, LAR and/or DFPS Caseworker, if the participant is in substitute care.

Provision of Service Documentation

The provider must retain invoices for purchases related to transitional services, per the transition plan, in the participant’s file, which will be reviewed by HHSC.
Billing

Transition services are limited to $2,500 dollars per Waiver participant. Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver. Information regarding unit designation, payment rate, and required documentation for submitting a claim for transitional services is detailed in [POLICY 0 9000.22 Billing: Transitional Services].
Quality Management (QM) activities are performed by HHSC and locally by YES Waiver Providers. HHSC regularly shares best practices and provides technical assistance to provider entities through quarterly meetings, quarterly conference calls, and one-on-one monthly liaison calls. In addition, YES Waiver Providers are encouraged to share evidence-based best practices with each other and their employees and subcontractors. YES Waiver Providers are also expected to continually monitor and improve the quality and effectiveness of services.

QM activities are designed to support our mission and vision that:

- participants have access to a full array of community-based services and supports; and
- services are family-centered, coordinated, and effective at preventing out-of-home placement and promoting lifelong independence and self-defined success.

HHSC conducts a range of quality improvement initiatives on an ongoing basis to ensure quality of clinical care and effectiveness of the program. Data from HHSC’s information systems including Behavioral Health Outpatient Data Warehouse (MBOW) and Clinical Management of Behavioral Health Services (CMBHS) are used to inform performance improvement activities and assessment of unmet needs of individuals, service delivery problems, and effectiveness of technical assistance and training. Examples of reports/data that are accessed through MBOW and CMBHS include:

- monthly enrollment reports;
- service utilization trends;
- access to services;
- length of stay;
- crisis/hospitalization rates;
- client demographics; and
- services received through Texas Resiliency and Recovery Services (TRR).

HHSC conducts an annual quality management review of all provider entities that include, but are not limited to:

- participant file reviews;
• case coordination;
• provider services including claims audit;
• provider credentialing and training requirements;
• notification of rights; and
• Critical Incident Reports.

HHSC reserves the right to conduct onsite or desk reviews with or without prior notice. HHSC may engage in any activities necessary to assure the health, safety, and welfare of YES participants.

Wraparound Facilitation and Planning

HHSC reviews the quality of Wraparound implementation as well as timely enrollment, development of a Crisis and Safety Plan, youth and family engagement, identification of natural supports, and participation in child and family team meetings. The YES Assessment is used to measure improvement in life domain functioning, emotional behavioral needs, school, risk behaviors, and caregiver needs and strengths. Review of participant Wraparound Plans and progress notes determine the following:

• the extent to which the planned strategies use identified strengths, address underlying needs, and include a family mission and vision;
• the CFT members work together to implement and update strategies and action plans to keep the participant and community safe while supporting the youth in maintaining in the community;
• response to and documentation of progress the participant and LAR have made towards their goals and objective, including addressing needs and strengths and limitations in achieving their goals and objectives;
• ensuring that Wraparound team meetings are occurring monthly in order in order to review and update the Waiver participant’s Safety and Crisis Plan so that it continues to be effective and that each participant’s IPC is reviewed and updated every 90 calendar days; and
• referrals are made if the participant requires increased interventions resulting from homicidality, suicidality, or the inability to function on a day-to-day basis.

Other activities related to care coordination and Wraparound planning may be reviewed.
Documentation of Choice and Notification of Rights

At the time of initial enrollment and annually if re-enrolled, participants and/or their LAR must sign and date the following YES Waiver forms:

- Freedom of Choice;
- Participant Agreement;
- Provider Selection; and
- Notice of Participant Rights.

These documents are evidence that participants are informed and offered:

- the right to seek services through an institutional program or through the Waiver;
- choice of Waiver services;
- choice of providers;
- the right to a fair hearing and how to file a grievance; and
- the process for reporting allegations of abuse, neglect, and exploitation and given the toll-free number for the Department of Family and Protective Services (DFPS).

Critical Incident Reports

All YES Waiver Provider staff and contractors are responsible for reporting critical incidents to HHSC. HHSC is responsible for the review of critical events and incident reports. HHSC evaluates the timeliness of provider reporting, as well as the appropriate response to the incident. If a YES Waiver Provider was involved in the incident, the HHSC staff evaluates the report to ensure that the Waiver Provider agency followed approved HHSC protocols.

YES Waiver Providers must report to the Department of Family and Protective Services and to the regulatory agency that is responsible for oversight and licensure of the specific provider. DFPS provides a report to HHSC of all allegations involving provider actions toward Waiver participants. HHSC reviews the final DFPS investigative reports to ensure appropriate corrective actions were taken by provider agencies.

HHSC is the agency that is responsible for overseeing the reporting of and response to critical incidents that affect Waiver participants. HHSC conducts quarterly risk
assessments of the Local Mental Health Authority, Local Behavioral Health
Authority, or the entity providing targeted case management, and YES Waiver
Providers, which includes a review of any reported critical incidents and events.
HHSC reviews all Critical Incident Reports (CIR) and enters data into a spreadsheet
for tracking and trending. HHSC also reviews CIRs to ensure appropriate action was
taken and may contact the provider for additional information as needed.

Critical incidents include, but are not limited to:

- medical injuries;
- behavioral or psychiatric emergencies and hospital admissions;
- allegations against client rights including abuse, neglect and exploitation;
- CPS Custody;
- criminal activities;
- death;
- restraints;
- property or vehicle loss or damage;
- medication errors;
- client departures;
- legal/juvenile justice department involvement; and
- out of home placements.

All incidents involving Waiver participants should be reported via secure email to
the HHSC YES Waiver Inbox (YESWaiver@hhsc.state.tx.us) within 72 hours or
three business days, by completing a Critical Incident Reporting form.

Quality Management Oversight Activities

HHSC and YES Waiver Providers must ensure and improve quality of services and
care by collecting data to measure, assess, and improve performance dimensions in:

- timely access and enrollment to Waiver services;
- plans of care and services address health and safety needs identified on the
  CANS and Clinical Eligibility, reason for referral, underlying needs, and include measurable target outcomes;
- Child and Family Team participation in meetings;
- Child and Family Teams meet at least every 30 calendar days to review and modify the plan.
● clinical eligibility annual renewals or termination prior to expiration of previous CE;
● collection and analysis of critical incident data;
● recruitment, credentialing, and training of service providers;
● continuity of care during out of home placements;
● service utilization and billing analysis;
● availability and appropriateness of services; and
● clinical outcomes analysis.

HHSC oversight of YES Waiver Providers may include, but are not limited to:

● evidence of coordination and communication across child-serving agencies to lay the groundwork for collaboration and cross-system involvement through various systems which can include, but are not limited to: school districts, juvenile justice, child protective services, psychiatric hospitals and residential treatment centers, and other child serving agencies regarding enrollment and eligibility;
● provider recruitment efforts to ensure a full array of Waiver services;
● internal process for resolution of participant complaints and grievances;
● progress toward implementing the recommendations/corrections made during the previous quality management reviews; and
● systems to prevent fraud and abuse of Medicaid funds by monitoring service utilization to ensure services are consistent with the participant’s individual plan of care in scope, frequency, and duration.

When harmful or non-compliant practices are identified, corrective action is taken to bring the YES Waiver Providers back into compliance. YES Waiver Providers must allow HHSC representatives and other state and federal agencies full and free access to direct service staff and all locations where the YES Waiver Providers or subcontractors perform duties related to the Waiver.

HHSC provides each YES Waiver Provider agency a final quality management report after each on-site or desk review to include positive observations and areas needing improvement. CMS mandated performance measures below 90% compliance require a Corrective Action Plan (CAP) within 30 calendar days after receiving the YES Quality Management Report. The CAP must explain how the provider will:

● come into compliance with training requirements within 30 calendar days;
and
● prevent future noncompliance.
HHSC will review the CAP within **10 business days** and if acceptable, an email notification is sent back to the YES Waiver Provider. The YES Waiver Provider must submit documentation of its progress addressing the concerns included in the site review report. HHSC will retain the CAP in its files and the YES Waiver Provider is responsible for retaining all documentation in its files.

If not acceptable, a conference call or email will be provided to explain concerns and request revisions. A revised CAP must be submitted by the YES Waiver Provider or HHSC will mandate a Corrective Action Plan with specific actions, due dates, outcomes, and evidence of progress on the YES Waiver Provider’s behalf.

If corrective actions are not taken by the YES Waiver Provider within the specified and agreed upon timeframes, contract action will occur. HHSC will continue to monitor the YES Waiver Provider to assure that the plan has resulted in a permanent system correction. This will be in addition to annual onsite or desk reviews conducted by the YES Waiver QM team. HHSC has the authority to require action from YES Waiver Providers for any non-compliance issues found during or outside of a QM review.
Enrollment in Texas Medicaid Healthcare Partnership

HHSC is responsible for credentialing each prospective WPO and CWP. HHSC determines the eligibility to enroll as a YES Waiver Provider with TMHP. TMHP processes all YES Waiver claims and makes payments to providers.

During the credentialing process, HHSC will issue a letter to the applicant entity confirming that permission to enroll with TMHP is granted by HHSC [see POLICY 0 6000 Comprehensive Waiver Provider General Responsibilities].

Local Mental Health Authority/Local Behavioral Health Authority

An LMHA/LBHA serving as the WPO and/or CWP will bill for YES Waiver services in accordance with [POLICY 0 9000 Billing].

Wraparound Provider Organization and Comprehensive Waiver Provider

WPO and CWP providers must enter service notes into CMBHS to bill for YES Waiver services and must maintain documentation of service provision for each invoiced amount in the participant’s file.

Medicaid billable services will not be reimbursed if:

- the individual who was provided the service did not meet the eligibility requirements;
- the service provided was an integral and inseparable part of another service;
- the service was provided by a person who was not qualified to provide the service in question;
- the service provided was not the type, amount, and duration authorized on the IPC;
- the service provided was not the type, amount, and duration as documented in the Wraparound Plan; or
two services are provided at the same day and time, except as otherwise indicated by HHSC in YES Waiver policy.

**Medicaid Verification**

The WPO, and CWP are responsible for verifying a participant’s Medicaid benefits at the beginning of each month prior to rendering YES Waiver services. Services delivered to a participant without active Medicaid cannot be reimbursed.

**Reimbursement Rate**

In accordance with the CWP and WPO agreements with HHSC, the current Waiver service reimbursement rate(s), or any amendment to the rate(s), is payment in full for the provision of Waiver services. More information on reimbursement rates can be found on the HHSC Rate Analysis page at:


**Additional Charges Prohibited**

The WPO and CWP are prohibited from assessing additional charges to a participant, any member of a participant family, or any other party, including a third-party payer, except as permitted by federal and/or state law, rule, regulation, or the Medicaid State Plan.

**Non-Reimbursed Services**

Services that are not reimbursed include those:

- Not identified on the participants Wraparound Plan;
- Not previously approved on the participant service authorization;
- Exceeding the limits authorized by HHSC;
- Provided on a date in which an active IPC was not in place; or
- Provided outside of the participant’s Waiver eligibility.

**State Plan Services**

Medicaid providers of State Plan services must submit claims for payment to TMHP, the appropriate MCO, or private insurance, as applicable. The YES Waiver program does not pay claims for State Plan services or for other non-Waiver services.
**Payer of Last Resort**

Medicaid is the payer of last resort. Any claims that may be covered by a private insurance benefit must be submitted for payment to the private insurance provider prior to submitting the claim to Medicaid; i.e. TMHP or a Medicaid MCO.

**Child and Family Team Participation**

No two services should be billed at the same time, per Medicaid, with the only exception being specialized therapies. Specialized therapists can bill clinical consultation at the same time ICM is being billed by the Wraparound Facilitator. However, the specialized therapist can only bill for **one hour**, regardless of the total meeting time of the CFT meeting.

Community living supports (CLS), family supports, and paraprofessional services team representatives are permitted to be present and to bill for time providing service as part of the CFT meeting, if the participant has an identified need for service(s) at that time. In order to bill for service during the CFT, billing time for Wraparound will need to be suspended. The service provider and Wraparound Facilitator are responsible for coordinating billing times.

**Billing Errors**

If claims were entered and processed twice for the same services, the recoup/payment amount should be remitted directly to TMHP. The contractor will need to complete the TMHP remittance form that includes an address to remit the payment.

When the payment is sent, the contractor will send an email to the contract management unit’s inbox MHContracts@hhsc.state.tx.us with a carbon copy (cc) to the YES Waiver Inbox (YESWaiver@hhsc.state.tx.us). The email should include the check number and amount. The contract management unit will verify payment with TMHP for documentation in the contractor’s contract file.

**Cost Neutrality**

Contractors shall stay below the maximum allowable amounts for 100% of authorized services as outlined in the CMS Waiver Application and below the annual participant cost limit as outlined in the CMS YES Waiver application. This shall be measured annually against any service limitations outlined in the manual, and
according to the following calculation: The number of Waiver participants whose paid claims exceed the limitations outlined in the Manual and/or in the CMS YES Waiver Application ÷ by the total number of Waiver Participants served.

Waiver participants must have an IPC at a cost within the cost ceiling. For Waiver participants with needs that exceed the cost limit, HHSC has a process to ensure their needs are met. The process includes examining third party resources or institutional services. Third party resources are examined during the CFT meeting that occurs when a Waiver participant is enrolled in the program, during each subsequent CFT meeting, and as the Waiver participant approaches the cost limit. If a Waiver participant’s needs exceed the cost limit, the CFT will explore a referral for other services or institutional settings.

Waiver participants will be informed of their rights and given the opportunity to request a Fair Hearing if HHSC proposes to terminate their Waiver eligibility.

**Notification to HHSC**

A representative from the WPO must notify HHSC when nearing the cost neutrality limit.

**Electronic Visit Verification (EVV)**

The YES Waiver is subject to the 21st Century Cures Act requirements for electronic visit verification. See HHSC’s Electronic Visit Verification website for more information:

9000.1 Billing: Adaptive Aids and Supports

Billable Aids and Supports
A provider can submit a claim for reimbursement for AA&S for services provided and within the approved limits of an authorized IPC. Billable AA&S must meet all policy and procedure standards [see POLICY 0 9000.1 Billing: Adaptive Aids and Supports]. There is a separate process for AA&S requests that must be followed before these services are provided and claims submitted.

Non-Billable Aids and Supports
A provider cannot bill Medicaid for AA&S above approved limits on the authorized IPC or for AA&S that do not meet YES Waiver policy standards and procedures [see POLICY 0 9000.1 Billing: Adaptive Aids and Supports].

Associated Fees

For LAR
A provider can submit a claim for reimbursement for entry, registration, or other applicable fee(s) to pay for a LAR to accompany a participant in order to facilitate a Waiver service on behalf of the service is required for participant participation.

For Provider
A provider cannot bill Medicaid for entry, registration, or other applicable fee(s) to pay for a provider to facilitate a Waiver service for the participant, as these fees are included in the provider's pay rate.

Payment Rate
The payment rate for an AA&S is dependent upon the direct and associated costs for the approved service.

Annual Limit
There is a combined limit of $5,000 for minor home modifications and AA&S, per 365-day IPC period. The amount approved cannot exceed the annual cost limit.
**Bids**

HHSC requires a CWP to obtain three bids for any AA&S costing $500 or more.

**Required Documentation**

In order to properly bill for the provision of AA&S, a provider must provide:

- a receipt of purchase; and
- documentation of a good faith effort to obtain multiple bids, when applicable;
- participant name;
- start and stop time of the service, if applicable;
- service name and description, if applicable;
- service location, if applicable;
- specific skill(s) received and method used to train participant in skill(s), and participant’s response to use of AA&S;
- verified use of the AA&S;
- an invoice or receipt for the purchase of the material(s), which is in compliance with Waiver policies and procedures;
- proof that at least three bids or prices were solicited for AA&S costing $500 or more;
- proof of completed health and safety and background checks.

NOTE: See the YES Waiver User Guide for instructions on requesting AA&S services.

**Requisition Fee**

HHSC directly reimburses the CWP for the requisition fee associated with the total cost of securing each identified support purchased, in accordance with the following:

<table>
<thead>
<tr>
<th>Cost of Service</th>
<th>Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $500</td>
<td>10% of cost</td>
</tr>
<tr>
<td>$500–$999.99</td>
<td>$54.03</td>
</tr>
<tr>
<td>$1,000–$1,499.99</td>
<td>$92.85</td>
</tr>
<tr>
<td>$1,500–$1,999.99</td>
<td>$105.66</td>
</tr>
<tr>
<td>$2,000–$2,499.99</td>
<td>$118.86</td>
</tr>
<tr>
<td>$2,500–$2,999.99</td>
<td>$134.21</td>
</tr>
<tr>
<td>$3,000–$3,499.99</td>
<td>$140.81</td>
</tr>
<tr>
<td>Cost of Service</td>
<td>Payment Rate</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>$3,500–$3,999.99</td>
<td>$147.02</td>
</tr>
<tr>
<td>$4,000–$4,499.99</td>
<td>$153.62</td>
</tr>
<tr>
<td>$4,500–$4,999.99</td>
<td>$160.22</td>
</tr>
<tr>
<td>$5,000</td>
<td>$168.96</td>
</tr>
</tbody>
</table>

**Reimbursement of Service Rate**

HHSC directly reimburses the CWP for the total cost, per identified support. If the AA&S was subcontracted, the CWP must reimburse the subcontractor the total cost.
Unit Designation and Payment Rate

The unit designation for CLS is 15-minutes. One 15-minute increment is billed as one unit. In order to bill for a unit, the entire unit must be provided to the participant, face-to-face.

Bachelor’s degree and master’s degree level CLS clinicians are paid at the same rate per unit. See the HHSC Rate Analysis page for current reimbursement amounts for YES Waiver services:


Availability of Annual Units

The availability of annual units varies, depending upon the recommendations of the CFT and must be included on the Wraparound Plan and authorized on the Individual Plan of Care (IPC).

Group Setting Service(s)

Waiver services that are permitted to be provided in a group setting are billed using the following formula:

\[
\text{Number of providers} \times \text{Time spent delivering service(s)} \div \text{Number of participants served} = \text{Billable Time.}
\]

Required Documentation

In order to properly bill for the provision of CLS service(s), a provider must document:

- date of contact with the participant;
- start and stop time of contact with the participant;
- progress towards goals set forth in the service authorization; and
- direct service provider’s printed name, signature, and credentials.
Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit, rate. The CWP is permitted to negotiate payment to its employees or subcontractors.
Unit Designation and Payment Rate

The unit designation for employment assistance is 15 minutes. One 15-minute increment is billed as one unit. In order to bill for a unit, the entire unit must be provided to the participant, face-to-face.

Employment assistance services are paid at the rate of $6.52 per unit.

Availability of Units

The availability of annual units varies, depending upon the recommendations of the CFT and the Wraparound Plan.

Required Documentation

In order to properly bill for the provision of employment assistance services, a provider must document:

- date of contact with the participant;
- start and stop time of contact with the participant;
- progress towards goals set forth in the service authorization; and
- direct service provider’s printed name, signature, and credentials.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit, rate. The CWP is permitted to negotiate payment to its employees or subcontractors.
9000.4 Billing: Family Supports

**Unit Designation and Payment Rate**

The unit designation for family supports is 15-minutes. One 15-minute increment is billed as one unit. In order to bill for a unit, the entire unit must be provided to the participant, face-to-face.

Family support services are paid at the rate of $6.25 per unit.

**Availability of Annual Units**

The availability of annual units varies, depending upon the recommendations of the CFT and the Wraparounds Plan.

**Group Setting Service(s)**

Waiver services that are permitted to be provided in a group setting are billed using the following formula:

\[
\text{Number of providers} \times \text{Time spent delivering service(s)} \div \text{Number of participants served} = \text{Billable Time}.
\]

**Required Documentation**

In order to properly bill for the provision of family support services, a provider must document:

- date of contact with the participant;
- start and stop time of contact with the participant;
- progress towards goals set forth in the service authorization; and
- direct service provider’s printed name, signature, and credentials.

**Reimbursement and Negotiation of Service Rate**

HHSC directly reimburses the CWP for the entire, per unit, rate. The CWP is permitted to negotiate payment to its employees or subcontractors.
9000.5 Billing: Minor Home Modification

Payment Rate
The payment rate for minor home modifications is dependent upon the direct and associated costs for the type of modification chosen.

Annual Limit
There is a combined limit of $5,000 for minor home modifications and AA&S per 365-day IPC period.

Availability of Units
The availability of minor home modifications varies, depending upon the recommendations of the CFT and the Wraparound Plan, in consideration of the annual cost limit.

Non-Billable Modifications
A provider cannot bill Medicaid for room and board, normal household expenses, or items not related to the improvement of the participant’s disability.

Bids
HHSC requires a CWP to obtain three bids for any modification costing $500 or more.

Required Documentation
In order to properly bill for minor home modifications, a provider must provide:

- a receipt of purchase; and
- documentation of a good faith effort to obtain multiple bids, when applicable.
- documentation verifying installation, completion of modification, or delivery of goods.
Requisition Fee

HHSC directly reimburses the CWP for the requisition fee associated with the total cost of each identified modification, in accordance with the following:

<table>
<thead>
<tr>
<th>Cost of Service</th>
<th>Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $500</td>
<td>10% of cost</td>
</tr>
<tr>
<td>$500–$999.99</td>
<td>$80.04</td>
</tr>
<tr>
<td>$1,000–$1,499.99</td>
<td>$118.86</td>
</tr>
<tr>
<td>$1,500–$1,999.99</td>
<td>$131.67</td>
</tr>
<tr>
<td>$2,000–$2,499.99</td>
<td>$163.89</td>
</tr>
<tr>
<td>$2,500–$2,999.99</td>
<td>$196.50</td>
</tr>
<tr>
<td>$3,000–$3,499.99</td>
<td>$227.19</td>
</tr>
<tr>
<td>$3,500–$3,999.99</td>
<td>$258.27</td>
</tr>
<tr>
<td>$4,000–$4,499.99</td>
<td>$284.28</td>
</tr>
<tr>
<td>$4,500–$4,999.99</td>
<td>$309.90</td>
</tr>
<tr>
<td>$5,000</td>
<td>$335.91</td>
</tr>
</tbody>
</table>

Reimbursement of Service Rate

HHSC directly reimburses the CWP for the total cost, per identified modification. If the modification was subcontracted, the CWP must reimburse the subcontractor the total cost.
Unit Designation and Payment Rate

The unit designation for non-medical transportation is one mile. One mile is billed as one unit. In order to bill for a unit, it must be provided to the participant, face-to-face.

Mileage incurred prior to picking the participant up or after dropping the participant off to access Waiver services are not units and cannot be billed.

Non-medical transportation is paid at the rate of $0.55 per unit.

Limitations

Payment for non-medical transportation is limited to the costs of transporting a participant to and from Waiver services included in the service authorization, or to access other activities and/or resources identified in the service authorization.

Whenever possible, members of the participant’s family, neighbors, friends, or community agencies which can provide non-medical transportation at no cost must be utilized prior to requesting it through the Waiver.

When costs for transportation are included in the provider rate for another Waiver service the participant is receiving at the same time, non-medical transportation will not be reimbursed separately as a Waiver service.

Non-medical transportation cannot be provided at the same time as:

- Community Living Supports;
- Supported Employment;
- Employment Assistance; or
- Paraprofessional Services.

Availability of Annual Units

The availability of annual units varies, depending upon the recommendations of the CFT and the Wraparound Plan.
Required Documentation

Providers are required to maintain a transportation log documenting the use of this service. The log may be requested during quality management audits. A template is available on the YES Waiver website. In order to properly bill for the provision of non-medical transportation, a provider must document:

- date of contact;
- mileage, including start and stop time; and
- direct service provider’s printed name, signature, and credentials.

Rounding Mileage

Mileage is rounded to the nearest whole mile, in accordance with the following:

<table>
<thead>
<tr>
<th>Mileage</th>
<th>Round</th>
</tr>
</thead>
<tbody>
<tr>
<td>.01–.49</td>
<td>Down</td>
</tr>
<tr>
<td>.50–.99</td>
<td>Up</td>
</tr>
</tbody>
</table>

Reimbursement and Negotiation Service Rate

HHSC directly reimburses the CWP for the entire, per unit rate. The CWP is permitted to negotiate payment to its employees or subcontractors.
9000.7 Billing: Paraprofessional Services

Unit Designation and Payment Rate

The unit designation for paraprofessional services is 15-minutes. One 15-minute increment is billed as one unit. In order to bill for a unit, the entire unit must be provided to the participant, face-to-face.

Paraprofessional services are paid at the rate of $6.15 per unit.

Availability of Annual Units

The availability of annual units varies, depending upon the recommendations of the CFT and the Wraparound Plan.

Group Setting Service(s)

Waiver services that are permitted to be provided in a group setting are billed using the following formula:

Number of providers × Time spent delivering service(s) ÷ Number of participants served = Billable Time.

Required Documentation

In order to properly bill for the provision of paraprofessional services, a provider must document:

- date of contact with the participant;
- start and stop time of contact with the participant;
- progress towards goals set forth in the service authorization; and
- direct service provider’s printed name, signature, and credentials.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit rate. The CWP is permitted to negotiate payment to its employees or subcontractors.
Unit Designation and Payment Rate

Reimbursement for Pre-Engagement services is only authorized for the LMHA/LBHA.

The unit designation for pre-engagement services is hourly. One hour is billed as one unit. Pre-engagement services are permitted to be billed a maximum of 16 hours.

Pre-engagement services are paid at the rate of $15.85 per unit.

Pre-Engagement Services are not billed by submitting a DSHS Form b13 and a YES-PE Invoice. This is a manual process and is not processed through CMBHS. LMHA/LBHA’s should contact their program liaison for additional guidance on submitting documentation for this service.
9000.10 Billing: Respite – In Home

Unit Designation and Payment Rate
The unit designation for in-home respite services is hourly. One hour is billed as one unit. In order to bill for a unit, the unit must be provided to the participant, face-to-face.

In-home respite services are paid at the rate of $20.88 per unit, and for one-to-one care of a single individual at the specified time.

Unit Limitation
Up to 720 consecutive or cumulative hours, or 30 calendar days, of any respite service, or combination of respite services, is permitted to be provided per participant per IPC year.

Required Documentation
In order to properly bill for the provision of in-home respite services, a provider must document:

- date of contact;
- start and stop time;
- progress towards goals set forth in the service authorization and how the treatment address and supports the reason for referral and the needs identified in the Wraparound Plan; and
- information about the service provider, including:
  - printed name;
  - signature (electronic signature is acceptable); and
  - credentials.

Reimbursement and Negotiation of Service Rate
HHSC directly reimburses the CWP for the entire, per unit rate or the amount up to the annual service maximum. The CWP is permitted to negotiate payment to its employees or subcontractors.
**9000.11 Billing: Respite – Out-of-Home Camp**

**Unit Designation and Payment Rate**

The unit designation for out-of-home camp respite services is a 15-minute unit rate. One hour is billed as four units. In order to bill for a unit, the unit must be provided to the participant face-to-face.

Out-of-home camp respite services are paid at the rate of $2.46 per unit.

**Incremental Billing**

HHSC permits out-of-home camp respite services to be billed in 15-minute increments; however, when billed incrementally, the entire 15-minute increment must be provided to the participant.

Incremental billing is in accordance with the following:

<table>
<thead>
<tr>
<th>Minutes</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>1.0</td>
</tr>
<tr>
<td>30</td>
<td>2.0</td>
</tr>
<tr>
<td>45</td>
<td>3.0</td>
</tr>
<tr>
<td>60</td>
<td>4.0</td>
</tr>
</tbody>
</table>

**Unit Limitation**

Up to **720 consecutive or cumulative hours**, or **30 calendar days**, of any respite service, or combination of respite services, is permitted to be provided per participant per IPC year.

**Required Documentation**

In order to properly bill for the provision of out-of-home camp respite services, a provider must document:

- date of contact;
- start and stop time;
- progress towards goals set forth in the service authorization and how the treatment address and supports the reason for referral and the needs identified in the Wraparound Plan;
- summary of activities, meals, and behaviors; and
- information about the service provider, including:
Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit rate or the amount up to the annual service maximum. The CWP is permitted to negotiate payment to its employees or subcontractors.

9000.12 Billing: Respite – Out-of-Home Licensed Childcare Center

Unit Designation and Payment Rate

The unit designation for out-of-home LCCC respite services is hourly. One hour is billed as one unit. In order to bill for a unit, the unit must be provided to the participant face-to-face.

Preschool Age

LCCC respite services for preschool youth, ages 3 to 5 years old, are paid at the rate of $5.32 per unit.

School Age

LCCC respite services for school age youth, 6 through 18 years of age, up to one month before the 19th birthday, are paid at the rate of $5.17 per unit.

Incremental Billing

HHSC permits LCCC respite services to be billed in ¼, or 15-minute, increments; however, when billed incrementally, the entire 15-minute increment must be provided to the participant.

Incremental billing is in accordance with the following:

<table>
<thead>
<tr>
<th>Minutes</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>.25</td>
</tr>
<tr>
<td>30</td>
<td>.5</td>
</tr>
<tr>
<td>45</td>
<td>.75</td>
</tr>
</tbody>
</table>
### Unit Limitation

Up to **720 consecutive or cumulative hours**, or **30 calendar days**, of any respite service, or combination of respite services, is permitted to be provided per participant per IPC year.

### Required Documentation

In order to properly bill for the provision of LCCC respite services, a provider must document:

- date of contact;
- start and stop time;
- progress towards goals set forth in the service authorization and how the treatment address and supports the reason for referral and the needs identified in the Wraparound Plan;
- a summary of activities, meals, and behaviors; and
- information about the service provider, including:
  - printed name;
  - signature (electronic signature is acceptable); and
  - credentials.

### Reimbursement and Negotiation of Service Rate

HHSC shall directly reimburse the CWP for the entire, per unit rate or the amount up to the annual service maximum. The CWP is permitted to negotiate payment to its employees or subcontractors.

Unit Designation and Payment Rate

The unit designation for out-of-home, licensed childcare center, TRS Provider respite services is hourly. One hour is billed as one unit. In order to bill for a unit, the unit must be provided to the participant face-to-face.

Preschool Age

TRS Provider respite services for preschool youth, ages 3 to 5 years old, are paid at the rate of $5.61 per unit.

School Age

TRS Provider respite services for school age youth, 6 through 18 years of age, up to one month before the 19th birthday, are paid at the rate of $5.54 per unit.

Incremental Billing

HHSC permits TRS Provider respite services to be billed in ¼, or 15-minute, increments; however, when billed incrementally, the entire 15-minute increment must be provided to the participant.

Incremental billing is in accordance with the following:

<table>
<thead>
<tr>
<th>Minutes</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>.25</td>
</tr>
<tr>
<td>30</td>
<td>.5</td>
</tr>
<tr>
<td>45</td>
<td>.75</td>
</tr>
<tr>
<td>60</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Unit Limitation

Up to 720 consecutive or cumulative hours, or 30 calendar days, of any respite service, or combination of respite services, are permitted to be provided per participant per IPC year.
Required Documentation

In order to properly bill for the provision of TRS Provider respite services, a provider must document:

- date of contact;
- start and stop time;
- progress towards goals set forth in the service authorization and how the treatment address and supports the reason for referral and the needs identified in the Wraparound Plan;
- a summary of activities, meals, and behaviors; and
- information about the service provider, including:
  - printed name;
  - signature (electronic signature is acceptable); and
  - credentials.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit rate or the amount up to the annual service maximum. The CWP is permitted to negotiate payment to its employees or subcontractors.


Unit Designation and Payment Rate

The unit designation for out-of-home LCCH respite services is hourly. One hour is billed as one unit. In order to bill for a unit, the unit must be provided to the participant face-to-face.

Preschool Age

LCCH respite services for preschool youth, ages 3 to 5 years old, are paid at the rate of $4.90 per unit.

School Age

LCCC respite services for school age youth, 6 through 18 years of age, up to one month before the 19th birthday, are paid at the rate of $4.86 per unit.
**Incremental Billing**

HHSC permits LCCH respite services to be billed in \( \frac{1}{4} \), or 15-minute, increments; however, when billed incrementally, the entire 15-minute increment must be provided to the participant.

Incremental billing is in accordance with the following:

<table>
<thead>
<tr>
<th>Minutes</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>.25</td>
</tr>
<tr>
<td>30</td>
<td>.5</td>
</tr>
<tr>
<td>45</td>
<td>.75</td>
</tr>
<tr>
<td>60</td>
<td>1.0</td>
</tr>
</tbody>
</table>

**Unit Limitation**

Up to **720 consecutive or cumulative hours**, or **30 calendar days**, of any respite service, or combination of respite services, are permitted to be provided per participant per IPC year.

**Required Documentation**

In order to properly bill for the provision of LCCH respite services, a provider must document:

- date of contact;
- start and stop time;
- progress towards goals set forth in the service authorization and how the treatment address and supports the reason for referral and the needs identified in the Wraparound Plan;
- summary of activities, meals, and behaviors; and
- information about the service provider, including:
  - printed name;
  - signature (electronic signature is acceptable); and
  - credentials.

**Reimbursement and Negotiation Service Rate**

HHSC directly reimburses the CWP for the entire, per unit rate or the amount up to the annual service maximum. The CWP is permitted to negotiate payment to its employees or subcontractors.
9000.15Billing: Respite – Out-of-Home Licensed Childcare Home Texas Rising Star Provider

Unit Designation and Payment Rate

The unit designation for out-of-home, licensed childcare home, TRS Provider respite services is hourly. One hour is billed as one unit. In order to bill for a unit, the unit must be provided to the participant face-to-face.

Preschool Age

TRS Provider respite services for preschool youth, ages 3 to 5 years old, are paid at the rate of $5.17 per unit.

School Age

TRS Provider respite services for school age youth, 6 through 18 years of age, up to one month before the 19th birthday, paid at the rate of $5.62 per unit.

Incremental Billing

HHSC permits TRS Provider respite services to be billed in ¼, or 15-minute, increments; however, when billed incrementally, the entire 15-minute increment must be provided to the participant.

Incremental billing is in accordance with the following:

<table>
<thead>
<tr>
<th>Minutes</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>.25</td>
</tr>
<tr>
<td>30</td>
<td>.5</td>
</tr>
<tr>
<td>45</td>
<td>.75</td>
</tr>
<tr>
<td>60</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Unit Limitation

Up to **720 consecutive or cumulative hours**, or **30 calendar days**, of any respite service, or combination of respite services, are permitted to be provided per participant per IPC year.
Required Documentation

In order to properly bill for the provision of TRS Provider respite services, a provider must document:

- date of contact;
- start and stop time;
- progress towards goals set forth in the service authorization and how the treatment address and supports the reason for referral and the needs identified in the Wraparound Plan;
- summary of activities, meals, and behaviors; and
- information about the service provider, including:
  - printed name;
  - signature (electronic signature is acceptable); and
  - credentials.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit rate or the amount up to the annual service maximum. The CWP is permitted to negotiate payment to its employees or subcontractors.

9000.16 Billing: Respite – Out-of-Home Registered Childcare Home

Unit Designation and Payment Rate

The unit designation for out-of-home RCCH respite services is hourly. One hour is billed as one unit. In order to bill for a unit, the unit must be provided to the participant face-to-face.

Preschool Age

RCCH respite services for preschool youth, ages 3 to 5 years old, are paid at the rate of $4.75 per unit.

School Age

RCCH respite services for school age youth, 6 through 18 years of age, up to one month before the 19th birthday, are paid at the rate of $3.83 per unit.
Incremental Billing

HHSC permits RCCH respite services to be billed in ¼, or 15-minute, increments; however, when billed incrementally, the entire 15-minute increment must be provided to the participant.

Incremental billing is in accordance with the following:

<table>
<thead>
<tr>
<th>Minutes</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>.25</td>
</tr>
<tr>
<td>30</td>
<td>.5</td>
</tr>
<tr>
<td>45</td>
<td>.75</td>
</tr>
<tr>
<td>60</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Unit Limitation

Up to 720 consecutive or cumulative hours, or 30 calendar days, of any respite service, or combination of respite services, are permitted to be provided per participant per IPC year.

Required Documentation

In order to properly bill for the provision of RCCH respite services, a provider must document:

- date of contact;
- start and stop time;
- progress towards goals set forth in the service authorization and how the treatment address and supports the reason for referral and the needs identified in the Wraparound Plan;
- summary of activities, meals, and behaviors; and
- information about the service provider, including:
  - printed name;
  - signature (electronic signature is acceptable); and
  - credentials.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit rate or the amount up to the annual service maximum. The CWP is permitted to negotiate payment to its employees or subcontractors.
9000.17 Billing: Respite – Out-of-Home Registered Childcare Home Texas Star Provider

Unit Designation and Payment Rate

The unit designation for out-of-home, registered childcare home, TRS Provider respite services is hourly. One hour is billed as one unit. In order to bill for a unit, the unit must be provided to the participant face-to-face.

Preschool Age

TRS Provider respite services for preschool youth, ages 3 to 5 years old, are paid at the rate of $4.99 per unit.

School Age

TRS Provider respite services for school age youth, 6 through 18 years of age, up to one month before the 19th birthday, are paid at the rate of $4.08 per unit.

Incremental Billing

HHSC permits TRS Provider respite services to be billed in ¼, or 15-minute, increments; however, when billed incrementally, the entire 15-minute increment must be provided to the participant.

Incremental billing is in accordance with the following:

<table>
<thead>
<tr>
<th>Minutes</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>.25</td>
</tr>
<tr>
<td>30</td>
<td>.5</td>
</tr>
<tr>
<td>45</td>
<td>.75</td>
</tr>
<tr>
<td>60</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Unit Limitation

Up to 720 consecutive or cumulative hours, or 30 calendar days, of any respite service, or combination of respite services, are permitted to be provided per participant IPC year.
Required Documentation

In order to properly bill for the provision of TRS Provider respite services, a provider must document:

- date of contact;
- start and stop time;
- progress towards goals set forth in the service authorization and how the treatment address and supports the reason for referral and the needs identified in the Wraparound Plan;
- summary of activities, meals, and behaviors; and
- information about the service provider, including:
  - printed name;
  - signature (electronic signature is acceptable); and
  - credentials.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit rate or the amount up to the annual service maximum. The CWP is permitted to negotiate payment to its employees or subcontractors.

9000.18 Billing: Respite – Out-of-Home Residential Childcare (OTHER)

Unit Designation and Payment Rate

The unit designation for out-of-home, residential childcare, DFPS respite services is daily. Any portion of a 24-hour period is permitted to be billed as one unit.

Foster Family

DFPS residential childcare respite services provided by a foster family are paid at the rate of $88.62 per unit, the mandated minimum in accordance with 40 TAC §700.1753.

Child Placing Agency

DFPS residential childcare respite services provided by a child placing agency are paid at the rate of $67.98 per unit.
General Residential Operation (GRO)

A respite service provider must be a residential child care operation, in accordance with 26 TAC 748 or a Waiver Provider agency certified by HHSC as a Local Mental Health Authority or a Local Behavioral Health Authority and are paid at the rate of $115.44 per unit.
9000.19 Billing: Specialized Therapies

Types of Specialized Therapies

There are five types of specialized therapies:

(1) Animal-Assisted Therapy;
(2) Art Therapy;
(3) Licensed Nutritional Counseling;
(4) Music Therapy; and
(5) Recreational Therapy.

Unit Designation

The unit designation for each specialized therapy is 15-minutes. One 15-minute increment is billed as one unit.

Provision of Service

In order to bill for a unit of providing a specialized therapy service, the entire unit must be provided to the participant, face-to-face. All service documentation must be submitted within two business days after each contact that occurs to provide services to the individual and LAR in the YES Waiver program.

Child and Family Team Meeting

In-Person Participation

In-person participation of a therapist during CFT meetings is strongly encouraged. A therapist who participates in a CFT meeting in person is permitted to bill for a maximum of one hour, for each CFT meeting attended.

Phone Participation

50 Miles or More

A therapist who must travel 50 miles or more to attend a CFT meeting is permitted to call in to participate in the meeting. The therapist is permitted to bill for a maximum of one hour, for each CFT meeting attended.
**Under 50 Miles**

A therapist who must travel 49 miles or less to attend a CFT meeting is also permitted to call in to participate in the meeting. The therapist is permitted to bill for a maximum of one unit, or one 15-minute increment, for each CFT meeting attended.

**Payment Rate**

The payment rate for each specialized therapy is in accordance with the following:

<table>
<thead>
<tr>
<th>Service</th>
<th>Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Animal-Assisted Therapy</td>
<td>$19.36</td>
</tr>
<tr>
<td>Art Therapy</td>
<td>$19.36</td>
</tr>
<tr>
<td>Music Therapy</td>
<td>$19.36</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>$13.82</td>
</tr>
<tr>
<td>Recreational Therapy</td>
<td>$19.36</td>
</tr>
</tbody>
</table>

**Availability of Annual Units**

The availability of annual units varies, depending upon the recommendations of the CFT and the Wraparound Plan.

**Group Setting Service(s)**

Waiver services that are permitted to be provided in a group setting are billed using the following formula:

\[
\text{Number of providers} \times \text{Time spent delivering service(s)} \div \text{Number of participants served} = \text{Billable Time.}
\]

**Required Documentation**

In order to properly bill for the provision of specialized therapy, a provider must document:

- date of contact with the participant;
- start and stop time of contact with the participant;
- progress towards goals set forth in the service authorization; and
- direct service provider’s printed name, signature, and credentials.
Requisition Fee

HHSC directly reimburses the provider for the requisition fee associated with the total per encounter cost, in accordance with the following:

<table>
<thead>
<tr>
<th>Cost of Service</th>
<th>Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $500</td>
<td>10% of cost</td>
</tr>
<tr>
<td>$500–$999.99</td>
<td>$54.03</td>
</tr>
<tr>
<td>$1,000–$1,499.99</td>
<td>$92.85</td>
</tr>
<tr>
<td>$1,500–$1,999.99</td>
<td>$105.66</td>
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<tr>
<td>$2,000–$2,499.99</td>
<td>$118.86</td>
</tr>
<tr>
<td>$2,500–$2,999.99</td>
<td>$134.21</td>
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<tr>
<td>$3,000–$3,499.99</td>
<td>$140.81</td>
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<td>$3,500–$3,999.99</td>
<td>$147.02</td>
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<td>$4,000–$4,499.99</td>
<td>$153.62</td>
</tr>
<tr>
<td>$4,500–$4,999.99</td>
<td>$160.22</td>
</tr>
<tr>
<td>$5,000</td>
<td>$168.96</td>
</tr>
</tbody>
</table>

Exception
Nutritional counseling does not have an associated requisition fee.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the actual direct service cost, up to the per unit maximum. The amount billed will reflect the payment amount to employees or subcontractors.

The CWP is permitted to negotiate payment to its employees or subcontractors, only for services that do not have an associated requisition fee. The CWP must pass the full payment rate to the direct service provider for services that have an associated requisition fee.
Unit Designation and Payment Rate

The unit designation for supported employment is 15 minutes. One 15-minute increment is billed as one unit. In order to bill for a unit, the entire unit must be provided to the participant, face-to-face.

Supported employment services are paid at the rate of $6.52 per unit.

Availability of Annual Units

The availability of annual units varies, depending upon the recommendations of the CFT and the Wraparound Plan.

Required Documentation

In order to properly bill for the provision of supported employment services, a provider must document:

- date of contact with the participant;
- start and stop time of contact with the participant;
- progress towards goals set forth in the service authorization; and
- direct service provider’s printed name, signature, and credentials.

Reimbursement and Negotiation of Service Rate

HHSC directly reimburses the CWP for the entire, per unit, rate. The CWP is permitted to negotiate payment to its employees or subcontractors.
9000.21 Billing: Supportive Family-Based Alternative

**Unit Designation and Payment Rate**

The unit designation for SFA is daily. Any portion of a 24-hour period is permitted to be billed as one unit.

**Support Family**

SFA services provided by a support family are paid at the rate of $69.25 per unit, the mandated minimum in accordance with 40 TAC §700.1753.

**Child Placing Agency**

SFA services provided by a child placing agency are paid at the rate of $67.98 per unit.

**Unit Limitation**

Up to 90 consecutive or cumulative calendar days of SFA are permitted to be provided, per participant, per IPC year.

**Required Documentation**

In order to properly bill for the provision of SFA service(s), a provider must document:

- date of contact with the participant;
- start and stop time of contact with the participant;
- progress towards goals set forth in the service authorization; and
- direct service provider’s printed name, signature, and credentials.

**Reimbursement and Negotiation of Service Rate**

HHSC directly reimburses the CWP for the entire, per unit rate. The CWP is permitted to negotiate payment to its employees or subcontractors for services
provided by a child placing agency; however, a support family must be paid the entire mandated maximum rate.
Payment

Transitional services are paid as a one-time, non-recurring expense, to a maximum of $2,500, per participant. Failure to use the full $2,500 at one time will result in a loss of the remainder amount. Costs for all Waiver services cannot exceed the individual annual cost ceiling established under the Waiver.

Required Documentation

In order to properly bill for transitional services, a provider must retain receipt(s) of purchase in the participant’s file [see POLICY 0 3700 Record Keeping].

Requisition Fee

HHSC reimburses the CWP for transitional services coordination in the amount of $158.28.

Reimbursement of Service Rate

In addition to the requisition fee, HHSC directly reimburses the CWP for the total amount of assistance, to the allowed maximum.

If transitional services were subcontracted, the CWP must reimburse the subcontractor for the total amount of assistance; however, the CWP retains the requisition fee.
Intensive Case Management Billing Code

ICM is not a YES Waiver service and reimbursement of this State Plan benefit is outside of the purview of YES.

The TMHP procedure code for delivering ICM to participants who are 18 years of age is T1017 with modifier TG.
Policy Statement: Managing Claims

In order to receive payment for Waiver services provided, a CWP must enter and manage claims through CMBHS as a service note.

Procedure: Entering Service Notes

(1) To enter a service note: There must be a client profile and IPC in CMBHS;
(2) In Special Services Documentation, select the ‘Client Services Toolbar, YES Waiver Services’;
(3) The ‘Progress Note Type’ field automatically populates;
(4) The ‘Progress Note Type’ displays ‘YES Waiver Service Note’ for each Waiver participant;
(5) The number of authorized units for each service, billing units, and the TMHP authorization automatically populate;
(6) The CWP must enter data in the following fields:
   (A) Service location;
   (B) Service date;
   (C) Start time and end time;
   (D) Service type; and
   (E) Service description;
(7) The following fields are calculated by CMBHS:
   (A) Number of service units used; and
   (B) Number of remaining units; and
(8) The CWP updates the document status as ‘Draft’ or ‘Ready for Review’; and
(9) CMBHS validates all of the required fields and creates a pending claim when the document is saved in ‘Ready for Review’ status.

A pending claim in ‘Ready to Review’ status is not considered ‘Submitted’ until it is addressed as a ‘Pending Claim’. Following the steps detailed in 9000.25 is required for submitting a ‘Pending Claim’.

Deleting a Service Note

A service note can be deleted from CMBHS before or after submission to TMHP by:
(1) Finding the service note in the Client Workspace;
(2) Highlighting the service note and selecting ‘View’; and
(3) Clicking ‘Delete’ at the top right corner of the page.

A ‘Canceled Claim’ must be created in CMBHS, and once the claim is canceled, the service units from the canceled claim will be re-added to the service authorization.
9000.25 Billing: Pending Claims

Procedure

To submit a pending claim in CMBHS, a CWP must:

(1) Hover over the ‘Business Office’ tab at the top of the page for the dropdown list;
(2) Select ‘Search Claims’;
(3) Select ‘Pending Claims’;
(4) Select ‘YES Waiver’ as the funding source;
(5) Select ‘YES Waiver’ as the ‘Supporting Document (SD) Type’;
(6) Enter ‘Service Begin Date’;
(7) Enter ‘Service End Date’;
(8) Select ‘Search’ (limited to a 92-day date range);
(9) Search the Pending Claims screen for the billable claim needing to be submitted;
(10) Select ‘YES Waiver Medicaid’ as the ‘Contract’;
(11) Verify accuracy of the information on the claim(s);
(12) Select the claims to submit by checking the corresponding box;
(13) Click the ‘Submit Claims’ button to submit claims to TMHP for payment.
Policy Statement

A claim for YES Waiver services is paid by TMHP. In order to receive payment for performing the service(s), a CWP must enter and manage claims through CMBHS as a service note [see POLICY 0 9000.24 Billing: Service Notes].

Procedure: Claims Management

Initial claims must be submitted to TMHP within 95 calendar days of the date of the provision of the Waiver service. To ensure accuracy during claim processing, TMHP verifies that all required information is included in the claim.

Payment

A claim that is ready for disposition at the end of each week will be paid via an Electronic Fund Transfer (EFT) or by a single check. The EFT includes an explanation of each payment or denial of payment.

Additional information regarding TMHP’s claims filing and reimbursement process is available at:


Appeal of Denied Payment

A provider is permitted to appeal a denial of payment of a claim to TMHP. All appeals of denied claims and/or adjustments on paid claims must be submitted to TMHP within 120 calendar days from the date of disposition of the Remittance and Status (R&S) Report on which the claim(s) appears.

Additional information regarding TMHP’s appeal process is available at:
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA&amp;S</td>
<td>Adaptive Aids &amp; Supports</td>
</tr>
<tr>
<td>ACA</td>
<td>American Camp Association</td>
</tr>
<tr>
<td>ANSA</td>
<td>Adult Needs and Strengths Assessment</td>
</tr>
<tr>
<td>ARD</td>
<td>Admission, Review, and Dismissal Report</td>
</tr>
<tr>
<td>ATCB</td>
<td>Art Therapy Credentials Board</td>
</tr>
<tr>
<td>CANS</td>
<td>Child and Adolescent Needs and Strengths Assessment</td>
</tr>
<tr>
<td>CAP</td>
<td>Corrective Action Plan</td>
</tr>
<tr>
<td>CBMT</td>
<td>Certification Board for Music Therapists</td>
</tr>
<tr>
<td>CE</td>
<td>Clinical Eligibility</td>
</tr>
<tr>
<td>CEU</td>
<td>Continuing Education Units</td>
</tr>
<tr>
<td>CIR</td>
<td>Critical Incident Report</td>
</tr>
<tr>
<td>CFT</td>
<td>Child and Family Team</td>
</tr>
<tr>
<td>CLS</td>
<td>Community Living Supports</td>
</tr>
<tr>
<td>CMBHS</td>
<td>Clinical Management for Behavioral Health Services</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicaid and Medicare Services</td>
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<tr>
<td>CPS</td>
<td>Child Protective Services</td>
</tr>
<tr>
<td>CSP</td>
<td>Comprehensive Service Provider</td>
</tr>
<tr>
<td>CWP</td>
<td>Comprehensive Waiver Provider</td>
</tr>
<tr>
<td>DADS</td>
<td>Department of Aging and Disability Services</td>
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<tr>
<td>DD</td>
<td>Developmental Delay</td>
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<tr>
<td>DFPS</td>
<td>Texas Department of Family and Protective Services</td>
</tr>
<tr>
<td>DSHS</td>
<td>Texas Department of State Health Services</td>
</tr>
<tr>
<td>DSM</td>
<td>Diagnostic and Statistical Manual</td>
</tr>
<tr>
<td>DUA</td>
<td>Data Use Agreement</td>
</tr>
<tr>
<td>EAGALA</td>
<td>Equine Assisted Growth and Learning Association</td>
</tr>
<tr>
<td>EFT</td>
<td>Electronic Fund Transfer</td>
</tr>
<tr>
<td>EMR</td>
<td>Employee Misconduct Registry</td>
</tr>
<tr>
<td>EPLS</td>
<td>Excluded Parties List System</td>
</tr>
<tr>
<td>FBI</td>
<td>Federal Bureau of Investigation</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Name</td>
</tr>
<tr>
<td>---------</td>
<td>-----------</td>
</tr>
<tr>
<td>FBR</td>
<td>Federal Benefit Rate</td>
</tr>
<tr>
<td>GRO</td>
<td>General Residential Operation</td>
</tr>
<tr>
<td>HHSC</td>
<td>Texas Health and Human Services Commission</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
</tr>
<tr>
<td>ICFs/IID</td>
<td>Intermediate Care Facilities for Individuals with Intellectual Disabilities</td>
</tr>
<tr>
<td>ICM</td>
<td>Intensive Case Management</td>
</tr>
<tr>
<td>ID</td>
<td>Intellectual Disability</td>
</tr>
<tr>
<td>IDD</td>
<td>Intellectual and Developmental Disabilities</td>
</tr>
<tr>
<td>IEP</td>
<td>Individualized Education Plan</td>
</tr>
<tr>
<td>IPC</td>
<td>Individual Plan of Care</td>
</tr>
<tr>
<td>LAR</td>
<td>Legally Authorized Representative</td>
</tr>
<tr>
<td>LBHA</td>
<td>Local Behavioral Health Authority</td>
</tr>
<tr>
<td>LCCC</td>
<td>Licensed Child Care Center</td>
</tr>
<tr>
<td>LCCH</td>
<td>Licensed Child Care Home</td>
</tr>
<tr>
<td>LEIE</td>
<td>List of Excluded Individuals/Entities</td>
</tr>
<tr>
<td>LMHA</td>
<td>Local Mental Health Authority</td>
</tr>
<tr>
<td>LOC</td>
<td>Level of Care</td>
</tr>
<tr>
<td>LPHA</td>
<td>Licensed Practitioner of the Healing Arts</td>
</tr>
<tr>
<td>MBOW</td>
<td>Behavioral Health Outpatient Data Warehouse</td>
</tr>
<tr>
<td>MCO</td>
<td>Managed Care Organization</td>
</tr>
<tr>
<td>MED</td>
<td>Medicaid Effective Date</td>
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<td>MEPD</td>
<td>Medicaid for Employed People with Disabilities</td>
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<tr>
<td>MEV</td>
<td>Medicaid Eligibility Verification</td>
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<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>MHFA</td>
<td>Mental Health First Aid</td>
</tr>
<tr>
<td>NCTRS</td>
<td>National Council of Therapeutic Recreation Certification</td>
</tr>
<tr>
<td>NWIC</td>
<td>National Wraparound Implementation Center</td>
</tr>
<tr>
<td>OBRA</td>
<td>Omnibus Budget Reconciliation Act</td>
</tr>
<tr>
<td>PATH</td>
<td>Professional Association of Therapeutic Horsemanship International</td>
</tr>
<tr>
<td>PDD</td>
<td>Pervasive Developmental Disorder</td>
</tr>
<tr>
<td>PEP</td>
<td>Provider Enrollment Portal</td>
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<tr>
<td>PHI</td>
<td>Protected Health Information</td>
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<td>Acronym</td>
<td>Full Name</td>
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<td>---------</td>
<td>-----------</td>
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<tr>
<td>QIT</td>
<td>Qualified Income Trust</td>
</tr>
<tr>
<td>QMHP-CS</td>
<td>Qualified Mental Health Professional</td>
</tr>
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<td>QM</td>
<td>Quality Management</td>
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<tr>
<td>RCCH</td>
<td>Registered Child Care Home</td>
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<td>RN</td>
<td>Registered Nurse</td>
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<tr>
<td>R&amp;S</td>
<td>Remittance and Status Report</td>
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<tr>
<td>RTC</td>
<td>Residential Treatment Center</td>
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<td>SED</td>
<td>Serious Emotional Disturbance</td>
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<td>SFA</td>
<td>Supportive Family-Based Alternatives</td>
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<td>SPI</td>
<td>Sensitive Personal Information</td>
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<td>SSI</td>
<td>Supplemental Security Income</td>
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<td>TAC</td>
<td>Texas Administrative Code</td>
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<td>TCM</td>
<td>Targeted Case Management</td>
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<td>TCOOMMI</td>
<td>Texas Correctional Office on Offenders with Medical or Mental Impairments</td>
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<td>TF-EAP</td>
<td>Trauma Focused Equine Assisted Psychotherapy</td>
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<td>TIERS</td>
<td>Texas Integrated Eligibility Redesign System</td>
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<td>Uniform Assessment</td>
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<td>UM</td>
<td>Utilization Management Guidelines</td>
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<td>WPO</td>
<td>Waiver Provider Organization</td>
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<tr>
<td>YES</td>
<td>Youth Empowerment Services</td>
</tr>
</tbody>
</table>
Appendix B: Definitions

**Action Steps**—Statements in a Wraparound Plan that describe specific activities that will be undertaken, including who will do them and within what time frame.

**Administrator**—The individual providing authorization for YES Waiver services through the YES assessment, also referenced as assessor.

**Annual Renewal**—A designation given to a Waiver participant annually, once clinical eligibility is re-authorized by the Health and Human Services Commission and after initial clinical eligibility into the YES Waiver program.

**Billable Service**—A YES Waiver service which a provider can bill for payment.

**Billable Time**—The billable units a service provider can bill, per participant.

**Capacity**—The total number of Waiver participant vacancies allotted to the LMHA/LBHA for a provider to enroll individuals.

**Child and Adolescents Needs and Strengths (CANS) Assessment**—A multipurpose tool used to determine clinical eligibility, identify needs and strengths, support development of the Wraparound Plan, facilitate quality improvement initiatives, and monitor the outcome(s) of Waiver services.

**Child and Family Team (CFT)**—The team identified by, and connected to, the family through natural, community, and formal support relationships. Members on this team develop and implement the family’s plan, address unmet needs, and work toward a collective team mission reflective of the family’s vision.

**Child and Family Team Meeting**—The meeting(s) during which the Child and Family Team members develop and monitor the participant’s Wraparound Plan.

**Clinical Management for Behavioral Health Services (CMBHS)**—An electronic health record system created and maintained by the Health and Human Services Commission for the use of contracted Mental Health and Substance Abuse services.

**Comprehensive Service Provider (CSP)**—The entity responsible for providing State Plan services through a managed care organization in the Texas Resiliency
and Recovery Level of Care, currently synonymous with Wraparound Provider Organization (WPO).

**Comprehensive Waiver Provider (CWP)**—An agency, organization, or corporation contracted with the Health and Human Services Commission for the provision of YES Waiver services.

**Crisis and Safety Plan**—Focuses on planning for, predicting, and preventing the occurrence of a crisis. The participant and LAR’s needs, strengths, and preferences are taken into consideration. Crisis and Safety Plans are incorporated into the Wraparound Plan with all CFT members knowing the roles they will play if and when a crisis arises.

**Critical Incident**—An incident which creates a significant risk of serious harm to the physical or mental health and/or the safety or well-being of a participant, as well as the risk of self-harm or harm to others by a participant.

**Day Camp**—A camp that operates during the day or any portion of the day between 7:00 a.m. and 10:00 p.m. for four or more consecutive days and that offers no more than two overnight stays during each camp session. The term does not include a facility that is required to be licensed with the Department of Family and Protective Services.

**Direct Service Provider**—An employee or subcontractor of a YES Waiver Provider, who, after meeting credentialing standards, provides YES Waiver services directly to a participant.

**Effective Team Process**—Wraparound is a process that requires active investment by a team, comprised of both formal and natural supports willing to be accountable for the results.

**Eligible**—A designation given to an interested individual once it is determined that all applicable Medicaid, demographic, and clinical eligibility are met.

**Enrolled**—A designation given to an interested individual once clinical eligibility is authorized by the Health and Human Services Commission.

**Enrolled and Receiving Services**—A designation given to a participant after receipt of the first YES Waiver service.
**Fair Hearing**–An informal proceeding requested by a participant or legally authorized representative to appeal an agency action before a Health and Human Services Commission hearings officer.

**Family Vision**–A statement constructed by the participant and the family, with help from the Wraparound Facilitator and possibly the CFT, that describes how they wish things to be in the future, individually, and as a family.

**Formal Supports**–Services and supports provided by professionals or other individuals under a structure of requirements for which there is oversight by state or federal agencies, national professional associations, or the general public arena.

**Good Faith Effort**–An HHSC required action YES Waiver Provider staff must make to interested individuals, participants, and LARs throughout different stages of the Waiver program and as defined and outlined in this manual.

**Individual**–A person age 3 through 18 who has registered on the Inquiry List and who is awaiting assessment to determine eligibility for YES Waiver services but is not currently enrolled in the program.

**Individual Plan of Care (IPC)**–Documentation of YES Waiver services, non-YES Waiver services, and State Plan services necessary to support a participant. The number of units requested and total dollar amount for services requested are documented on the individual’s IPC.

**Intensive Case Management (ICM)**–The Medicaid State Plan service that coordinates all services and supports a participant receives.

**Inquiry Line**–A dedicated phone line LMHA/LBHAs are required to have in order to receive contact information from individuals interested in obtaining YES Waiver services.

**Inquiry List**–A list used to establish the order of assessments of interested individuals for the YES Waiver program.

**Legally Authorized Representative (LAR)**–A person authorized by law to act on behalf of an individual or participant including, but not limited to, a parent, guardian, Managing Conservator, or Medical Consenter.

**Level of Care (LOC)**–A designation given to the department’s standardized packages of mental health services, based on the uniform assessment and the
utilization management guidelines, which specify the type, amount, and duration of MH case management services to be provided to an individual.

**Local Mental/Behavioral Health Authority (LMHA/LBHA)**—An entity designated by the executive commissioner of HHSC in accordance with Texas Health and Safety Code, §533.035(a).

**Licensed Practitioner of the Healing Arts (LPHA)**—A person who is licensed by the State of Texas to provide certain mental health services. This person may be a: Physician; Physician Assistant (PA); Licensed Professional Counselor (LPC); Licensed Clinical Social Worker (LCSW); Licensed Marriage and Family Therapist (LMFT); Licensed Psychologist; or an Advanced Practice Registered Nurse (APRN).

**Managing Conservator**—A parent, competent adult, DFPS, or a licensed child placing agency appointed by a court to be the conservator or a child or youth and given certain rights and duties, including:

- the duty to provide the child or youth with clothing, food, shelter, education, and medical, psychological, and dental care;
- the right to consent for the child or youth to medical, psychiatric, psychological, dental, and surgical treatment and to have access to the child’s medical record; and
- the right to represent the child or youth in legal action and to make other decisions of substantial legal significance concerning the child (Texas Family Code, Title 5, Sections 153.005, 153.132, and 153.371 and DFPS).

**Measurable Target Outcomes**—Measurable target outcomes are derived from multiple team member perspectives. The team’s overall success is demonstrated by how much closer the family is to their vision and how well the family needs have been addressed.

**Medical Consenter**—A person who a court has authorized to consent to medical and behavioral health treatment decisions for a child or youth in DFPS conservatorship, including the child’s foster parent or the child’s parent, the Department or an agent of the Department. A youth in substitute care who is at least 16 years old may also consent to their own medical care upon a court determination. (Texas Family Code, Title 5, Section 266.004 and DFPS)

**Medical Necessity**—The clinical determination that services are reasonable and necessary for the treatment of a mental health diagnosis to improve, maintain, or prevent deterioration of functioning resulting from such a diagnosis; that services
are in accordance with accepted standards of practices in behavioral health care; are furnished in the most appropriate level or amount of services that can be safely provided, and could not have been omitted without adversely affecting the individual’s mental and/or physical health or the quality of care rendered.

Natural Supports—Individuals or organizations in the family’s own community, kinship, social, or spiritual networks, such as friends, extended family members, ministers, neighbors, etc.

Non-Waiver Services—Services provided by any funding source other than the Waiver, including, but not limited to, State Plan services such as case management, rehabilitation, counseling, medication management, Temporary Assistance for Needy Families (TANF), and personal care services (PCS).

Participant—A child or youth age 3 through 18 currently enrolled in the Waiver and receiving Waiver services.

Protected Health Information (PHI)—Individually identifiable health information transmitted by electronic media or maintained in any medium, in accordance with 25 TAC §1.501. PHI excludes education records or information protected by the Family Educational Rights and Privacy Act (FERPA), employment records, and records of a person deceased for more than 50 years.

Qualified Income Trust (QIT)—A QIT is an irrevocable trust established for the benefit of a person or the person’s spouse, or both, the corpus of which is composed only of the person’s or the couple’s income (including accumulated income). The trust must include a provision that the State is designated as the residuary beneficiary to receive, at the person’s death, funds remaining in the trust equal to the total amount of Medicaid paid on the person's behalf. Additional information is available in 1 TAC §358.339.

Qualified Mental Health Professional—Community Services (QMHP–CS)—A person who:

- has a bachelor’s degree from an accredited college or university with a minimum number of hours that is equivalent to a major, as determined by the local mental/behavioral health authority (LMHA/LBHA), Managed Care Organization (MCO), or provider, in accordance with 26 TAC §301.331.
  - major course work must be in one of the following: psychology; social work; medicine; nursing; rehabilitation; counseling; sociology; human growth and development; physician assistant; gerontology; special
education; educational psychology; early childhood education; or early childhood intervention;

- is a registered nurse (RN); or
- completes an alternative credentialing process approved by HHSC.

Reserved Capacity—The State reserves Waiver enrollment vacancies based on a percentage of the anticipated number of children who will enroll in the YES Waiver, for children and youth who are at imminent risk of being relinquished to conservatorship of the state.

Sensitive Personal Information (SPI)—An individual’s non-encrypted first name or first initial and last name, in combination with any one of the following: Social Security number; driver’s license or government-issued identification number; or account number or credit or debit card number in combination with any required security or access code or password that would permit access to the individual’s financial account(s). Any information that identifies an individual and relates to: physical or mental health or other condition; provision of any health care service(s); or payment for the provision of any health care service(s).

Serious Emotional Disturbance (SED)—A diagnosed mental health disorder that substantially disrupts a child’s or adolescent's ability to function socially, academically, and emotionally.

Service Authorization—The process by which YES Waiver services documented in an IPC are authorized.

Service Note—Detailed documentation of Waiver service(s) provided to a participant used to process claims for payment for the provision of service(s). All service documentation must be completed in accordance with the requirements of this manual and submitted within two business days after each contact that occurs to provide services to the individual and LAR in the YES Waiver program.

State Plan Services—Services offered under the Medicaid State Plan service array, which can be provided by a local mental/behavioral health authority (LMHA/LBHA) or any other credentialed Medicaid State Plan service provider.

Strengths Perspective—Strengths are defined as interests, talents, and unique contributions that make things better for the family. Within an entire process that is grounded in a strengths perspective, the family story is framed in a balanced way that incorporates family strengths rather than a focus solely on problems and challenges. A strengths perspective should be overt and easily recognized,
promoting strengths that focus on the family, team, and community, while empowering and challenging the team to use strengths in a meaningful way.

**Subcontractor**–A single person, organization, or agency that enters into an agreement with a local mental/behavioral health authority (LMHA/LBHA), comprehensive waiver provider (CWP), or Wraparound Provider Organization (WPO) to provide one or more YES Waiver services.

**Substitute Care**–Substitute care is provided from the time a child is removed from their home and placed in DFPS conservatorship until the child returns home safely or is placed in another living arrangement that does not require DFPS supervision.

Specifically, substitute care consists of:

- the residential care and support provided to the child; and
- the supportive and therapeutic services provided to the child, the child’s natural or adoptive parents, and the child’s substitute caregiver (40 TAC 700).

**Substitute Care Provider**–A person who provides residential care for children for 24 hours a day, including a foster family home, as defined by Texas Human Resources Code, §42.002.

**Team Mission**–A statement crafted by the CFT that provides a one to two sentence summary of what the team is working toward with the youth and family.

**Texas Resilience and Recovery (TRR)**–The State of Texas publicly funded mental health service delivery system.

**Underlying Needs**–Define the underlying reasons why behaviors happen in a situation. In a needs-driven process, the set of underlying conditions that cause a behavior and/or situation to exist are These needs would be identified across family members in a range of life areas beyond the system defined areas. These underlying conditions would be articulated and overt agreement with the family and all team members about which to select for action or attention would occur. The process involves flexibility of services and supports that will be tailored to meet the needs of the family.

**Uniform Assessment**–The standardized tool used to gather information on individuals to determine Waiver eligibility, which includes: the Child and Youth
Strengths and Needs (CANS) Assessment; community data; the Recommended Level of Care (LOC-R); and Authorized Level of Care (LOC-A).

**Unit**—A set period of time used to determine how Waiver services are provided and billed.

**Utilization Management Guidelines**—The utilization guidelines for behavioral health service provided through Texas Resilience and Recovery, available at:


**Waiver**—A Medicaid program that provides services to a limited number of eligible children or youth, in accordance with the provisions of the Waiver approved under the federal Social Security Act, §1915(c).

**Waiver Services**—Medicaid community-based services provided under the YES Waiver.

**Waiver Vacancy**—One of the total number of allotments for individuals enrolled in the Waiver in accordance with program capacity.

**Wraparound**—An ecologically-based process and approach to care planning that builds on the collective action of a committed group of family, friends, community, professional, and cross-system supports mobilizing resources and talents from a variety of sources resulting in the creation of a plan of care that is the best fit between the family vision and story, team mission, strengths, needs, and strategies.

**Wraparound Facilitator**—The primary contact person for the participant’s family and Wraparound Team who is trained to coordinate the Wraparound process.

**Wraparound Plan**—Developed using the Wraparound planning process, is the comprehensive plan of all services the participant is receiving, including the Waiver services to be requested on the IPC. Ideally, the plan is comprehensive to the degree that it can be used/meet the needs of all plans (across all child serving systems) developed to address the needs of the participant.

**Wraparound Provider Organization (WPO)**—A qualified entity responsible to coordinate Waiver services to individuals enrolled in the YES Waiver and to develop a person-centered plan using the National Wraparound Implementation Center
(NWIC) model. WPOs must qualify as comprehensive service providers of targeted case management and meet the training standards to deliver Intensive Case Management services to individuals enrolled in the YES Waiver.

**YES Assessment**—The standardized tool used to gather information on individuals to determine Waiver eligibility, which includes: the Child and Youth Strengths and Needs (CANS) Assessment and Community Data questionnaire as well as YES-specific questions.
Appendix C: Adaptive Aids and Supports Non-Billable List

(1) Services requested as a diversion or for recreational purposes;
(2) Services provided in lieu of an available service in the YES service array;
(3) Room and board;
(4) Goods and services that a household that does not include a person with a
disability would be expected to pay for as household expenses (ex. Cable
television, food, clothing, beauty and hygiene products);
(5) Special education and related services that are included in a child’s
Individualized Education Plan (IEP);
(6) Forms of cash assistance (for example, gift cards, reimbursement for
services already rendered);
(7) Furniture and household items outside of transitional services;
(8) Goods or services for someone other than the participant, unless mandatory
for participant participation;
(9) Name brand items and services (When name brand items or services are
more expensive than the generic brand and they offer no additional medical
benefit); and
(10) Self-care services not related to the performance of instrumental activities of
daily living (for example: spa treatments, personal trainers, beauty classes,
etc.).
Appendix D: Adaptive Aids and Supports
Heightened Scrutiny List

The following requests will likely require a review with heightened scrutiny to be approved:

- musical instruments;
- non-psychoeducational toys, games or related items;
- camps that are licensed by the state of Texas or accredited by The American Camp Association (respite services should be utilized instead of AA&S requests, when possible);
- electronic devices;
- memberships (for example: zoos, gyms, museums);
- music or art lessons;
- exercise equipment;
- art/creative materials;
- out-of-state supports or services;
- animals or products for animals;
- tutoring, school classes, or tuition;
- specialized therapies (outside of the distinct YES Waiver service array);
- GPS tracking devices;
- video monitoring devices;
- weapon safety products; and
- out-of-state services unless the service meets Medicaid Waiver policy.

Policy and requirements for requesting items listed on the Heightened Scrutiny list are outlined in [POLICY 0 9000.1 Billing: Adaptive Aids and Supports].