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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Texas Home Living Program

C. Waiver Number:TX.0403

D. Amendment Number:TX.0403.R03.04

E. Proposed Effective Date: (mm/dd/yy)
03/09/20

Approved Effective Date: 03/09/20
Approved Effective Date of Waiver being Amended: 03/01/17

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

This amendment request proposes to make the following changes:

Appendix B
•Revise the terminology for the Medicaid eligibility groups for consistency with payment codes.

Appendix C
• Correct the licensing chapter for Behavioral Support service providers.
• Correct the licensing chapter for dentists as Dental service providers and adding dental hygienists as Dental service providers.

Appendix D
• Remove measure D.b.1, relating to number and percent of face-to-face utilization reviews conducted according to HHSC policies and procedures, which CMS no longer requires states to report.
• Remove measure D.e.1, relating to the number and percent of individuals who were afforded choice between waiver services and institutional care during enrollment or service plan renewal, which CMS no longer requires states to report.
• Replace references to Consumer Rights and Services/Consumer Rights Intellectual Disabilities (CRS/CRID) with Intellectual and Developmental Disability Ombudsman (IDD Ombudsman) to reflect organizational changes at the Health and Human Services Commission (HHSC).

Appendix E
• Clarify the budget authority for participants in the consumer-directed services option around requests to change the budget by the participant.

Appendix F
• Replace references to CRS/CRID with IDD Ombudsman to reflect organizational changes at HHSC.

Appendix G
• Replace the term “adult daycare” with “day activity and health services” to reflect a change in state law.
• Replace references to CRS/CRID with references to IDD Ombudsman to reflect organizational changes at HHSC.

Appendix H
• Specify the type of survey tool the state uses to measure an individual’s experience of care and quality of life.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☐ **Waiver Application**	
☐ **Appendix A Waiver Administration and Operation**	
☒ **Appendix B Participant Access and Eligibility**	B-2.b; B-3.f; B-4.b
☒ **Appendix C Participant Services**	C-1.a
☒ **Appendix D Participant Centered Service Planning and**	D-1.b; D-1.e; D-2.b

Component of the Approved Waiver	Subsection(s)
Delivery	
☒ **Appendix E Participant Direction of Services**	E-2.b.i
☒ **Appendix F Participant Rights**	F-3.c
☒ **Appendix G Participant Safeguards**	G-1.d; G-1.; G-2.a.i; G-3e
☒ **Appendix H**	H-2
☐ **Appendix I Financial Accountability**	
☐ **Appendix J Cost-Neutrality Demonstration**	

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

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

Specify:

Appendix B, C, D, E, F, G, and H will be amended for system improvements based on state law and rule, federal regulation, and CMS direction.

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

1. Request Information (1 of 3)

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

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Texas Home Living Program

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Waiver Number:TX.0403.R03.04

Draft ID: **TX.043.03.03**

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 03/01/17
Approved Effective Date of Waiver being Amended: 03/01/17

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

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

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

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

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

Consistent with Texas Administrative Code, Title 40, Part 1, Subchapter N, §9.556 (relating to Eligibility Criteria for TxHmL Program Services and Community First Choice Services) and Subchapter E, Division 5 (relating to Eligibility, Enrollment and Review) set forth the eligibility criteria for levels of care in the TxHmL program, this waiver is limited to intermediate care facility level of care I or VIII.

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

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

- ☐ **§1915(b)(1) (mandated enrollment to managed care)**
- ☐ **§1915(b)(2) (central broker)**
- ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
- ☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

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

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

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

2. Brief Waiver Description

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

The Texas Home Living Program (TxHmL), first authorized March 1, 2004, provides essential community-based services and supports to individuals with intellectual and developmental disabilities or a related condition living in their own homes or with their families. Services and supports are intended to enhance quality of life, functional independence, and health and well-being in continued community-based living in their own or family home and to enhance, rather than replace, existing informal or formal supports and resources. TxHmL makes all service components available through both the consumer directed services option and the traditional service delivery option. Individuals choose which services will be delivered through either service delivery option. Individuals enrolling in the waiver are assisted by a service coordinator employed by one of HHSCs 39 local intellectual and developmental disability authorities. Service coordination for individuals enrolled in the TxHmL Program is funded through HHSC's Targeted Case Management Program. The local intellectual and developmental disability authority serving the geographic area in which the individual lives provides initial and ongoing service coordination in accordance with its Performance Contract with HHSC and with HHSC's rules, which govern the program. The service coordinator, using a person-directed planning process, is responsible for facilitating an individual's enrollment, coordinating the development of the individual's service plan, informing the individual of the service delivery options, assisting the individual in accessing non-waiver services, and continuously monitoring the provision of services and effectiveness of the service plan. The process emphasizes the provision of supports and services necessary to maintain successful integration in the community and to acquire skills necessary for participation in activities that are personally important. The service plan describes the medical and other services (regardless of funding source) to be furnished, the frequency of each service delivered, and the type of provider who will furnish each service. All waiver services are furnished pursuant to the individual's written service plan.

The single State Medicaid Agency, HHSC, exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules, and regulations related to the waiver. HHSC directly performs financial eligibility determinations for prospective enrollees; develops the reimbursement rate methodology and sets reimbursement rates; and conducts Medicaid Fair Hearings in accordance with 42 CFR §431, Subpart E, and as described in Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A (relating to Medicaid Fair Hearings).

HHSC delegates routine functions necessary to the operation of the waiver to Medicaid and CHIP Services Division (the State's Medical Assistance Unit). These functions include managing waiver enrollment against approved limits, monitoring waiver expenditures against approved levels, conducting level of care evaluation activities and authorizing levels of care, reviewing individual service plans to ensure that waiver requirements are met, conducting utilization management and waiver service authorization functions, enrolling providers and executing the HHSC Texas Medicaid provider agreements, conducting training and technical assistance concerning waiver requirements, and performing quality management functions.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

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

- ◉ **No**
- ○ **Yes**

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

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

I. Public Input. Describe how the state secures public input into the development of the waiver:

HHSC distributed the TxHmL Amendment Tribal Notification to the tribal representatives on November 1, 2019. The Tribal Notification provided contact information to request copies of the amendment, provide comments, and request information from the State via email, mail, or telephone. The State provides copies free of charge.

The Public Notice of Intent (PNI) for this amendment was published in the Texas Register on November 1, 2019 (http://www.sos.state.tx.us/texreg/index.shtml), allowing a 30-day comment period in compliance with federal and state requirements. The Texas Register is published weekly and is the journal of state agency rulemaking for Texas. In addition to activities related to rules, the Texas Register publishes various public notices including attorney general opinions, gubernatorial appointments, state agency requests for proposals and other documents, and it is used regularly by stakeholders. HHSC publishes all Medicaid waiver submissions in the Texas Register in addition to many other notices. The publication is available online and in hard copy at the Texas State Library and Archives Commission, the State Law Library, the Legislative Reference Library located in the State Capitol building, and the University of North Texas libraries. All of these sites are located in Austin, except for the University of North Texas, which is located in Denton.

Printed copies of the Texas Register are also available through paid subscription; subscribers include cities, counties, and public libraries throughout the state. The PNI provided contact information to request copies of the amendment, provide comments, and, request information from the State via email, mail, or telephone. The State provides copies free of charge. No requests or comments were received.

The State posted the amendment on the HHSC website at https://hhs.texas.gov/laws-regulations/policies-rules/waivers/txhml-waiver-applications.

HHSC sent a request to the HHSC Office of Social Services to distribute notice of the renewal to 290 local eligibility offices with instructions to post the notice in public areas on November 1, 2019.

The public comment period expired on December 1, 2019. The State did not receive any public comments.

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

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

7. Contact Person(s)

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

Last Name: Montalbano

First Name: Kathi

Title: Manager, Policy Development Support

Agency: Texas Health and Human Services Commission

Address: 4900 North Lamar Blvd.

Address 2: Mail Code H-620

City: Austin

State: **Texas**

Zip: 78751

Phone: (512) 730-7490 **Ext:** ☐ **TTY**

Fax: (512) 487-3403

E-mail: kathi.montalbano@hhsc.state.tx.us

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Texas**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the

waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Kendrah Buckley

State Medicaid Director or Designee

Submission Date: Feb 14, 2020

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

Last Name: Muth

First Name: Stephanie

Title: State Medicaid Director

Agency: Health and Human Services Commission

Address: 4806 N Lamar Blvd

Address 2:

City: Austin

State: **Texas**

Zip: 78751

Phone: (512) 707-6096 **Ext:** ☐ **TTY**

Fax: (512) 487-3403

E-mail: TX_Medicaid_Waivers@hhsc.state.tx.us

Attachments

Attachment #1: Transition Plan

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

☐ **Replacing an approved waiver with this waiver.**

☐ **Combining waivers.**

☐ **Splitting one waiver into two waivers.**

☐ **Eliminating a service.**

☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**

☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**

☐ **Reducing the unduplicated count of participants (Factor C).**

☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**

☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

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

Texas Home Living Settings Transition Plan

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

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

The State administers the Texas Home Living (TxHmL) program that provides essential services and supports for people with intellectual disabilities as an alternative to living in an intermediate care facility for individuals with intellectual disabilities. Recipients must live in their own home or their family's home.

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

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

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

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

Provider assessments: The State may administer surveys of providers and include a validity check against self-evaluations. Settings presumed not to be home and community-based: Where the State bases its assessment on state standards, the State will

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

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

In the first phase of the assessment process, Texas conducted a systemic/internal review of current waiver program rules and policies identifying areas that were in compliance with the new regulation, non-compliant, or silent , in other words, the State will assess all settings in which services are provided under this waiver except the following settings: (1) Individuals in this waiver reside in their own homes or family homes and CMS has indicated that these settings are presumed compliant, thus they will not be assessed and (2) Clinical services provided through the waiver occur in the individual's home or family home or in professional settings within the community, which are open to all persons, including persons without disabilities, thus they will not be assessed. The remaining settings where services are provided are for day habilitation and employment services and, as referenced in the timeline, these settings will be assessed. TxHmL does not provide services in any foster care settings.

In addition, the State reviewed oversight processes to determine if revisions were needed to ensure ongoing compliance with new HCBS rules. The results of the systemic/internal review of rules and policies yielded an assessment document for the 1915(c) waivers operated by the Texas Department of Aging & Disability Services (DADS outlining areas of compliance and non-compliance across all of the waiver programs. The document indicated whether the rules and policies were silent, non-compliant or partially compliant. The assessment document is posted on the DADS website allowing ongoing input on the assessment process. The Texas Health & Human Services Commission (HHSC) website links to the DADS website to support access to the assessment document. The settings assessment document, titled "Impact of Federal HCBS Rules on DADS 1915(c) Waiver Process," may be found at:

http://www.dads.state.tx.us/providers/HCBS/hcbs-settingsassessment.pdf
In July and August 2014 the State gave public notice for preliminary settings transition plans for CBA, CLASS, HCS, MDCP, and YES. Comments received were considered for incorporation into the assessment. Some suggestions were already underway, for example, the State was already in the process of adding supported employment and employment assistance to the waivers.

In addition to the systemic/internal review, the State sought additional public input on the waiver specific preliminary settings transition plans, for all of the 1915(c) waivers (CBA, CLASS, HCS, MDCP, and YES). For example, the State held an open meeting for stakeholders and the general public on October 13, 2014. The meeting was also webcast to allow for greater participation across the State. The State accepted public testimony on waiver specific preliminary settings transition plans and additional recommendations for improving the assessment process for all of the 1915(c) waivers.

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

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

- Provider self-assessment surveys: In order to validate the results of the first assessment phase, DADS is releasing a provider self-assessment survey to a representative sample of providers. The survey will be based on the exploratory questions provided by CMS with input from external stakeholders. The provider self-assessment survey will be developed in conjunction with providers, provider associations and advocacy organizations to ensure a comprehensive approach. Providers who are not a part of the sample can still obtain and complete a self-assessment survey on the agency websites and provide data that will be considered as the State moves forward. Based on the results of the survey, ongoing remediation strategies and the assessment document will be updated
- Participant surveys: In order to validate the provider self-assessment surveys, DADS is releasing a participant survey to a representative sample of individuals receiving services. The survey will be based on the questions asked in the provider self-assessment. Participants who are not a part of the sample can still obtain and complete a participant survey on the agency websites and provide data that will be considered as the State moves forward. Based on the results of the survey, ongoing remediation strategies and the DADS assessment document will be updated.
- Site specific assessments: DBMD and CLASS residential providers are small in number and state resources provide for onsite visits of DBMD providers offering assisted living residential services and CLASS providers offering support family services to

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

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

Third Phase of Assessment June 2015-May 2016

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

Remedial Strategy:

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

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

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

State Activity
Texas has identified a number of remediation strategies to address issues of potential non-compliance for all settings referenced in the rule that are applicable to this waiver, for example, day habilitation and settings in which supported employment and employment assistance are provided.

- Rule and policy revisions: State rule revisions require extensive input from stakeholders including providers, advocates, individuals receiving services, legally authorized representatives and other interested parties. Stakeholders are allowed two opportunities to review draft rule language and provide comments prior to rules becoming effective. The first opportunity is through email announcing rule drafts are available for public comment on agency websites. Based on written comments, stakeholders may be contacted by agency staff for additional dialogue regarding proposed rule language. The second opportunity for input is through the formal 30-day public comment process outlined in statute. Policy manual revisions are also shared externally and stakeholders are asked to provide comments on drafts of the policy before it becomes effective.
- Revisions to processes used for provider oversight: All waiver programs have oversight processes administered by regulatory (Waiver, Survey and Certification) or contract monitoring staff. Applicable tools will be revised to reflect changes in rule and policy to ensure ongoing provider assessment will include compliance with HCBS regulations to the greatest extent possible. Written guidance concerning rights and responsibilities will be revised to ensure individuals receiving services understand their rights and know how to file a complaint with the appropriate state agency if there are restrictions being imposed on rights without adequate discussion and documentation through the person centered planning process.

- Provider education: Providers will have multiple opportunities to learn about the new regulations and understand rule and policy changes. The State will offer webinars as a main source for provider education in addition to revising new provider orientation curriculum.

Texas does not have any settings in the current 1915(c) Medicaid waivers that are presumed not to be community-based settings according to the regulations. The only possible exception may be day habilitation sites. However, if the State determines the need to submit evidence to CMS for the application of heightened scrutiny for settings that are presumed not to be home and community- based, the Settings Transition Plan will be amended to include information that demonstrates that the setting does not have the characteristics of an institution and meets the HCB settings requirements.

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

Public Input and Notice:

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

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

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

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

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

The public had at least two 30-day public notice opportunities to make formal comments, as a result of July and August 2014 public notices of the preliminary settings transition plans, and a November 2014 public notice of the Statewide Settings Transition Plan which included the TxHmL waiver setting transition plan. HHSC provides notice of the Statewide Settings Transition Plan through the Texas Register, and on the HHSC, DADS and DSHS websites. The notices provide information about the Statewide Settings Transition Plans, the comment period, a link to the Statewide Settings Transition Plan and locations and addresses where comments may be submitted. In addition, the DADS website sends out automatic website notices to individuals who request it. The State also provides notice to the Federally Recognized tribes in accordance with the Texas Medicaid State Plan. The State considered and modified the Statewide Settings Transition Plan, as the State deemed appropriate, to account for public comment, prior to submission of the plan to CMS.

In addition, the State has implemented the following public input strategy, aimed at achieving optimum public input:
- Stakeholder education webinars: DADS conducted two webinars on September 11 and September 14, 2014, to provide all stakeholders an opportunity to learn about the new regulations prior to the October 13, 2014 open meeting held in Austin.
- Stakeholder meetings: On October 13, 2014, the State held an open stakeholder meeting in Austin providing all stakeholders

the opportunity to provide input on the new regulations. - Electronic notices: The State posted the Statewide Settings Transition Plan on agency websites and in the Texas Register in November 2014. The DADS assessment was also posted on the agency website. The preliminary transition plans for several of the waivers were posted in the Texas Register and on the agency websites.
- Feedback mechanism: Dedicated electronic mail boxes and websites for HHSC and DADS are available to provide information about the new rules and accept feedback. The websites and the option to make comments will remain active throughout the transition and the State will take any comments received into consideration, until the State completes the transition. State websites are located at the following:
http://www.hhsc.state.tx.us/medicaid/hcbs/index.shtml
http://www.dads.state.tx.us/providers/HCBS/index.cfm

- Presentations at statutorily mandated committees: The State regularly provides updates to the following groups and offers them opportunities to comment on ongoing assessment and remediation activities:
-Promoting Independence Advisory Committee: comprised of individuals receiving services, advocacy organizations, and providers across target populations.
-Employment First Task Force: comprised of advocates and providers interested in employment issues.
-Texas Council on Autism and Pervasive Developmental Disorders: comprised of parents of individuals with autism and professionals.
-IDD Redesign Advisory Committee: comprised of individuals receiving services, advocacy organizations and providers.
- Presentations at agency workgroups: The agencies also have agency-established workgroups comprised of advocates and providers whose purpose is to examine ongoing rule and policy issues. Staff will provide updates on HCBS transition activities and provide the workgroup members the opportunity to provide comments.
- Presentations at conferences: Provider associations hold annual conferences and State staff have been invited to speak at these conferences. This provides access to a large number of providers for purposes of education, coordination and input regarding changes being made to rules and policy.

For more information or to obtain free copies of the Statewide Settings Transition Plan, you may contact Becky Brownlee by mail at Texas Health and Human Services Commission, P.O. Box 13247, Mail Code H-370, Austin, Texas, 78711-3247 phone (512) 487-3402, fax (512) 730-7472 or by email at TX-_Medicaid_Waivers@hhsc.state.tx.us.

Timeline of Texas Home Living Settings Transition Plan

*Represents milestone activities

*First Phase of the Assessment: March 2014 - September 2014

1) State (HHSC and DADS) staff system/internal review of rules and policies and oversight processes governing the waivers for all settings referenced in the rule that are applicable to this waiver, for example, settings in which day habilitation, supported employment and employment assistance are provided.

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

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

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

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

6) August 22, 2014: Submission of CBA Settings Transition Plan indicating all individuals served would move to the 1115 demonstration waiver effective September 1, 2014, and that the HCBS settings requirements would be addressed in the 1115 demonstration waiver.

*Second Phase of the Assessment Process: September 2014 - December 2015

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

2) November 2014 – December 2014: Public notice and comment period for the Statewide Settings Transition Plan.

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

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

5) *July 2015 (after the close of the legislative session) through December 2015: Hold additional stakeholder meetings providing individuals receiving services and providers an opportunity to provide input on the assessment and Statewide Settings Transition Plan.

6) July 2015 (after the close of the legislative session) through December 2015: The State will continue to refine the Statewide Settings Transition Plan and settings assessment based on public input.

7) The State will update the assessment after completion of the entire assessment phase.
The update to the assessment will be posted on the agency websites. The assessment will cover all settings referenced in the rule that are applicable to this waiver, for example, settings in which day habilitation, supported employment and employment assistance are provided. If as a result of the assessment, there was a change in assessment findings, or the State has added additional remedial action and milestones, the State will submit an amendment or modification to the transition plan, after the required public notice and comment period.

Third Phase of the Assessment Process: January 2015 - May 2016

1) January 2015 – May 2016: DADS will survey a representative sample of day habilitation/prevocational providers to ascertain whether providers are in compliance with CMS guidance

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

Public Input

*1) *July 2014 – September 2014: Internal assessment document outlining compliance and non-compliance with settings requirements across all 1915(c) waivers operated by DADS posted for public input.

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

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

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

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

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

7) November 2014 continuing through the end of the transition period: Internal assessment document outlining compliant and non-compliant settings requirements for YES waiver posted for public input.

*6) November 2014 – December 2014: The Statewide Settings Transition Plan posted for public comment. Two forms of public notice were utilized: notice in the Texas Register and on the HHSC, DADS, and DSHS websites.

7) Ongoing through the end of the transition period: The State may implement additional stakeholder communications as such

opportunities are identified.

8) Once the assessment phase is completed, if the assessment has resulted in a change in the findings or added specific remedial action and milestones to a waiver, the State will incorporate the public notice and input process into the appropriate submissions to CMS.

TxHmL REMEDIATION Activities: November 2014 – October 2018

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

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

3)* January 2016 – May 2017: Amend TxHmL program rules and Chapter 49 contracting rules to address all applicable settings, for example, those rules governing settings in which day habilitation, supported employment and employment assistance are provided to ensure the services comply with the new HCBS guidelines. Stakeholder input is actively solicited during the rule making process.

4) June 2016 – May 2017: Revise the TxHmL policy manual, including rights and responsibilities forms/publications and billing guidelines to further outline HCBS requirements for all settings referenced in the rule that are applicable to this waiver, for example, those settings in which day habilitation, supported employment and employment assistance are provided.

5)* June 2016 – May 2017: Based on CMS guidance regarding day habilitation, seek additional funding in 2017 legislative session.

6) December 2016 – July 2017: Revise certification review process for all settings referenced in the rule that are applicable to this waiver, for example, settings in which day habilitation, supported employment and employment assistance are provided, to incorporate focus on HCBS setting requirements based on rule revisions. Certification reviewers monitor TxHmL providers to ensure compliance with program rules.

7) August 2017 – December 2017: Review and include appropriate revisions to the TxHmL Settings Transition Plan.

8) January 2018 – February 2018: Public notice and public comment period for review of the revised TxHmL Settings Transition Plan.

9) *March 2018 – March 2018: Submit TxHmL amendment updating the Settings Transition Plan with appropriate changes based on public input after the required public notice.

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

11) June 2017 – July 2018: Revise the TxHmL policy manual, including rights and responsibilities forms/publications and billing guidelines to further outline HCBS requirements for day habilitation based on CMS guidance.

12) December 2017 – August 2018: Review and include appropriate revisions to the TxHmL Settings Transition Plan.

13) August 2018 – September 2018: Public notice and public comment period for review of the revised TxHmL Settings Transition Plan.

14) *October 2018 – October 2018: Submit TxHmL amendment updating the Settings Transition Plan with appropriate changes based on public input after the required public notice.

STAKEHOLDER COMMENTARY

DADS will update the transition plan to include public comment specific to the TxHmL waiver listed below.

Comment: With regard to protecting each individual's privacy, the commenters indicated that TxHmL may force a choice

between employment and remaining eligible for the program by requiring eligibility based on a lower income level than most HCBS programs. Commenters stated that TxHmL does not have the institutional income limit up to 300% and that increasing the limit would allow this lower cost program with an overall cost cap of $17,000 annually, to serve individuals who could also work part time. Additionally, commenters suggested that the program would be ideal for keeping children in families if, like the other programs, the parent's income was not counted.

STATE RESPONSE: The State interprets this comment to be a request that it increase the income limit for waiver participants so that they can remain in the waiver and work. This suggestion appears to be outside the scope of the settings requirements imposed by the new rule. Thus, the State is not currently making changes to the statewide settings transition plan to address the comment. However, the State notes for the commenters' benefit that adopting a higher income threshold for TxHmL may be under consideration in the State's upcoming 2015 legislative session.

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

◉ **The waiver is operated by the state Medicaid agency.**

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

◉ **The Medical Assistance Unit.**

Specify the unit name:

Medicaid and CHIP Services

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

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

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency
Participant waiver enrollment	☒
Waiver enrollment managed against approved limits	☒
Waiver expenditures managed against approved levels	☒

Function	Medicaid Agency
Level of care evaluation	☒
Review of Participant service plans	☒
Prior authorization of waiver services	☒
Utilization management	☒
Qualified provider enrollment	☒
Execution of Medicaid provider agreements	☒
Establishment of a statewide rate methodology	☒
Rules, policies, procedures and information development governing the waiver program	☒
Quality assurance and quality improvement activities	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

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

b. Methods for Remediation/Fixing Individual Problems

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

N/A

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	Aged			☐

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

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

Eligible individuals:
1. Meet the level of care I criteria for intermediate care facilities for individuals with an intellectual disability or related condition as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter E and have had a determination of an intellectual and developmental disability performed in accordance with state law or have been diagnosed by a physician as having a related condition;
2. Qualify for a level of need assignment 1, 5, 6, or 8 as defined in Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter N, §9.562;
3. Live in his or her own home or family's home;
4. Are not concurrently enrolled in another 1915(c) waiver program; and
5. Choose participation in the TxHmL Program over participation in the intermediate care facility for individuals with an Intellectual Disability or Related Conditions (ICF/IID).

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

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

  - ○ **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ○ **Other**

    Specify:

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

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

  This waiver is intended to serve persons who are currently eligible to receive Medicaid State Plan services and who can continue to live in their own or family homes if the supports of their informal networks are augmented with basic services and supports through the waiver.

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

  - ◉ **The following dollar amount:**

    Specify dollar amount: 17000

    The dollar amount *(select one)*

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

      Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

The service planning team reviews evaluative information and develops a person-directed plan that must include a description of the current natural supports and non-waiver services that will be available to the applicant if enrolled in the waiver and a description of the waiver services and supports required for the applicant to live in a community setting. The service planning team supports the applicant's active participation in the assessment and planning process. The applicant's service planning team must concur that the waiver services and, if applicable, non-waiver services for which the applicant is eligible, are sufficient to assure his or her health and welfare in the community.

The waiver is intended to serve individuals who would require institutionalization in an intermediate care facility for individuals with an Intellectual Disability or Related Conditions (ICF/IID)without the services and supports available to them through the waiver. All waiver individuals must have a service plan at a cost within the cost ceiling ($17,000). For Texas Home Living individuals with needs that exceed the cost limit, HHSC has a process to ensure their needs are met. The process includes examining third party resources, possible transition to another waiver, or institutional services.

An applicant or individual whose request for eligibility for the waiver program is denied or is not acted upon with reasonable promptness is entitled to a fair hearing in accordance Title 1 of the Texas Administrative Code, Chapter 357, Subchapter A. HHSC must send written notification to the individual or the individual's legally authorized representative, indicating the individual's right to a fair hearing and the process to follow to request a fair hearing.

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

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

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

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

☒ **Other safeguard(s)**

Specify:

If an individual has an increased need for a covered service that would cause the cost of the individual's service plan to exceed the total service limit established by the State, HHSC evaluates the individual's needs to ensure the individual's health and welfare by any one or combination of the following:

- Accessing additional assistance of family or local community organizations and other natural supports; or
- Seeking funding through non-waiver resources such as Medicaid state plan services, local intellectual and developmental disability authorities, or local community agencies.

To the extent that the above efforts are unsuccessful, and the State finds that the absence of sufficient service(s) prevents the State from assuring the individual's health and welfare in the community, the following will apply:

- The individual will be given an opportunity to request services through another existing home and community-based service program for which the individual may be eligible;
- The individual will be assisted in seeking admission to an intermediate care facility for individuals with an Intellectual Disability or Related Conditions (ICF/IID), if appropriate; and
- The individual will be informed of and given the opportunity to request a fair hearing in accordance with Title 1 of the Texas Administrative Code, Chapter 357, Subchapter A, if the State proposes to terminate the individual's waiver eligibility.

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	6540
Year 2	6540
Year 3	6540
Year 4	6540
Year 5	6540

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

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	5460

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 2	5460
Year 3	5460
Year 4	5460
Year 5	5460

Appendix B: Participant Access and Eligibility

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

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

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

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

Purpose(s) the state reserves capacity for:

Purposes
Individuals with level of care I or VIII residing in a nursing facility (MFP)

Appendix B: Participant Access and Eligibility

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

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

Individuals with level of care I or VIII residing in a nursing facility (MFP)

Purpose *(describe):*

This Money Follows the Person target group reserves capacity for individuals with level of care I or VIII residing in or at imminent risk of entering a nursing facility.

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved
Year 1	0
Year 2	31
Year 3	63
Year 4	63
Year 5	63

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

A local intellectual and developmental disability authority must maintain an up-to-date interest list of TxHmL applicants living in the local intellectual and developmental disability authority's service area. The local intellectual and developmental disability authority enters the individual's name into the Client Assignment and Registration system. As the local intellectual and developmental disability authority enter the individuals' names, the Client Assignment and Registration system organizes the entries into chronological order. HHSC, in turn, maintains a statewide interest list for the TxHmL program comprised of the names entered into the Client Assignment and Registration system by the local intellectual and developmental disability authorities.

HHSC determines the number of TxHmL waiver slots that will be allocated to each local intellectual and developmental disability authority.

HHSC and each local intellectual and developmental disability authority coordinate TxHmL program vacancies as they occur, either through waiver slot attrition or the creation of new TxHmL slots. The local intellectual and developmental disability authority offers the TxHmL program vacancy to the applicant or legally authorized representative whose name is first on the interest list for the TxHmL program. The local intellectual and developmental disability authority reviews the applicant's Medicaid type in addition to other TxHmL program requirements to determine if the applicant is eligible for the TxHmL program.

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

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

If an applicant is a military family member living outside of Texas and claimed Texas as their state of residency prior to joining the military, they cannot be denied an interest list offer while they are living outside Texas during their family's time of military service. If the applicant who is a military family member is offered enrollment while he or she is living outside of Texas during military service, the applicant shall retain his or her position on the interest list for up to one year after his or her family's military service ends.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

- ( ) **No**
- (●) **Yes**

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

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

☐ **Low income families with children as provided in §1931 of the Act**

☒ **SSI recipients**

☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

☐ **Optional state supplement recipients**

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

Select one:

○ **100% of the Federal poverty level (FPL)**

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

Specify percentage:

☒ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

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

Specify:

References are to the Social Security Act or the Code of Federal Regulations.

• Adoption Assistance and Foster Care Children: §1902(a)(10)(A)(i)(I), §473(b)(3), 42 CFR §435.145
• Children with Non-IV-E Adoption Assistance: §1902(a)(10)(A)(ii)(VIII), 42 CFR §435.227
• Coverage Infants and Children under age 19: §1902(a)(10)(A)(i)(III), (IV), (VI), and (VII); §1902(a)(10)(A)(ii)(IV) and (IX); §1931(b) and (d); 42 CFR §435.118
• Deemed Newborn Children: §1902(e)(4); 2112(e); 42 CFR §435.117
• Disabled Adult Children: §1634(c), §1939(a)(2)(D)
• Disabled Widow(er): §1634(b), §1939, 42 CFR §435.137
• Early Aged Widow(er): §1634(d), §1939, 42 CFR §435.138
• Earnings Transitional Medical Assistance: §1902(e)(1), §1925, 42 CFR §435.112
• Former Foster Care Children: §1902(a)(10)(A)(i)(IX), 42 CFR §435.150
• Independent Foster Care Adolescents; Medicaid for Transitioning Foster Care Youth: §1902(a)(10)(A)(ii)(XVII), 42 CFR §435.226
• Medicaid for Breast and Cervical Cancer: §1902(a)(10)(A)(ii)(XVIII), §1902(aa), 42 CFR §435.213
• Parents and Caretaker Relatives: §1931(b) and (d), 42 CFR §435.110
• Pickle Group: §1939(a)(5)(E), 42 CFR §435.135
• Pregnant Women: §1902(a)(10)(A)(i)(III) and (IV); §1902(a)(10)(A)(ii)(I), (IV), and (IX); and §1931(b) and (d), 42 CFR §435.116
• Reasonable Classification Children Under 21: §1902(a)(10)(A)(ii)(I) and (IV), 42 CFR §435.222
• Spousal Support Transitional: §1902(a)(10)(A)(i)(I); 42 CFR §435.115(f)

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

◉ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver**

group under 42 CFR §435.217. *Appendix B-5 is not submitted.*

○ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

○ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

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

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

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

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

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

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

○ **Other**
Specify:

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

The educational/professional qualifications of people performing initial evaluations of level of care for individuals participating in the waiver are: licensed registered nurses, licensed social workers, or qualified intellectual disability professional as defined in 42 CFR 483.430(a).

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

The required intermediate care facility for individuals with an Intellectual Disability or Related Conditions level of care I is set forth in Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter E, (relating to Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (IDF/IID) Program--Contracting) as follows:

(a) To meet the level of care I criteria, a person must:

(1) Meet the following criteria:

(A) Have a full scale intelligence quotient score of 69 or below, obtained by administering a standardized individual intelligence test; or

(B) Have a full scale intelligence quotient score of 75 or below, obtained by administering a standardized individual intelligence test, and have a primary diagnosis by a licensed physician of a related condition that is included on the HHSC approved Diagnostic Codes for Persons with Related Conditions), available at this link: http://www.dads.state.tx.us/providers/guidelines/icd10-codes.pdf

(2) Have an adaptive behavior level of I, II, III, or IV (i.e., mild to extreme deficits in adaptive behavior) obtained by administering a standardized assessment of adaptive behavior.

(b) If a person has a sensory or motor deficit for which a specially standardized intelligence test or a certain portion of a standardized intelligence test is appropriate, the appropriate score should be used.

(c) If a full-scale intelligence quotient score cannot be obtained from a standardized intelligence test due to age, functioning level, or other severe limitations, an estimate of a person's intellectual functioning should be documented with clinical justification.

To meet the level of care VIII criteria, an individual must:
(1) have a primary diagnosis by a licensed physician of a related condition that is included on the HHSC approved Diagnostic Codes for Persons with Related Conditions), available at this link: http://www.dads.state.tx.us/providers/guidelines/icd10-codes.pdf; and
(2) have an adaptive behavior level of II, III, or IV (i.e., moderate to extreme deficits in adaptive behavior) obtained by administering a standardized assessment of adaptive behavior.

Individuals with a level of care VIII can only enter the waiver through the reserve capacity group, which is defined as "Individuals with level of care I or VIII residing in a nursing facility."

The level of care is assigned based on information submitted electronically by the local intellectual and developmental disability authority providing service coordination to the individual via the Client Assignment and Registration system utilizing the Intellectual Disability/Related Condition Assessment. The Intellectual Disability/Related Condition Assessment includes all factors that are assessed in evaluating a level of care determination, including:

- diagnostic information that includes age of onset of the condition;
- results of standardized intelligence testing and assessments of adaptive behavior;
- measures from the Inventory for Client and Agency Planning; and
- behavioral status.

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

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

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

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

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

The local intellectual and developmental disability authority completes the Intellectual Disability/Related Condition Assessment and requests a level of care determination for an applicant or annually for an enrolled individual by electronically submitting the initial or renewal Intellectual Disability/Related Condition Assessment, via the Client Assignment and Registration system database system, indicating the recommended level of care. The process for evaluation and annual reevaluation are the same, except the submission of the Intellectual Disability/Related Condition Assessment is done by the program provider at re-evaluation.

A level of care determination must be made by HHSC in accordance with criteria specified in B-6.d of this Appendix, and is assigned based on information submitted electronically via the Client Assignment and Registration system utilizing the Intellectual Disability/Related Condition Assessment. Information on the Intellectual Disability/Related Condition Assessment must be supported by current data obtained from standardized evaluations and formal assessments that measure physical, emotional, social, and cognitive factors.

The local intellectual and developmental disability authority must maintain the signed Intellectual Disability/Related Condition Assessment and documentation supporting the recommended level of care in the applicant's or individual's record. The electronically transmitted Intellectual Disability/Related Condition Assessment must contain information identical to that on the signed Intellectual Disability/Related Condition Assessment.

HHSC must approve and enter the appropriate level of care into the Client Assignment and Registration system or send written notification to the service coordinator that a level of care has been denied. A level of care determination is valid for 364 calendar days after the level of care effective date determined by the department.

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

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

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

  Specify the qualifications:

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

The State employs the following procedures to ensure timely reevaluations of level of care:

1. Edits in the automated Client Assignment and Registration system; and
2. Annual review of local intellectual and developmental disability authorities to determine that reevaluations occur timely.

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

Records of evaluations and re-evaluations of level of care are maintained in the following locations: HHSC, the State Medicaid Agency; local intellectual and developmental disability authorities; and TxHmL program providers.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
B.a.1 Number and percent of applicants who accepted an offer to participate in the enrollment eligibility process and received a level of care evaluation. N: Number of applicants who accepted an offer to participate in the enrollment eligibility process and received a level of care evaluation. D: Number of applicants who accepted an offer to participate in the enrollment eligibility process.

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

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

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
B.b.1 Number and percent of enrolled renewing individuals for whom annual level of care renewal forms were completed as required. N: Number of enrolled renewing individuals for whom annual level of care renewal forms were completed as required. D: Number of enrolled renewing individuals requiring an annual level of care determination.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
B.c.1 Number and percent of newly enrolled individuals for whom initial level of care was completed prior to receipt of first service. N: Number of newly enrolled individuals for whom initial level of care was completed prior to receipt of first service. D: Number of newly enrolled individuals requiring an initial level of care determination.

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

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

	Specify:	

Data Aggregation and Analysis:

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

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

The Client Assignment and Registration system prohibits the completion of an individual's enrollment without an approved level of care. The system also prohibits the renewal of an individual's service plan if the individual's level of care is not current.

The Client Assignment and Registration system produces daily reports of all pending level of care determinations. This report is used to initiate reviews of all pending levels of care. The Client Assignment and Registration system prevents the delivery of services prior to the State's authorization of the level of care. HHSC also has a process for supervisory review of a sample of level of care determinations made each quarter by HHSC.

b. Methods for Remediation/Fixing Individual Problems

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

A level of care must be approved for each individual prior to service delivery. Services delivered prior to the initial level of care or during the time frame when a level of care has expired are not reimbursed by HHSC.

HHSC approves all levels of care and verifies that they are developed using the prescribed tools and processes. If the State determined that a level of care was submitted that did not utilize the approved instruments and processes, it would be returned to the local intellectual and developmental disability authority for correction prior to being approved. Providers are not paid for services until the level of care is completed.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

request through the Medicaid agency or the operating agency (if applicable).

A local intellectual and developmental disability authority service coordinator informs applicants/individuals of services available under the waiver at enrollment and upon renewal. The service coordinator presents the applicant/individual with program information for both the TxHmL waiver program and the intermediate care facilities for individuals with intellectual disabilities and related conditions. Following the presentation of this information, the service coordinator offers the applicant/individual the opportunity to make an informed choice between these programs and documents the applicant's/individual's decision to accept or refuse the TxHmL on the Freedom of Choice Verification Form.

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

The local intellectual and developmental disability authority retains the Freedom of Choice Verification Form in the applicant's record.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

HHSC operational policy A-572 acknowledges the department's legal obligation to ensure that programs and services are accessible to the diverse population of Texas and requires HHSC service delivery to comply with state and federal laws and mandates.

Each HHSC program, activity and provider must offer a variety of methods to ensure access to services in a timely manner by providing language assistance services to applicants, recipients and stakeholders with limited English proficiency.

The Communications Office coordinates translations for HHSC. HHSC routinely provides Spanish translation of forms and letters and is responsive to other translation needs.

Local intellectual and developmental disability authority service coordinators and TxHmL program providers must assure that interpreter services are available to individuals during service planning and service delivery.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Day Habilitation**		
Statutory Service	**Respite**		
Statutory Service	**Supported Employment**		
Extended State Plan Service	**Prescription Medications**		
Supports for Participant Direction	**Financial Management Services**		
Supports for Participant Direction	**Support Consultation**		
Other Service	**Adaptive Aids**		
Other Service	**Audiology Services**		
Other Service	**Behavioral Support**		
Other Service	**Community Support**		

Service Type	Service		
Other Service	**Dental Treatment**		
Other Service	**Dietary Services**		
Other Service	**Employment Assistance**		
Other Service	**Minor Home Modifications**		
Other Service	**Nursing**		
Other Service	**Occupational Therapy Services**		
Other Service	**Physical Therapy Services**		
Other Service	**Speech-Language Pathology**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Day Habilitation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	**Sub-Category 4:**

The Day Habilitation service component provides individuals assistance with acquiring, retaining, or improving self-help, socialization, and adaptive skills necessary to live successfully in the community and participate in home and community life. Day Habilitation provides the individual with individualized activities in environments designed to foster the development of skills and behavior supportive of greater independence and personal choice, and consistent with achieving the outcomes identified in the individual's person-directed plan. Activities are also designed to reinforce therapeutic outcomes targeted by other waiver service components, school, or other support providers. Day Habilitation is normally furnished in a group setting other than the individual's residence for up to six hours a day, five days per week on a regularly scheduled basis.

Day Habilitation includes personal assistance for individuals who cannot manage their personal care needs during the Day Habilitation activity, and assistance with medications and the performance of tasks delegated by a registered nurse in accordance with state law. This component also provides transportation during Day Habilitation activities necessary for the individual's participation in those activities.

Documentation is maintained in the file of each individual receiving this service to indicate that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Day Habilitation may not be provided to an individual at the same time Supported Employment, Respite, Community First Choice, or Community Support is provided.

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

N/A

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency
Individual	Consumer directed services direct service provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Employee Requirements:
The provider of the Day Habilitation service component must be 18 years of age and cannot be the individual's legally authorized representative or the spouse of the legally authorized representative. The provider must have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served, as demonstrated through a written competency-based assessment and at least three personal references from persons not related by blood that evidence the ability to provide a safe and healthy environment for the individual(s) to be served.

State laws are expected to be followed. Transportation of individuals must be provided in accordance with applicable state laws. Assisting individuals with tasks delegated by a Registered Nurse must be provided in accordance with applicable state law. The provider of Day Habilitation must complete initial and periodic training provided by the
individual/employer in accordance with 40 Texas Administrative Code §9.579(d), (relating to Certification Principles: Qualified Personnel).

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency
HHSC

Frequency of Verification:

The provider agency verifies provider qualifications prior to hiring. HHSC verifies provider qualifications during annual on-site reviews.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

The provider of the Day Habilitation service component must be 18 years of age and cannot be the individual's legally authorized representative or the spouse of the legally authorized representative. The provider must have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served, as demonstrated through a written competency-based assessment and at least three personal references from persons not related by blood that evidence the ability to provide a safe and healthy environment for the individual(s) to be served.

State laws are expected to be followed. Transportation of individuals must be provided in accordance with applicable state laws. Assisting individuals with tasks delegated by a Registered Nurse must be provided in accordance with applicable state law. The provider of Day Habilitation must complete initial and periodic training provided by the individual/employer in accordance with 40 Texas Administrative Code §9.579(d), (relating to Certification Principles: Qualified Personnel).

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual employer and financial management services agency
HHSC

Frequency of Verification:

Individual/employer and financial management services agency verify provider qualifications prior to hiring.

HHSC verifies provider qualifications during on-site reviews, completed every three years at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

The Respite service component is provided for the planned or emergency short-term relief of the unpaid caregiver of an individual when the caregiver is temporarily unavailable to provide supports. This component provides an individual with personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks, assistance with planning and preparing meals, transportation or assistance in securing transportation, assistance with ambulation and mobility, reinforcement of Behavioral Support or specialized therapies activities, assistance with medications and the performance of tasks delegated by a registered nurse in accordance with state law, and supervision of the individual's safety and security. This component includes habilitation activities that facilitate the individual's inclusion in community activities, use of natural supports and typical community services available to all people, social interaction and participation in leisure activities, and development of socially valued behaviors and daily living and functional living skills.

Respite will be provided in an individual's home or family home and in Home and Community-based Services waiver program host/companion care home, Home and Community-based Services waiver group home, in the Respite provider's home, or in a group Respite facility operated by a certified waiver program provider, or at a camp accredited by the American Camp Association.

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

All other waiver and non-waiver services indicated on the individual's service plan may be provided during the period of Respite except that hourly-reimbursed Respite may not be provided at the same time Community Support, Supported Employment, Day Habilitation or Community First Choice state plan service is provided. Federal Financial Participation (FFP) will not be claimed for the cost of room and board except when provided as part of Respite furnished in a facility approved by the State that is not a private residence.

Respite cannot be provided in an institution such as a nursing facility, intermediate care facility for individuals with intellectual disabilities, or a hospital. Respite cannot be provided at the same time as Community Supports or Community First Choice state plan services.

Respite cannot be provided in an institution such as a nursing facility, intermediate care facility for individuals with intellectual disabilities, or a hospital. Respite cannot be provided at the same time as Community Supports or Community First Choice state plan services.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer directed services direct service provider
Agency	Agencies holding a TxHmL Provider Agreement

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Employee Requirements:
The provider of the Respite service component must be 18 years of age and cannot be the individual's legally authorized representative or the spouse of the legally authorized representative. The provider must have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served, as demonstrated through a written competency-based assessment and at least three personal references from persons not related by blood that evidence the ability to provide a safe and healthy environment for the individual(s) to be served.

State laws are expected to be followed. Transportation of individuals must be provided in accordance with applicable state laws. Assisting individuals with tasks delegated by a Registered Nurse must be provided in accordance with applicable state law. The provider of Respite must complete initial and periodic training provided by the
individual/employer in accordance with 40 Texas Administrative Code §9.579(d), (relating to Certification Principles: Qualified Personnel).

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual employer and financial management services agency
HHSC

Frequency of Verification:

Individual/employer and financial management services agency verify provider qualifications prior to hiring.
HHSC verifies provider qualifications during on-site reviews, completed every three years at a minimum.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Employee Requirements:
The provider of the Respite service component must be 18 years of age and cannot be the individual's legally authorized representative or the spouse of the legally authorized representative. The provider must have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served, as demonstrated through a written competency-based assessment and at least three personal references from persons not related by blood that evidence the ability to provide a safe and healthy environment for the individual(s) to be served.

State laws are expected to be followed. Transportation of individuals must be provided in accordance with applicable state laws. Assisting individuals with tasks delegated by a Registered Nurse must be provided in accordance with applicable state law. The provider of Respite must complete initial and periodic training provided by the
individual/employer in accordance with 40 Texas Administrative Code §9.579(d), (relating to Certification Principles: Qualified Personnel).

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency
HHSC

Frequency of Verification:

The provider agency verifies provider qualifications prior to hiring. HHSC verifies provider qualifications annually during on-site reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Supported Employment means assistance provided, in order to sustain competitive employment, to an individual who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which individuals without disabilities are employed. Supported Employment includes employment adaptations, supervision, and training related to an individual's assessed needs. Individuals receiving Supported Employment earn at least minimum wage (if not self-employed).

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.

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

In the state of Texas, this service is not available to individuals receiving these services under a program funded under section 110 of the Rehabilitation Act of 1973. Documentation is maintained in the individual's record that the service is not available to the individual under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.).

This service may not be provided to the individual with the individual present at the same time that Day Habilitation, Community Support, Employment Assistance, or Respite is provided.

The service does not include sheltered work or other types of vocational services in specialized facilities, or for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

(A) Incentive payments made to an employer to encourage hiring the individual;

(B) Payments that are passed through to the individual; or

(C) Payments for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business; or

(D) Payments used to defray the expenses associated with starting up or operating a business.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer directed services direct service provider
Agency	Agencies holding a TxHmL Provider Agreement

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The service provider must be at least 18 years of age, maintain current driver's license and insurance if transporting individual, and satisfy one of these options:

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

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

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

Under the consumer directed services option, the provider cannot be the individual's legally authorized representative or the spouse of the legally authorized representative.

The provider of Supported Employment must complete initial and periodic training provided by the individual/employer in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 9, §9.579(d), (relating to Certification Principles: Qualified Personnel).

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/ employer and financial management services agency

HHSC

Frequency of Verification:

Individual/employer and financial management services agency verify provider qualifications prior to hiring.

HHSC verifies provider qualifications during on-site reviews, completed every three years at a minimum.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The service provider must be at least 18 years of age, maintain current driver's license and insurance if transporting individual, and satisfy one of these options:

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

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

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

The provider of Supported Employment must complete initial and periodic training provided by the participant/employer in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 9, §9.579(d), (relating to Certification Principles: Qualified Personnel).

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency
HHSC

Frequency of Verification:

The provider agency verifies provider qualifications prior to hiring. HHSC verifies provider qualifications during annual on-site reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Prescription Medications

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Provides unlimited Prescription Medications to individuals enrolled in the waiver who are eligible for both Medicaid and Medicare (dually eligible). An individual who is dually eligible must obtain Prescribed Medications through the Medicare Prescription Drug Plan or, through the Texas Medicaid state plan (for certain medications excluded from Medicare), before medications are furnished under the waiver.

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

Individuals in the waiver who are enrolled in managed care for their acute care services receive unlimited Prescription Medications through their managed care and therefore do not qualify for Prescription Medications under the waiver. Individuals who are dually eligible are excluded from enrollment into managed care and are still eligible for Prescription Medications under the waiver if they meet the requirements in the above service definition.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Pharmacies holding a Medicaid Provider Agreement-Vendor Drug with Texas Health and Human Services Commission (HHSC)

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Prescription Medications

Provider Category:

Individual

Provider Type:

Pharmacies holding a Medicaid Provider Agreement-Vendor Drug with Texas Health and Human Services Commission (HHSC)

Provider Qualifications

License *(specify):*

Pharmacy
Texas State Board of Pharmacy

Certificate *(specify):*

N/A

Other Standard *(specify):*

Must hold Vendor Drug Provider Agreement with HHSC.

The provider must complete training as required by HHSC.

Verification of Provider Qualifications

Entity Responsible for Verification:

Texas State Board of Pharmacy

Frequency of Verification:

Every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Financial Management Services provides assistance to individuals with managing funds associated with the services elected for self-direction. The service includes initial orientation and ongoing training related to responsibilities of being an employer and adhering to legal requirements for employers. The Financial Management Services provider, referred to as the financial management services agency, also provides assistance in the development, monitoring and revision of the individual's budget for each service component delivered through the consumer directed services option and must maintain a separate account for each individual's budget. The financial management services agency provides assistance in determining staff wages and benefits subject to State limits, assistance in hiring by verifying employees' citizenship status and qualifications, and conducting required background checks. The financial management services agency verifies and maintains documentation of employee qualifications, including citizenship status, and documentation of services delivered. The financial management services agency also collects timesheets, processes timesheets of employees, processes payroll and payables and makes withholdings for, and payment of, applicable federal, state and local employment-related taxes. The financial management services agency tracks disbursement of funds and provides periodic reports to the individual of all expenditures and the status of the individual consumer directed services budget.
The financial management services agency must not provide service coordination to the individual.

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

n/a

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial management services agencies

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Financial Management Services

Provider Category:

Agency

Provider Type:

Financial management services agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The provider of Financial Management Services must hold a Medicaid provider agreement to be a financial management services agency. The financial management services agency must successfully complete a mandatory three-day orientation and training conducted annually by HHSC. The rules for the consumer directed services option, located at Title 40 of the Texas Administrative Code, Part 1, Chapter 41, detail the responsibilities of an employer agent, including the revocation of IRS Form 2678 if the individual terminates the consumer directed services option or transfers to another financial management services agency.

The financial management services agency must complete initial and periodic training. During monitoring reviews, financial management services agencies are required to meet 90 percent compliance. The monitoring assesses performance based on standards related to conducting background checks, licensure verification, and orientation of the consumer directed services employer, new hire process, employer budgets and expenditure reports, and payroll. Current financial management services agencies are required to attend a three-day orientation and training provided by HHSC at least once a year. HHSC also holds quarterly conference calls with the financial management services agencies to discuss operational issues. Training and technical assistance are often provided on those calls.

The financial management services agency provider must be at least 18 years of age and must not be the individual's spouse, the individual’s legally authorized representative, the spouse of the individual’s legally authorized representative, the individual's designated representative, or the spouse of the individual's designated representative.

Upon the request of an individual or an individual’s legally authorized representative, the financial management services agency must have Support Consultation services available.

Verification of Provider Qualifications

Entity Responsible for Verification:

HHSC

Frequency of Verification:

The provider agency verifies provider qualifications prior to hiring. HHSC verifies provider qualifications every three years during on-site reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Support Consultation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Support Consultation is an optional service component that offers practical skills training and assistance to enable an individual or his/her legally authorized representative to successfully direct those services the individual or the legally authorized representative elect for self-direction. This component includes skills training related to recruiting, screening, and hiring workers, preparing job descriptions, verifying employment eligibility and qualifications, completion of documents required to employ an individual, managing workers, and development of effective backup plans for services considered critical to the individual's health and welfare in the absence of the regular provider or in an emergency situation. This component provides sufficient information and assistance to assure individuals and their representatives understand the responsibilities involved with self-direction. The scope and duration of Support Consultation will vary depending on an individuals need for Support Consultation.

Support Consultation may be provided by a qualified professional associated with a financial management services agency selected by the individual, his/her legally authorized representative, or by an independent qualified professional hired by the individual.

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

N/A

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

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

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer directed services direct service provider

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Support Consultation

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Individual provider must have certification of successful completion of required training conducted or approved by HHSC.

Other Standard *(specify):*

The support consultation provider must be at least 18 years old, have a high school diploma or Certificate of High School Equivalency (GED credentials), have documentation of attendance and completion of initial training required by and conducted or authorized by HHSC, and any ongoing training if required by and conducted or authorized by HHSC.

The support consultation provider does not provide Service Coordination or any other waiver service other than Support Consultation to the individual. The support consultation provider cannot be the individual's legally authorized representative, the spouse of individual's legally authorized representative, the individual's designated representative, or the spouse of the individual's designated representative.

The support consultation provider must complete initial and periodic training provided by the individual.

Support consultation providers must be at least 18 years of age and must not be the individual's spouse, the individual's legally authorized representative, the spouse of the individual's legally authorized representative, the individual's designated representative, or the spouse of the individual's designated representative.

Upon the request of an individual or an individual's legally authorized representative, the financial management services agency must have Support Consultation services available.

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer and financial management services agency
HHSC

Frequency of Verification:

Individual/employer and financial management services agency verify provider qualifications prior to hiring.
HHSC verifies provider qualifications during on-site reviews, completed every three years at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adaptive Aids

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

The Adaptive Aids service component provides devices, controls, or appliances that are necessary to address specific needs identified by the individual's service plan. Adaptive Aids enable individuals to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live. Adaptive Aids include items that assist an individual with mobility, communication, ancillary supplies, and equipment necessary for the proper functioning of such items. Also included are medically necessary supplies and items needed for life support. Items reimbursed with waiver funds are only accessible after medical equipment and supplies furnished under the Medicaid state plan are maximized. All items must meet applicable standards of manufacture, design, and installation.

An Adaptive Aid is provided for a specific individual and becomes the exclusive property of that individual. Excluded are those items and supplies that are not of direct medical or remedial benefit to the individual and items and supplies that are available to the individual through the Medicaid state plan, through other governmental programs, or through private insurance. The individual's service planning team must authorize all Adaptive Aids. Items costing more than $500 must be authorized by the service planning team based upon written evaluations and recommendations from the individual's physician, a licensed occupational or physical therapist, a psychologist or behavior analyst, a licensed nurse, a licensed dietician, or a licensed audiologist or speech/language pathologist qualified to assess the individual's need for the specific Adaptive Aid. The written evaluation and recommendation must document the necessity and appropriateness of the Adaptive Aid to meet the specific needs of the individual. Adaptive Aids are limited to the following categories, including repair and maintenance not covered by warranty:

- Lifts
- Mobility aids
- Positioning Devices
- Control switches/pneumatic switches and devices
- Environmental control units
- Medically necessary supplies
- Communication aids (including batteries)
- Adaptive/modified equipment for activities of daily living
- Safety Restraints and Safety Devices

The link below contains the complete list of billable Adaptive Aids:

https://hhs.texas.gov/laws-regulations/handbooks/texas-home-living-txhml-program-billing-guidelines/appendices/appendix-iv-billable-adaptive-aids

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

The maximum amount available for Adaptive Aids is $10,000 per individual per service plan year.
If necessary, an individual's service coordinator assists the individual in locating additional resources through family or local community organizations, including the local intellectual and developmental disability authority, and other natural supports or seeking funding through non-waiver resources To the extent that the above efforts are unsuccessful, and the State finds that the absence of sufficient service(s) prevents the State from assuring the individual's health and welfare in the community, the following will apply:

- The individual will be given an opportunity to request services through another existing home and community-based service program for which the individual may be eligible;
- The individual will be assisted in seeking admission to an intermediate care facility for individuals with an intellectual disability or related conditions, if appropriate; and
- The individual will be informed of and given the opportunity to request a fair hearing in accordance with 1 Texas Administrative Code, Part 15, Chapter 357, Subchapter A, if the State proposes to terminate the individual's waiver eligibility.

Adaptive Aids are provided under this waiver if no other financial resource for such Adaptive Aids are available or if other available resources have been used. Individuals who are under 21 years of age must access adaptive aids benefits through the Texas Health Steps--Comprehensive Care Program (EPSDT) before Adaptive Aids may be provided under this waiver.

To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a TxHmL Provider Agreement
Individual	Consumer directed services direct service provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adaptive Aids

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Adaptive Aids must be prescribed by a provider acting within the scope of his or her license.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency
HHSC

Frequency of Verification:

HHSC verifies during billing and payment reviews.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adaptive Aids

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Adaptive Aids must be provided by contractors/suppliers capable of providing Adaptive Aids meeting applicable standards of manufacture, design and installation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer and financial management services agency
HHSC

Frequency of Verification:

Individual/employer and financial management services agency verify provider qualifications prior to hiring.
HHSC verifies provider qualifications during on-site reviews, completed every three years at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Audiology Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

The Audiology service component provides assessment and treatment by licensed audiologists, and includes training and consultation with an individual's family members or other support providers.

The Audiology service includes:
- Screening and assessment;
- Development of therapeutic treatment plans;
- Direct therapeutic intervention;
- Assistance, and training with adaptive aids and augmentative communication devices;
- Consulting with other service providers and family members; and
- Participating on the interdisciplinary team, when appropriate.

Audiology services are provided under this waiver if no other financial resource for such services are available or if other available resources have been used.

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

This waiver service is only provided to individuals age 21 and over. All medically necessary Audiology services for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer directed services direct service provider
Agency	Agencies holding a TxHmL Provider Agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Audiology Services

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

Speech/Language Pathologist, Audiologist (Texas Occupations Code)

Certificate *(specify):*

N/A

Other Standard *(specify):*

The provider cannot be the individual's legally authorized representative or the spouse of the legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer and financial management services agency
HHSC

Frequency of Verification:

Individual/employer and financial management services agency verify provider qualifications prior to hiring.
HHSC verifies provider qualifications during on-site reviews, completed every three years at a minimum.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Audiology Services

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License *(specify):*

Speech/Language Pathologist, Audiologist
(Texas Occupations Code)

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency
HHSC

Frequency of Verification:

Prior to completing service agreement; prior to expiration of license.
Annual on-site reviews

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not

specified in statute.

Service Title:

Behavioral Support

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

The Behavioral Support service component provides specialized interventions that assist an individual to increase adaptive behaviors to replace or modify maladaptive or socially unacceptable behaviors that prevent or interfere with the individual's inclusion in home and family life or community life. The component includes assessment and analysis of assessment findings of the behavior(s) to be targeted so that an appropriate behavioral support plan may be designed; development of an individualized behavioral support plan consistent with the outcomes identified in the individual's person-directed plan; training of and consultation with family members or other support providers and, as appropriate, with the individual in the purpose/objectives, methods and documentation of the implementation of the behavioral support plan or revisions of the plan; monitoring and evaluation of the success of the behavioral support plan implementation; and modification, as necessary, of the behavioral support plan based on documented outcomes of the plan's implementation.

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

Behavioral Support is provided under this waiver if no other financial resource for such service is available or if other available resources have been used.

To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a TxHmL Provider Agreement
Individual	Consumer directed services direct service provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Support

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License *(specify):*

Psychologist
(Texas Occupations Code Chapter 501)

Psychological Associate
(Texas Occupations Code Chapter 501)

Clinical Social Worker
(Texas Occupations Code Chapter 505)

Professional Counselor
(Texas Occupations Code Chapter 503)

Licensed Behavior Analyst
(Texas Occupations Code Chapter 506)

No expected reduction in service providers.

Certificate *(specify):*

HHSC-certified Authorized Provider
(Texas Health and Safety Code Sections 593.004-593.005)
Board-certified Behavior Analyst
(Certification as Behavior Analyst by the national Behavior Analyst Certification Board, Inc.)

Other Standard *(specify):*

Legally authorized representatives and persons related to the individual within the fourth degree of consanguinity or within the second degree of affinity may not provide behavioral support services for the individual.

Behavioral Support providers must follow service specifications in Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter N. The TxHmL provider is responsible for ensuring that the provider of Behavioral Support services receives certain training prescribed by HHSC.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency

HHSC

Frequency of Verification:

The provider agency verifies provider qualifications prior to completing a service agreement, and prior to execution of license or certification. HHSC verifies provider qualifications during annual on-site reviews.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Support

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

Psychologist
(Texas Occupations Code Chapter 501)

Psychological Associate
(Texas Occupations Code Chapter 501)

Clinical Social Worker
(Texas Occupations Code Chapter 505)

Professional Counselor
(Texas Occupations Code Chapter 503)

Licensed Behavior Analyst
(Texas Occupations Code Chapter 506)

No expected reduction in service providers.

Certificate *(specify):*

HHSC-certified Authorized Provider
(Texas Health and Safety Code Sections 593.004-593.005)

Board-certified Behavior Analyst
(Certification as Behavior Analyst by the national Behavior Analyst Certification Board, Inc.)

Other Standard *(specify):*

Legally authorized representatives and persons related to the individual within the fourth degree of consanguinity or within the second degree of affinity may not provide Behavioral Support services for the individual.

Behavioral Support providers must follow service specifications in Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter N. The Behavioral Support service provider must receive certain training prescribed by HHSC.

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/ employer and financial management services agency
HHSC

Frequency of Verification:

Individual/employer and financial management services agency verify provider qualifications prior to hiring.
HHSC verifies provider qualifications during on-site reviews, completed every three years at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Support

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	**Sub-Category 4:**

The Community Support service component provides services and supports in an individuals home and at other community locations such as city bus terminals, libraries, or stores, etc. that are necessary to achieve outcomes identified in the individuals person-directed plan. This component provides habilitative or support activities that provide, foster improvement of, or facilitate an individuals ability to perform functional living skills and other activities of daily living. Habilitative or support activities are provided that foster improvement of or facilitate an individuals ability and opportunity to participate in typical community activities, including activities that lead to successful employment, to access and use available non-waiver program services or supports for which the individual may be eligible, and to establish or maintain relationships with people who are not paid service providers that expand or sustain the individual's natural support network. The community support component provides assistance with medications and the performance of tasks delegated by a registered nurse in accordance with state law. Transportation or assistance in obtaining transportation is provided by this component the cost of which is included in the rate paid to the program provider.

With the availability of Community First Choice (CFC) effective June 1, 2015, the majority of Community Support services are now available to all TxHmL waiver participants through the CFC state plan services. However, transportation remains an exclusive TxHmL waiver service. State plan services, including those provided under CFC, must be exhausted before using TxHmL waiver services.

This component does not include payment for room or board and may not be provided at the same time that the hourly-reimbursed Respite, Day Habilitation, or Supported Employment service component is provided.

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

N/A

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer directed services direct service provider
Agency	Agencies holding a TxHmL Provider Agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Support

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Employee Requirements:
The provider of Community Support must be 18 years of age and cannot be the individual's legally authorized representative or the spouse of the legally authorized representative. The provider must have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served, as demonstrated through a written competency-based assessment and at least three personal references from persons not related by blood that evidence the ability to provide a safe and healthy environment for the individual(s) to be served.

State laws are expected to be followed. Transportation of individuals must be provided in accordance with applicable state laws. Assisting individuals with tasks delegated by a Registered Nurse must be provided in accordance with applicable state law.
Assisting with tasks delegated by a Registered Nurse must be in accordance with state law. The provider must not live with the individual.

The provider cannot be the individual’s legally authorized representative or the spouse of the legally authorized representative.

The provider of Community Support services must complete initial and periodic training provided by the participant/employer in accordance with 40 Texas Administrative Code §9.579(d), (relating to Certification Principles: Qualified Personnel).

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer and financial management services agency
HHSC

Frequency of Verification:

Individual/employer and financial management services agency verify provider qualifications prior to hiring.
HHSC verifies provider qualifications during on-site reviews, completed every three years at a minimum.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Support

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Employee Requirements:
The provider of Community Support must be 18 years of age and cannot be the individual's legally authorized representative or the spouse of the legally authorized representative. The provider must have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served, as demonstrated through a written competency-based assessment and at least three personal references from persons not related by blood that evidence the ability to provide a safe and healthy environment for the individual(s) to be served.

State laws are expected to be followed. Transportation of individuals must be provided in accordance with applicable state laws. Assisting individuals with tasks delegated by a Registered Nurse must be provided in accordance with applicable state law. The provider of Community Support must complete initial and periodic training provided by the program provider in accordance with 40 Texas Administrative Code §9.579(d), (relating to Certification Principles: Qualified Personnel).

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency
HHSC

Frequency of Verification:

The provider agency verifies provider qualifications prior to hiring. HHSC verifies provider qualifications during annual on-site reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Dental Treatment

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Elements of this component include the following:
(A) Emergency dental treatment. Those procedures necessary to control bleeding, relieve pain, and eliminate acute infection; operative procedures that are required to prevent the imminent loss of teeth; and treatment of injuries to the teeth or supporting structures.
(B) Preventive dental treatment. Examinations, oral prophylaxes, and topical fluoride applications.
(C) Therapeutic dental treatment. Treatment that includes, but is not limited to, pulp therapy for permanent and primary teeth; restoration of carious permanent and primary teeth; maintenance of space; and limited provision of removable prostheses when masticatory function is impaired, when an existing prosthesis is unserviceable, or when aesthetic considerations interfere with employment or social development.
(D) Orthodontic dental treatment. Procedures that include treatment of retained deciduous teeth; crossbite therapy; facial accidents involving severe traumatic deviations; cleft palates with gross malocclusion that will benefit from early treatment; and severe, handicapping malocclusions affecting permanent dentition with a minimum score of 26 as measured on the Handicapping Labio-lingual Deviation Index. Cosmetic orthodontia is excluded from the dental treatment component.

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

Dental Treatment is provided under this waiver if no other financial resource for such treatment is available or if other available resources have been exhausted. This waiver service is only provided to individuals age 21 and over. All medically necessary Dental Treatment for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

The total amount allowable for the Dental Treatment component is limited to a maximum expenditure of $1,108.06 per individual per service plan year.

If necessary, an individual's service coordinator assists the individual in locating additional resources through family or local community organizations, including the local intellectual and developmental disability authority, local community agencies, and other natural supports.

To the extent that the above efforts are unsuccessful, and the State finds that the absence of sufficient service(s) prevents the State from assuring the individual's health and welfare in the community, the following will apply:
- The individual will be given an opportunity to request services through another existing home and community-based service program for which the individual may be eligible;
- The individual will be assisted in seeking admission to an intermediate care facility for individuals with an intellectual disability or related conditions, if appropriate; and
- The individual will be informed of and given the opportunity to request a fair hearing in accordance with 1 Texas Administrative Code, Part 15, Chapter 357, Subchapter A, if the State proposes to terminate the individual's waiver eligibility.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer directed services direct service provider
Agency	Agencies holding a TxHmL Provider Agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dental Treatment

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

The person providing dental treatment must be licensed as a dentist or dental hygienist under Texas Occupations Code Chapter 256.

No expected reduction in service providers.

Certificate *(specify):*

N/A

Other Standard *(specify):*

The provider cannot be the individual's legally authorized representative or the spouse of the legally authorized representative.

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer and financial management services agency

HHSC

Frequency of Verification:

Individual/employer and financial management services agency verify provider qualifications prior to hiring.
HHSC verifies provider qualifications during on-site reviews, completed every three years at a minimum.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dental Treatment

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License *(specify):*

The person providing dental treatment must be licensed as a dentist or dental hygienist under Texas Occupations Code Chapter 256.

No expected reduction in service providers.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency
HHSC

Frequency of Verification:

The provider agency verifies provider qualifications prior to hiring. HHSC verifies provider qualifications during annual on-site reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Dietary Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

The Dietary service component assists individuals in meeting their basic and/or special therapeutic nutritional needs. Medically oriented nutritional services are especially important to ensure and maintain the health of persons on modified diets required by a disability and those requiring enteral or parenteral nutrition regimens. The Dietary service component consists of assessment and treatment by licensed dietitians and includes training and consultation with an individual's family members or other support providers. Services include:

- Screening and assessment;
- Development of therapeutic treatment plans;
- Direct therapeutic intervention; and
- Participating on the interdisciplinary team, when appropriate.

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

This waiver service is only provided to individuals age 21 and over. All medically necessary dietary services for children under the age of 21 are covered in the State plan pursuant to the EPSDT benefit.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a TxHmL Provider Agreement
Individual	Consumer directed services direct service provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Dietary Services

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License *(specify):*

Dietitian
(Texas Occupations Code Chapter 701)

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency

HHSC

Frequency of Verification:

The provider agency verifies provider qualifications prior to completing service agreement; and prior to expiration of license. HHSC verifies provider qualifications during annual on-site reviews.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dietary Services

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

Dietitian
(Texas Occupations Code Chapter 701)

Certificate *(specify):*

N/A

Other Standard *(specify):*

The provider cannot be the participant's legally authorized representative or the spouse of the legally authorized representative.

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer and financial management services agency
HHSC

Frequency of Verification:

Individual/employer and financial management services agency verify provider qualifications prior to hiring.
HHSC verifies provider qualifications during on-site reviews, completed every three years at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Employment Assistance

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Employment Assistance is assistance provided to an individual to help the individual locate paid employment in the community. Employment Assistance includes:
- identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions;
- locating prospective employers offering employment compatible with the individual's identified preferences, skills, and requirements; and
- contacting a prospective employer on behalf of an individual and negotiating the individual's employment.

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

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

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

This service may not be provided to the individual with the individual present at the same time that Day Habilitation, Community Support, or Respite is provided.

The service does not include incentive payments, subsidies, or unrelated vocational training expenses such as the following:
(A) Incentive payments made to an employer to encourage hiring the individual;
(B) Payments that are passed through to the individual;
(C) Payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business; or
(D) Payments used to defray the expenses associated with starting up or operating a business.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a TxHmL Provider Agreement
Individual	Consumer directed services direct service provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Employment Assistance

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The service provider must be at least 18 years of age, maintain current driver's license and insurance if transporting individual, and satisfy one of these options:

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

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

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

The provider of Employment Assistance must complete initial and periodic training provided by the individual/employer in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 9, §9.579(d), (relating to Certification Principles: Qualified Personnel).

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency
HHSC

Frequency of Verification:

The provider agency verifies provider qualifications prior to hiring. HHSC verifies provider qualifications during annual on-site reviews.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Employment Assistance

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The service provider must be at least 18 years of age, maintain current driver's license and insurance if transporting individual, and satisfy one of these options:

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

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

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

The provider cannot be the individual's legally authorized representative or if the individual is a minor the spouse of the legally authorized representative.

The provider of Employment Assistance must complete initial and periodic training provided by the individual/employer in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 9, §9.579(d), (relating to Certification

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer and financial management services agency
HHSC

Frequency of Verification:

Individual/employer and financial management services agency verify provider qualifications prior to hiring.
HHSC verifies provider qualifications during on-site reviews, completed every three years at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Minor Home Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

This service component provides physical adaptations to an individual's home that are required to address specific needs identified by an individual's service plan. Minor Home Modifications are necessary to ensure the health, welfare, and safety of the individual, or to enable the individual to function with greater independence in his or her home. Without the Minor Home Modification, the individual would require institutionalization.

Minor Home Modifications may include the installation of ramps and grab bars, widening of doorways, and other specialized accessibility adaptations, modification of kitchen and bathroom facilities, or safety adaptations necessary for the welfare of the individual.

Excluded are those adaptations or improvements to the home, which are of general utility, and are not of direct medical or remedial benefit to the individual. Examples of items excluded are installation of carpeting, roof repair, installation of central air conditioning, major home renovations, and construction of additional rooms or other modifications, which add to the total square footage of the home.

All Minor Home Modifications must be authorized by the individual's service planning team. Any modification or combination of modifications costing more than $1,000 must be authorized by the team based on prior written evaluations and recommendations from the individual's physician, a licensed occupational or physical therapist, or a psychologist or behavior analyst qualified to assess the individual's need for the specific Minor Home Modification. The written evaluation must document the necessity and appropriateness of the Minor Home Modification to meet the specific needs of the individual.

Minor Home Modifications must be provided in accordance with applicable state or local building codes and are limited to the following categories including the repair and/or maintenance of modifications:

(A) Purchase or repair of wheelchair ramps
(B) Modifications to bathroom facilities
(C) Modifications to kitchen facilities
(D) Specialized accessibility and safety adaptations

The complete list of billable Minor Home Modifications can be found at:
https://hhs.texas.gov/laws-regulations/handbooks/texas-home-living-txhml-program-billing-guidelines/appendices/appendix-v-billable-minor-home-modifications

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

The maximum lifetime expenditure for this service component is $7,500. Once that maximum is reached, $300 per service plan year per individual will be allowed for repair, replacement, or additional modifications.

If necessary, an individual's service coordinator assists the individual in locating additional resources through family or local community organizations, including the local intellectual and developmental disability authority, and other natural supports or seeking funding through non-waiver resources. To the extent that the above efforts are unsuccessful, and the State finds that the absence of sufficient service(s) prevents HHSC from assuring the individual's health and welfare in the community, the following will apply.

- The individual will be given an opportunity to request services through another existing home and community-based service program for which the individual may be eligible;
- The individual will be assisted in seeking admission to an intermediate care facility, if appropriate; and
- The individual will be informed of and given the opportunity to request a fair hearing in accordance with Title 1 of the Texas Administrative Code, Chapter 357, Subchapter A, if the State proposes to terminate the individual's waiver eligibility.

To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a TxHmL Provider Agreement
Individual	Consumer directed services direct service provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Minor Home Modifications

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Qualified contractors provide minor home modifications in accordance with state and local building codes and other applicable regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency
HHSC

Frequency of Verification:

Prior to completing service agreement and during annual on-site reviews

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Minor Home Modifications

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Qualified contractors provide Minor Home Modifications in accordance with state and local building codes and other applicable regulations.

The provider cannot be the Individual's legally authorized representative or the spouse of the legally authorized representative.

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer and financial management services agency
HHSC

Frequency of Verification:

Individual/employer and financial management services agency verify provider qualifications prior to hiring.
HHSC verifies provider qualifications during on-site reviews, completed every three years at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

The Nursing service component provides treatment and monitoring of health care procedures prescribed by a physician/medical practitioner and/or required by standards of professional practice or state law to be performed by licensed nursing personnel.

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

Nursing is provided under this waiver if no other financial resource for such service is available or if other available resources have been used. Individuals who are under 21 years of age must access Nursing benefits through the Texas Health Steps--Comprehensive Care Program (EPSDT) before Nursing may be provided under this waiver. All medically necessary Nursing Services for children under the age of 21 are covered in the State plan pursuant to the EPSDT benefit, except for nursing tasks that are required for the provision of a waiver service.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer directed services direct service provider
Agency	Agencies holding a TxHmL Provider Agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

Registered Nurse
(Texas Occupations Code Chapter 301)

Licensed Vocational Nurse
(Texas Occupations Code Chapter 301)

Certificate *(specify):*

N/A

Other Standard *(specify):*

The provider cannot be the individual's legally authorized representative or the spouse of the legally authorized representative.

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer and financial management services agency
HHSC

Frequency of Verification:

Individual/employer and financial management services agency verify provider qualifications prior to hiring.
HHSC verifies provider qualifications during on-site reviews, completed every three years at a minimum.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License *(specify):*

Registered Nurse
(Texas Occupations Code Chapter 301)

Licensed Vocational Nurse
(Texas Occupations Code Chapter 301)

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency
HHSC

Frequency of Verification:

The provider agency verifies provider qualifications prior to completing the service agreement; and prior to expiration of license. HHSC verifies provider qualifications during annual on-site reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Occupational Therapy Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Occupational Therapy services consists of the full range of activities provided by a licensed occupational therapist, or a licensed occupational therapy assistant, under the direction of a licensed occupational therapist, within the scope of state licensure. Texas assures that Occupational Therapy is cost-effective and necessary to avoid institutionalization. The scope of Occupational Therapy services offered in this waiver exceeds the Medicaid state plan occupational therapy benefit. Under the waiver, Occupational Therapy will be provided to maintain the individual's optimum condition. Services include:

- Screening and assessment;
- Development of therapeutic treatment plans;
- Direct therapeutic intervention;
- Assistance, and training with adaptive aids and augmentative communication devices
- Consulting with other service providers and family members; and
- Participating on the service planning team, when appropriate.

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

Occupational Therapy is provided under this waiver when no other financial resource for such therapy is available or when other available resources have been used. This waiver service is only provided to individuals age 21 and over. All medically necessary Occupational Therapy services for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a TxHmL Provider Agreement
Individual	Consumer directed services direct service provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Occupational Therapy Services

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License *(specify):*

Occupational Therapist
(Texas Occupations Code Chapter 454)

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency

HHSC

Frequency of Verification:

The provider agency verifies provider qualifications prior to completing service agreement; and prior to expiration of license. HHSC verifies provider qualifications during annual on-site reviews.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Occupational Therapy Services

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

Occupational Therapist
(Texas Occupations Code Chapter 454)

Certificate *(specify):*

N/A

Other Standard *(specify):*

The provider cannot be the participant's legally authorized representative or the spouse of the legally authorized representative.

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer and financial management services agency

HHSC

Frequency of Verification:

Individual/employer and financial management services agency verify provider qualifications prior to hiring.
HHSC verifies provider qualifications during on-site reviews, completed every three years at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Physical Therapy Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Physical Therapy services consist of the full range of activities provided by a licensed physical therapist, or a licensed physical therapy assistant under the direction of a licensed physical therapist, within the scope of his state licensure. The scope of Physical Therapy services offered in this waiver exceeds the Medicaid state plan physical therapy benefit. Under the waiver, Physical Therapy will be provided to maintain the individual's optimum condition. Services include:

- Screening and assessment;
- Development of therapeutic treatment plans;
- Direct therapeutic intervention;
- Assistance, and training with adaptive aids and augmentative communication devices
- Consulting with other service providers and family members; and
- Participating on the service planning team, when appropriate.

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

Physical Therapy is provided under this waiver if no other financial resource for such therapy is available or if other available resources have been used. This waiver services is only provided to individuals age 21 and over. All medically necessary Physical Therapy services for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer directed services direct service provider
Agency	Agencies holding a TxHmL Provider Agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Physical Therapy Services

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

Physical Therapist
(Texas Occupations Code Chapter 453)

Certificate *(specify):*

N/A

Other Standard *(specify):*

The provider cannot be the participant's legally authorized representative or the spouse of the legally authorized representative.

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer and financial management services agency
HHSC

Frequency of Verification:

Individual/employer and financial management services agency verify provider qualifications prior to hiring.
HHSC verifies provider qualifications during on-site reviews, completed every three years at a minimum.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Physical Therapy Services

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License *(specify):*

Physical Therapist
(Texas Occupations Code Chapter 453)

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency

HHSC

Frequency of Verification:

The provider agency verifies provider qualifications prior to completing service agreement; and prior to expiration of license. HHSC verifies provider qualifications during annual on-site reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Speech-Language Pathology

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Speech-Language Pathology services consist of the full range of activities provided by a licensed Speech-Language Pathologist, or a licensed associate in Speech-Language Pathology, under the direction of a licensed Speech-Language Pathologist, within the scope of licensure. Services include:

- Screening and assessment;
- Development of therapeutic treatment plans;
- Direct therapeutic intervention;
- Assistance, and training with adaptive aids and augmentative communication devices
- Consulting with other service providers and family members; and
- Participating on the service planning team, when appropriate.

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

Speech-Language Pathology services are provided under this waiver if no other financial resource for such therapies is available or if other available resources have been used. This waiver service is only provided to individuals age 21 and over. All medically necessary Speech-Language Pathology services for children under the age of 21 are covered in the state plan pursuant to the EPSDT benefit.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer directed services direct service provider
Agency	Agencies holding a TxHmL Provider Agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Speech-Language Pathology

Provider Category:

Individual

Provider Type:

Consumer directed services direct service provider

Provider Qualifications

License *(specify):*

Speech-Language Pathologist,
Audiologist (Texas Occupations Code Chapter 401)

Certificate *(specify):*

N/A

Other Standard *(specify):*

The provider cannot be the individual's legally authorized representative or the spouse of the legally authorized representative.

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer and financial management services agency
HHSC

Frequency of Verification:

Individual/employer and financial management services agency verify provider qualifications prior to hiring.
HHSC verifies provider qualifications during on-site reviews, completed every three years at a minimum.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Speech-Language Pathology

Provider Category:

Agency

Provider Type:

Agencies holding a TxHmL Provider Agreement

Provider Qualifications

License *(specify):*

Speech-Language Pathologist,
Audiologist (Texas Occupations Code Chapter 401)

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider agency
HHSC Waiver Survey and Certification

Frequency of Verification:

The provider agency verifies provider qualifications prior to completing service agreement; and prior to expiration of license. HHSC verifies provider qualifications during annual on-site reviews.

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☒ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

HHSC contracts with local community centers, established in accordance with Texas Health and Safety Code, Chapter 534, and with a local Council of Government established in accordance with Texas Local Government Code, Chapter 391. These entities have been designated by HHSC as local intellectual and developmental disability authorities in accordance with Texas Health and Safety Code, §533.035, and as part of their contractual responsibilities provide targeted case management for TxHmL waiver program individuals.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

TxHmL providers, individuals/employers, and financial management services agencies must comply with the Title 4 of the Texas Health and Safety Code, Chapter 250, including taking the following actions regarding applicants, contractors, and employees:

- Obtain Texas criminal history record information from the Texas Department of Public Safety that relates to an unlicensed applicant, volunteer, contractor, or employee whose duties would or do involve direct contact with an individual; and
- Refrain from employing or contracting with, or immediately discharge, a person who has been convicted of an offense that bars employment under Title 4 of the Texas Health and Safety Code, Chapter 250, §250.006(a), or an offense that the provider or participant employer determines is a contraindication to the person's employment to contract to provide services to the individual.

Individuals choosing to self-direct services must choose a financial management services agency that provides guidance and assistance to the individual with employer-related tasks.

Financial management services agencies must complete a criminal history check before a person may become an employee, volunteer, or a contractor, in compliance with Title 40 of the Texas Administrative Code, Part 1, Chapter 41, and Title 40 of the Texas Administrative Code, Part 1, Chapter 49. Financial management services agencies and individual/employers or their designated representative must comply with rules in Title 40 of the Texas Administrative Code, Part 1, Chapter 41. These rules require a criminal history check before a person may become an employee or a contractor of the individual/employer in compliance with Title 40 of the Texas Administrative Code, Part 1, Chapter 41. If contracting with a service provider, the employer or designated representative must complete an agreement with the entity certifying that the entity has checked and verified that each person delivering a service to the individual on behalf of the entity has not been convicted of an offense listed in Title 4 of the Texas Health and Safety Code, Chapter 250, §250.006(b) within the previous five years. The financial management services agency is required to have verification of criminal history checks prior to the individual-employer hiring a contractor or employee.

All TxHmL providers, financial management services agencies, and individuals/employers are required to maintain documentation of the criminal history checks performed.

Financial management services agencies, TxHmL providers and local intellectual and developmental disability must screen all employees and contractors for exclusion prior to hiring or contracting, and on an ongoing monthly basis, by searching both the State and federal Office of Inspector General lists of excluded individuals and entities. All TxHmL providers must develop and implement written policies and procedures that require the provider to review the list of excluded individuals and entities at the Texas HHSC Office of Inspector General website and the federal HHSC Office of Inspector General website before hiring or contracting with a person or entity and at least once a month while the provider employs or contracts with the person or entity. If any exclusion is discovered the provider must immediately report the findings to HHSC.

Financial management services agencies are required to document and maintain the time and the result of the registry check on the HHSC Criminal Conviction History and Registry Checks form which is reviewed by HHSC during a monitoring review and may be reviewed during a complaint investigation.

During the on-site reviews, HHSC verifies that the financial management services agencies, TxHmL providers and local intellectual and developmental disability agencies have conducted screening for exclusion and performed other applicable registry checks.

In addition, regulatory boards (e.g., Texas Board of Nursing) conduct criminal background checks on licensed professionals and HHSC ensures during surveys that licenses are appropriate as part of the licensing process.

As part of on-site reviews of providers and financial management services agencies, HHS monitors if criminal history checks are conducted as required.

Providers, employers, and financial management services agencies must comply with the Texas Health and Safety Code, Chapters 250 and 253, including taking the following action regarding applicants, contractors, and employees:

- annually search the Nurse Aide Registry maintained by HHSC in accordance with Texas Health and Safety

Code, Chapter 250, and refrain from employing or contracting with, or immediately discharge, a person who is designated in the registry as having abused, neglected, or mistreated an individual receiving services or has misappropriated an individual's property; and

- annually search the Employee Misconduct Registry maintained by HHSC, in accordance with Texas Health and Safety Code, Chapter 253, and refrain from employing or contracting with or immediately discharge, a person whose duties would or do involve direct contact with an individual, and who is designated in the registry as having abused, neglected, or exploited an individual or has misappropriated an individual's property.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Providers, individuals/employers, and financial management services agencies are also required to perform Nurse Aide Registry and Employee Misconduct Registry checks on contractors.

HHSC staff that are involved in licensure, survey, and enforcement activities select a sample of individuals' records for monitoring as part of their reviews of providers, to verify if Nurse Aide Registry and Employee Misconduct Registry checks are being conducted as required.

Providers, financial management services agencies, and individual/employers are required to maintain documentation of the Nurse Aide Registry and Employee Misconduct Registry checks that they performed. Financial management services agencies and individual/employers document results on the Criminal Conviction History and Registry Checks form for all service providers who are not licensed. The appropriate licensure boards are responsible for monitoring licensed professionals.

Each individual who chooses self-direction must choose a financial management services agency that provides guidance and assistance to the individual with employer-related tasks. The financial management services agency is required to have verification of registry checks prior to hiring on behalf of the individual.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Required information is contained in response to C-5	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Required information is contained in response to C-5

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Required information is contained in response to C-5

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Minor Home Modifications	☐
Physical Therapy Services	☐
Behavioral Support	☐
Occupational Therapy Services	☐
Dental Treatment	☐
Support Consultation	☐
Audiology Services	☐
Day Habilitation	☐
Adaptive Aids	☐
Nursing	☐
Respite	☒
Community Support	☐
Dietary Services	☐
Supported Employment	☐
Financial Management Services	☐
Prescription Medications	☐
Employment Assistance	☐
Speech-Language Pathology	☐

Facility Capacity Limit:

Required information is contained in response to C-5

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☐
Sanitation	☐
Safety	☐
Staff : resident ratios	☐
Staff training and qualifications	☐
Staff supervision	☐
Resident rights	☐
Medication administration	☐
Use of restrictive interventions	☐
Incident reporting	☐
Provision of or arrangement for necessary health services	☐

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Required information is contained in response to C-5

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

◉ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

○ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

☐ **Self-directed**

☐ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

◉ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives and guardians, who are not legally responsible for the individual, and who meet qualifications, may provide TxHmL service components with the following exceptions: Community Support and Respite may not be provided by persons, including guardians and relatives, who live with the individual. Guardians and persons related to the individual within the fourth degree of consanguinity or within the second degree of affinity may not provide Behavioral Support services or Adaptive Aids for the individual.

Documentation requirements are the same for relatives and guardians who are service providers as for all other service providers. Program providers must assure completion of required documentation and financial management services agencies require submission of required documentation before paying the provider of services and submitting a billing claim.

During scheduled billing and payment reviews of TxHmL program providers and reviews of financial management services agencies, HHSC determines compliance with policies concerning eligibility of individual providers and completion of required documentation.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The following processes are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:
In order to obtain a provider agreement as a TxHmL program provider, a provider applicant must apply for such in accordance with Title 40 of the Texas Administrative Code Part 1, Chapter 49, relating to Contracting for Community Services.

Entities interested in becoming financial management services agencies must also participate in training and pass a knowledge test in order to obtain a Medicaid provider agreement.

Providers currently contracted as providers in the Home and Community-based Services program (HCS) (waiver # 0110) may also be enrolled as TxHmL program providers under the following conditions.

---Upon request of a provisionally certified HCS provider, HHSC may provisionally certify the HCS provider as a TxHmL provider. HHSC provisionally certifies only those HCS applicants that:
(A) Complete provider applicant traning and recieve a score of 85 percent on the provider competency exam; and
(B) Comply with all requirements of Title 40 of the Texas Administrative Code, Part 1, Chapter 49.

Upon request of an HCS provider that is certified, HHSC may certify the provider as a TxHmL provider. An HCS provider becomes certified after passing a certification review conducted by HHSC no later than 120 days following the enrollment of the provider’s first consumer.

Qualified TxHmL program providers agree to provide all TxHmL program services. This model of service delivery has been approved by CMS since 1985 and is in use in other currently CMS-approved Texas home and community- based services waivers. This model of service delivery accomplishes the following for individuals receiving TxHmL program services:
- ensures the availability of each service component across the state, even in rural areas where--without the use of our current definition of qualified provider--not all service components of the waiver would be readily accessible;
- recognizes that a vast majority of individuals are not single service users but require supports across service disciplines that must be closely integrated and coordinated to achieve beneficial outcomes;
- promotes effective response to temporary or permanent changes in individuals service needs as provider agencies are required to make all services components available when and as they are needed by individuals;
- establishes a single point of accountability for provision of needed services; and
- decreases administrative costs.

In addition to promoting efficient service delivery, the TxHmL program service delivery model does not compromise an individual’s choice of qualified provider agencies or providers of individual service components. In all 254 counties, no matter how sparsely populated, individuals have a choice between at least two provider agencies. In most cases, individuals have a choice among numerous provider agencies. With regard to an individual’s choice of an individual to provide a particular service component, state rules governing the operation of the TxHmL program set forth in Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter N, §9.579(c), require the TxHmL program provider agency to employ or contract with a service provider of the individual's or legally authorized representative's choice if that service provider:
(1) is qualified to provide the service component;
(2) will provide the service within the direct services portion of the applicable TxHmL program rate and;
(3) will contract with or be employed by the program provider.

Information for obtaining a TxHmL contract is provided by contacting the HHSC Community Services Contracts unit.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services

are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
C.a.1 Number and percent of newly enrolled contracted providers that initially met contract requirements before providing services. N: Number of newly enrolled contracted providers that initially met contract requirements before providing services. D: Number of newly enrolled contracted providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
System of Contract Operation and Reporting

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
C.a.2 Number and percent of active, surveyed contracts for which the provider met contract requirements following enrollment and continually thereafter. N: Number of active, surveyed contracts for which the provider met contract requirements following enrollment and continually thereafter, as evidenced by the avoidance of decertification or vendor hold. D: Number of active, surveyed contracts.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Client Assignment and Registration System

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

(check each that applies):		
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
C.a.3 Number and percent of surveys for which the provider met contract requirements following enrollment and continually thereafter. N: Number of surveys for which the provider met contract requirements following enrollment and continually thereafter, as evidenced by the avoidance of decertification or vendor hold. D: Number of surveys conducted.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Client Assignment and Registration System

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
C.a.4 Number and percent of contracts surveyed according to the schedule required by policy, to ensure that providers are continually meeting all standards. N: Number of contracts surveyed according to the schedule required by policy, to ensure that providers are continually meeting all standards. D: All contracts meeting the requirements for a scheduled survey.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Client Assignment and Registration System

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
C.a.5 Number and percent of contracts released from vendor hold. N: Number of contracts released from vendor hold. D: Number of contracts released from vendor hold plus those moved to decertification because of a failure to be released from vendor hold.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Contract Monitoring Database

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

Data Aggregation and Analysis:

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

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

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

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

Performance Measure:
C.b.1 Number and percent of newly enrolled financial management services agencies that met initial qualifications. N: Number of newly enrolled financial management services agencies that met initial qualifications. D: Number of newly enrolled financial management services agencies.

Data Source (Select one):
Other
If 'Other' is selected, specify:
System of Contract Operation and Reporting

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

Data Aggregation and Analysis:

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

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

Performance Measure:
C.b.2 Number and percent of monitored FMSA legal entities that continually met contract monitoring requirements, evidenced by an overall monitoring score of at least 90%. N: Number of monitored FMSA legal entities that continually met contract monitoring requirements, evidenced by an overall monitoring score of at least 90%. D: Number of FMSA legal entities monitored using the CDS-Program Tool.

Data Source (Select one):
Other
If 'Other' is selected, specify:
System of Contract Operation and Reporting

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

	Ongoing	Specify: FMSA legal entities are selected for monitoring based on contract effective date, previous formal monitoring exit date, overall compliance score of the previous formal monitoring, and expenditures.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
C.b.3 Number and percent of monitored FMSA legal entities that continually met

fiscal monitoring requirements, evidenced by an overall monitoring score of at least 90%. N: Number of monitored FMSA legal entities that continually met fiscal monitoring requirements, evidenced by an overall monitoring score of at least 90%. D: Number of FMSA legal entities monitored using the CDS-Tax Tool.

Data Source (Select one):
Other
If 'Other' is selected, specify:
System of Contract Operation and Reporting

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: FMSA legal entities are selected for monitoring based on contract effective date, previous formal monitoring exit date, overall compliance score of the previous formal monitoring, and expenditures.

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

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

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

Performance Measure:
C.c.1 Number and percent of providers meeting provider training requirements according to the approved waiver. N: Number of providers meeting provider training requirements according to the approved waiver. D: Number of providers that required training.

Data Source (Select one):
Other

If 'Other' is selected, specify:

System of Contract Operation and Reporting

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

Data Aggregation and Analysis:

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

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

Performance Measure:
C.c.2 Number and percent of financial management services agencies that attended all required training in accordance with the approved waiver. N: Number of financial management services agencies that attended all required training in accordance with the approved waiver. D: Number of financial management services agencies requiring training.

Data Source (Select one):
Other
If 'Other' is selected, specify:
System of Contract Operation and Reporting

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

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

Data Aggregation and Analysis:

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

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

During initial on-site and annual certification reviews of TxHmL program providers, HHSC Waiver, Survey, and Certification verify that all minimum provider qualifications are met and required training has been accomplished through personnel records review.

b. Methods for Remediation/Fixing Individual Problems

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

Certification Survey
If HHSC determines after an initial or annual survey that the TxHmL provider is in compliance with all certification principles, HHSC certifies the TxHmL provider. If HHSC determines based on a survey that the TxHmL provider is not in compliance with the certification principles, HHSC may take one or more of the follow actions: request a plan of correction, impose an administrative penalty; request written evidence of correction; conduct a survey or onsite visit; impose a vendor hold; or deny certification.

Plan of correction
A TxHmL provider's plan of correction must specify the date by which corrective action will be completed for each violation, and such date must for a violation that is a condition of a serious nature, as stated in the preliminary survey report be no later than 30 calendar days after the date of the survey exit conference, and for a violation, that is not a condition of a serious nature be no later than 45 calendar days after the date of the survey exit conference.

If HHSC approves the plan of correction; the TxHmL provider must complete the corrective action in accordance with the plan of correction. If HHSC does not approve the plan of correction, the TxHmL provider must submit a revised plan of correction

Verification of corrective action:
HHSC may:
- request that the TxHmL provider submit written evidence of correction to HHSC; or
- conduct a survey or an on-site visit for a violation that is:
- a condition of a serious nature that is determined by HHSC to be a critical violation no sooner than 31 calendar days after the survey exit conference; and
- not a condition of a serious nature that is determined by HHSC to be a non-critical violation, no sooner than 46 calendar days after the survey exit conference.

Administrative Penalties
HHSC may impose and collect an administrative penalty against a TxHmL provider for a violation of a certification principle contained in the Texas Administrative Code pertaining to the TxHmL program. HHSC may also impose and collect an administrative penalty against a TxHmL provider for any of the following actions: making a false statement of a material fact the program provider knows or should know is false with respect to a matter under investigation by HHSC; falsifying documentation; or willfully interfering with the work of a representative of HHSC.

Vendor Hold
If HHSC implements a vendor hold against the TxHmL provider, HHSC conducts a second on-site follow-up review between 30 and 45 calendar days after the effective date of the vendor hold. Based on the results of the review, HHSC may certify the TxHmL provider and remove the vendor hold or may deny certification of the TxHmL provider and initiate termination of the Medicaid provider agreement.

Contracts Monitoring Review: Financial Management Services Agencies
Throughout the HHSC review of financial management services agencies, technical assistance is shared with providers. If during a contract monitoring review, a financial management services agency is discovered to not have met Medicaid provider agreement requirements the agency is required to submit a corrective action plan to HHSC. The corrective action plan must contain the following elements: the title of the person responsible for the action; the description of the action to be accomplished; the date the action will be implemented; and the action to ensure compliance.

Corrective action plan
Upon submittal, HHSC reviews the corrective action plan and either approves or, if the submitted plan does not include all of the required elements, requests revisions and resubmission of the plan. Financial management services agencies are informed that their failure to ensure HHSC receives an acceptable corrective action plan by the date specified by HHSC may result in HHSC taking adverse action against the agency, up to and including termination of the Medicaid provider agreement. HHSC monitors the corrective action plan until the financial management services agency is in compliance.

Sanction Action Review Committee
HHSC staff submits Medicaid provider agreement/contract action recommendations for financial management services agencies to the Sanction Action Review Committee when a complaint investigation against a financial management services agency substantiates a reported allegation or staff recommend the agency receive a contract action/sanction greater than a corrective action plan. Sanction Action Review Committee members review the monitoring review results and, if applicable, review complaint investigation findings to ensure the circumstances support the recommended provider agreement/contract action. The Sanction Action Review Committee makes a decision on the appropriate action to take, including submission of a corrective action plan; placing a hold on individual referrals for new clients; placing a hold on provider payments; financial recoupment; involuntary contract termination; and debarment.

Annual monitoring by HHSC includes reviewing data from the quarterly quality measures and annual CMS 372 reports and implementing the Quality Review Team processes. The Quality Review Team meets quarterly and reviews comprehensive quality reports from each waiver at least annually. These reports include data on all of the waiver's quality improvement strategy measures. These reports also include remediation activities and outcomes. Improvement plans are developed as issues are identified by HHSC, and the Quality Review Team reviews, modifying if needed, and approves all improvement plans. All active improvement plans for all waivers are monitored at each quality review team meeting.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR

441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

HHSC is still assessing settings compliance in accordance with the settings transition plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person-directed Plan (PDP)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker**
Specify qualifications:

☒ **Other**
Specify the individuals and their qualifications:

To support the philosophy of person-directed planning, service plans in TxHmL are actually comprised of three documents. The three documents include the person-directed plan, the implementation plan, and the individual plan of care. The local intellectual and developmental disability authority service coordinator in conjunction with the individual and legally authorized representative is responsible for developing the person-directed plan, which outlines the individual's desired outcomes and goals for waiver services and identifies the service components of the waiver the individual needs to meet their desired outcomes. Service coordinators must be employees of the local intellectual and developmental disability authorities to provide service coordination to individuals in this waiver and must meet the following criteria:

1. Have a bachelor's or advanced degree from an accredited college or university with a major in a social, behavioral, or human service field, including psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human development, gerontology, educational psychology, education, and criminal justice; or

2. Have a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma with two years of paid experience as a case manager in a state or federally funded Parent Case Management program or have graduated from Partners in Policy Making, and personal experience as an immediate family member of an individual with an intellectual and developmental disability.

Based on the person-directed plan, the service coordinator, individual, legally authorized representative and the program provider develop the service plan. The service plan identifies the amount needed for each waiver service component that is identified in the person-directed plan.

The program provider, the individual, and legally authorized representative develop the implementation plan document. This plan outlines how, through the provision of each waiver service component, the program provider will support the individual to achieve his or her desired outcome for each waiver service component. This plan outlines the schedule for service provision and provides detail regarding how each service component will help achieve the individual's desired outcome for the service.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

The State permits an individual's TxHmL waiver service provider to be responsible for the individual's person-centered service plan only when there is no other entity available, other than the individual's TxHmL waiver service provider, who can develop the person-centered service plan.

As noted in Appendix C-1 (c), HHSC contracts with local community centers, established in accordance with Texas Health and Safety Code, Chapter 534, and with a local Council of Government established in accordance with Texas Local Government Code, Chapter 391. These entities have been designated by HHSC as local intellectual and developmental disability authorities in accordance with Texas Health and Safety Code, §533.035, and, as part of their contractual responsibilities, provide targeted case management for TxHmL waiver program individuals. A community center, in its role as a local intellectual and developmental disability authority, provides service coordination to individuals in TxHmL programs consistent with the provisions relating to targeted case management for persons with intellectual and developmental disabilities contained in the approved Texas Medicaid state plan. Under those provisions, employees of local intellectual and developmental disability authorities are authorized to provide targeted case management. Recipients may request a change in service coordinators from the local intellectual and developmental disability authority, but the service coordinator must be an employee of the local intellectual and developmental disability authority serving the geographic area where the recipient receives TxHmL program services.

Entities that develop the service plan and provide services are not able to do so without prior approval by the State. The community center or local intellectual and developmental disability authority may also hold a Health and Human Services Texas Medicaid Provider Agreement (contract) with the Health and Human Services Commission (HHSC) to provide waiver services. However, under the provisions of the performance agreement between HHSC and the local community center, a person who provides service coordination to an individual is prohibited from providing any other direct waiver service to that individual. The service coordinator may not provide other waiver services to the individual.

The local intellectual and developmental disability authority is held responsible for ensuring that service plan monitoring occurs as stated in the individual's person directed plan, required documentation is completed, and appropriate follow-up actions on monitoring findings are taken.
HHSC provides oversight of the local intellectual and developmental disability authority's role through an annual on-site review during which the local intellectual and developmental disability authority's compliance with provisions of the state rules governing the TxHmL program and the performance contract is evaluated.

The TxHmL program service delivery model does not compromise an individual's choice of qualified provider agencies or providers of individual service components. In all 254 counties individuals have a choice between at least two provider agencies. A LIDDA service coordinator informs applicants/individuals of all services available under the waiver at enrollment and upon renewal. Individuals are informed no less than annually of their right to choose another TxHmL provider at any time by requesting assistance from their service coordinator.

HHSC monitoring elements include verification of freedom of choice of providers, verification that a complete list of available providers have been given to individuals and that individuals are informed no less than annually of their right to choose another TxHmL provider at any time by requesting assistance from their service coordinator. Additionally, DADS Regulatory conducts certification reviews at least annually of all TxHmL providers who hold Medicaid provider agreements and who are providing services to at least one individual, at which time a sample of individuals, legally authorized representatives, or both are interviewed and records are reviewed to determine whether the TxHmL provider is in compliance with all of the TxHmL certification principles.

There is always a choice of waiver service providers outside the LIDDA entity. Additionally, the LIDDA is required to ensure an individual is informed orally and in writing of the process for filing complaints. Individuals in TxHmL must be provided the toll-free telephone number to the HHSC Intellectual and Developmental Disability Ombudsman (IDD Ombudsman) to file complaints regarding service provision or service coordination. The IDD Ombudsman will conduct an investigation of all complaints received, other than those for abuse, neglect and exploitation. Any unresolved complaints will be forwarded to the appropriate department for additional follow-up.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The service coordinator assures that the applicant/individual and legally authorized representative participate in developing a person-directed plan that meets the individual's identified needs and service outcomes. The service coordinator supports the individual and legally authorized representative in setting goals that address the needs identified during assessment and educating the individual or legally authorized representative about service delivery options and the services available through the TxHmL program to achieve these goals. The person-directed plan must be developed in accordance with "Person Directed Planning and Family Directed Planning Guidelines for Individuals Living in the Community." The service coordinator must inform the applicant/individual or legally authorized representative orally and in writing of the eligibility criteria for participation in the TxHmL program, the services and supports provided by the TxHmL program and the limits on those services and supports, and the reasons an individual may be terminated from the TxHmL program.

The local intellectual and developmental disability authority must assure that the individual and family or legally authorized representative as appropriate, can contact the service coordinator to secure information regarding services and supports and service delivery options, and can request to change the person-directed plan and services due to changes in needs, goals, or preferences. At least annually, the service coordinator must present information to the individual or legally authorized representative regarding available waiver services and supports and the available service delivery options.

The service planning team consists of the applicant or individual, legally authorized representative, service coordinator, and other people such as family members, service providers, or friends chosen or designated by the applicant, individual, or legally authorized representative to participate in service planning.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The local intellectual and developmental disability authority must assure that a service coordinator initiates, coordinates and facilitates the person-directed planning process so that an individual's service plan addresses the desires and needs as identified by an individual and legally authorized representative. The service coordinator, the individual or legally authorized representative, and others (e.g., family, friends, or service providers) as chosen or designated by the individual or legally authorized representative comprise the service planning team. The service planning team must develop an initial service plan based on the person-directed plan for each applicant within 45 business days of the date an applicant or legally authorized representative chooses the TxHmL program. At least annually, the service planning team and TxHmL provider must review the individual's person-directed plan and initiate changes in the service plan in response to changes in the individual's needs and identified outcomes as documented in the person-directed plan. The individual and legally authorized representative must sign the service plan to indicate understanding of and agreement with the plan.

The service planning team must document that the TxHmL program service components identified for inclusion in the service plan are necessary for the individual to live in the community and to prevent his or her admission to institutional services, and are sufficient, when combined with services or supports available from non-TxHmL program sources (if applicable), to assure the individual's health and welfare in the community.

At a minimum, the person-directed plan process and resulting service plan must address the following:
(A) A description of the needs and preferences identified by the applicant/individual and legally authorized representative;
(B) A description of the services and supports the applicant/individual requires to continue living in his or her own home or family home;
(C) A description of the applicant's/individual's current existing natural supports and non-TxHmL program services that will be or are available;
(D) A description of applicant/individual outcomes to be achieved through TxHmL program service components and justification for each service component to be included in the service plan;
(E) Documentation that the type, frequency, and amount of each service component included in the applicant's/individual's service plan do not replace existing natural supports or non-TxHmL program sources for the service components for which the applicant/individual may be eligible; and
(F) A description of actions and methods to be used to reach identified service outcomes, projected completion dates, and person(s) responsible for completion.

The service coordinator assures that the person-directed plan process identifies and focuses on the desires and needs as identified by the applicant/individual and legally authorized representative, and the applicant's/individual's and legally authorized representative's assessment of the services and supports being received in relation to the applicant's/individual's needs, preferences and personal goals. The service coordinator supports the applicant's/individual's and legally authorized representative's participation in the process by encouraging the expression of preferences, goals and ambitions and providing education about the services available through the TxHmL program as well as through other non-waiver resources for which the applicant/individual may be qualified. In addition, formal assessments regarding health, level of functioning, specialized therapeutic interventions are completed as the need is identified by the service planning team. The person-directed plan identifies and addresses risk factors, and specifies the type and frequency of waiver services and non-waiver services (e.g., state plan services) to be included in the service plan to address risk factors as well as the applicant's/individual's other needs, preferences and desired outcomes. The HHSC website provides service coordinators and other service planning team members access to a "Person-directed Plan Discovery Tool," which provides team members a number of probes that may be used to help identify areas of need, goals, abilities and strengths, and preferences.

At enrollment, as requested by the applicant/individual or legally authorized representative, and at least annually, the service coordinator must present information to the applicant/individual or legally authorized representative regarding available services and supports and the available service delivery options. The service coordinator must also inform the applicant/individual or legally authorized representative that the service coordinator assists the applicant/individual or legally authorized representative to transfer the applicant's/individual's TxHmL program services from one program provider to another program provider or financial management service provider to another program provider or financial management service provider as chosen by the applicant/individual or legally authorized representative. The local intellectual and developmental disability authority must assure an applicant/individual or legally authorized representative is informed of the name of the individual's service coordinator and how to contact the service coordinator.

The applicant/individual and legally authorized representative, service coordinator, and other team members work

together to develop a person-directed plan and service plan that integrates TxHmL services and supports and non-waiver services (e.g., state plan services) so that the plan's goals may be achieved and services are complementary and not duplicative.

The person-directed planning process and service plan must include a description of actions and methods to be used to reach identified service outcomes, projected completion dates, and entity or person(s) responsible for implementing the methodology. The service plan must specify the type and amount of each service component to be provided to the applicant/individual, as well as services and supports to be provided by other, non-TxHmL program sources during the service plan year.

The individual's service coordinator is responsible for monitoring the implementation of the service plan. The TxHmL program provider is responsible for ensuring implementation of those TxHmL service components it is assigned to provide while the individual or legally authorized representative electing the consumer directed service option is responsible for ensuring implementation of self-directed services.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

During the service planning process, both the service coordinator and the TxHmL provider ensure consideration of information from the individual, legally authorized representative, other service planning team members, and from assessments to determine any risks that might exist to health and welfare of the individual as a result of living in the community. Strategies, including waiver services and supports and formal and informal non-waiver services and supports, are developed to mitigate these risks, and are incorporated into the service plan.

The discovery process utilized by the service coordinator is designed to address all areas of an individual's life: social inclusion/relationships, health and safety, work/school, self-determination, financial security, living environment, physical/emotional/behavioral, rights/legal status, and daily living skills. Following the discovery process and development of the person-directed plan, the service planning team identifies and documents in the person-directed plan those services that are critical to the health and welfare of the individual for which a backup plan must be developed. Backup plans may use paid or unpaid service providers, other third party resources, and other community resources.

If a service has been identified as needed to ensure health and safety of the individual, but the individual or his or her legally authorized representative refuse the offered service, the service coordinator will monitor the individual's health and safety through the service coordination function. Linkage to non-waiver services and supports may be provided. The Department of Family and Protective Services may be contacted if the individual's health and safety is jeopardized.

The service planning team identifies risk factors for an individual by discussing relevant areas of an individual's life with the individual and legally authorized representative and others who provide supports to the individual and have been invited to participate in the person-centered planning process. An example of risk factors that may affect service planning might be an individual's inability to recognize the possible danger associated with certain strangers.

In the consumer directed services delivery option, the individual/employer is responsible for developing the backup plan(s) and the local intellectual and developmental disability authority service coordinator is responsible for reviewing the backup plan(s) to determine whether the strategies are reasonable and that viable contingencies exist in the event an individual is unable to receive a critical waiver service by their regular direct service provider. If the service coordinator determines a strategy is unreasonable or viable, the service coordinator must support the individual/employer, as needed, to revise the backup plan. The service coordinator may also suggest the individual/employer consider using Support Consultation to assist in the development of a backup plan. The individual/employer is responsible for providing the financial management services agency with a copy of each service backup plan after it has been approved by the service planning team. The service coordinator must conduct and document monitoring activities, including: determining whether the individual has made progress toward the outcomes identified on the person-directed plan; determining whether TxHmL service(s) are being delivered, including the delivery of services included in backup plans, as needed, by the TxHmL provider or Financial Management Services as appropriate; determining whether non-waiver services are being delivered; ensuring coordination and compatibility of waiver and non-waiver services with the TxHmL provider; and determining whether the individual's health or safety is at risk in the environments where the individual receives waiver and non-waiver services and if necessary taking action to protect the individual's health and safety. Action may include addressing the risk with the TxHmL provider or notifying the appropriate authorities.

If as a result of monitoring the service coordinator identifies a concern with an individual's progress toward outcomes in the person-directed plan, the delivery of TxHmL services, including implementation of the backup plan or the individual's health and safety, the service coordinator must communicate such concern to the TxHmL provider via a mechanism determined by the local intellectual and developmental disability authority and TxHmL provider. The service coordinator and the TxHmL provider are responsible for resolving any identified concern. If the concern cannot be resolved, the service coordinator may report the concern to HHSC Consumer Rights and Services.

Title 40 of the Texas Administrative Code Part 1, Chapter 9, Subchapter N requires the TxHmL program provider to ensure the continuous availability of trained, qualified employees and contractors to provide the services in a service plan. Thus, program providers must implement plans that adequately prevent service interruptions or delays that may place the individual's health or safety at risk.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Rules governing the TxHmL program (Title 40 of the Texas Administrative Code Part 1, Chapter 9, Subchapter N) require a local intellectual and developmental disability authority to:

(A) provide a list to the individual or legally authorized representative with contact information for all TxHmL program providers in the local intellectual and developmental disability authority 's local service area;
(B) assist in educating and securing tools for use by the individual or legally authorized representative in evaluating providers' experience and compatibility with the specific needs and preferences of the individual;
(C) arrange for meetings/visits with potential TxHmL program providers as desired by the applicant or the legally authorized representative; and
(D) assure that the applicant's or legally authorized representative's choice of a TxHmL program provider is documented, signed by the individual or the legally authorized representative, and retained by the local intellectual and developmental disability authority in the applicant's record.

These rules also require local intellectual and developmental disability authorities to have a mechanism that assures objectivity in the process it uses to assist an individual or legally authorized representative in the selection of a program provider and a system for training all local intellectual and developmental disability authority staff who may assist an individual or legally authorized representative in such process.

HHSC has also posted on its website an "interview tool" individuals and families may tailor for their own use during the process of provider selection.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

HHSC, the Medicaid agency for the TxHmL waiver program has the responsibility for the day-to-day approval of service plans. HHSC approves all criteria, processes and documentation requirements related to the development and approval of individual service plans. In addition to approving the above systems and processes, HHSC verifies compliance through a look-behind review process for service plans previously approved and those reviewed on-site during the review.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☒ **Medicaid agency**

☐ **Operating agency**

☐ **Case manager**

☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Service coordinators employed by local intellectual and developmental disability authorities monitor implementation of service plans, individual health and welfare, and assess how well services are meeting an individual's needs and enabling the individual to achieve the goals/outcomes described in the person-directed plan. In conducting their monitoring responsibilities, service coordinators must complete contacts in person; the frequency of which is determined by the service planning team and documented in the person-directed plan, but must occur no less frequently than every 90 calendar days. Contacts in addition to the identified minimum may be completed in person or by telephone. The service coordinator must review and document the following:

- whether waiver and non-waiver services and supports are implemented and provided in accordance with the service plan and continue to meet the individual's needs, goals, and preferences;
- whether the individual and legally authorized representative are satisfied with implementation of services;
- whether the individual's health and welfare are reasonably assured;
- whether the individual or legally authorized representative exercises free choice of providers and accesses non-waiver services including health services; and
- for the individual electing the consumer directed services option, whether implementation of the backup plan has been required and, if so, document a determination made with the individual whether or not it was effective; and
- if warranted, the service coordinator assures the backup plan is revised.

The service coordinator takes appropriate actions to address identified problems including counseling with the individual or legally authorized representative, convening a service planning meeting to resolve problems or advocating on the individual's behalf with the TxHmL program provider or non-waiver resources. If monitoring identifies changes in needs or preferences, the service coordinator may convene service planning team meetings to address problems/identified changes or confer with service providers concerning improving implementation strategies. If a self-directing individual's backup plan was not effective, the service coordinator and participant determine the revisions that should be made to the plan. The service coordinator must document in the individual's record that the plan was effective or that revisions were required. The service coordinator assures that a revised backup plan is developed whenever necessary.

Deficiencies in service plan monitoring or implementation noted during HHSC annual or intermittent on-site reviews of program providers are entered into the HHSC Client Assignment and Registration System. Deficiencies in this area are reported annually through the CMS 372(S) report.

b. Monitoring Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

As noted in Appendix C-1 (c), certain local governmental entities are designated as local intellectual and developmental disability authorities. A local governmental entity, in its role as a local intellectual and developmental disability authority, provides service coordination to TxHmL program individuals pursuant to a performance contract with HHSC. The governmental entity may also hold a TxHmL provider agreement with HHSC.

The local intellectual and developmental disability authority is held responsible for ensuring that service plan monitoring occurs as stated in the individual's person-directed plan, required documentation is completed, and appropriate follow-up actions on monitoring findings are taken.

Local intellectual and developmental disability authorities enter into a performance contract with HHSC that prohibits staff providing TxHmL service coordination from providing any other direct "provider" service to the individual through the TxHmL program or other funding source such as state plan services. Rules governing the TxHmL program also prohibit the service coordinator from providing TxHmL services to an individual for whom he or she provides service coordination.

HHSC provides oversight of the local intellectual and developmental disability authority's role through an annual on-site review during which the local intellectual and developmental disability authority's compliance with provisions of the state rules governing the TxHmL program and the performance contract are evaluated.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
D.a.1 Number and percent of individuals with service plans that address their assessed needs, including health and safety risk factors and personal goals. N: Number of individuals with service plans that address their assessed needs, including health and safety risk factors and personal goals. D: Number of individuals with reviewed service plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Client Assignment and Registration System

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

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

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

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

Performance Measure:
D.c.1 Number and percent of service plans that were reassessed and renewed annually prior to the service plan expiration date. N: Number of service plans that were reassessed and renewed annually prior to the service plan expiration date. D: Number of service plans that required annual reassessment and renewal.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Client Assignment and Registration System

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

Data Aggregation and Analysis:

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

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

Performance Measure:
D.c.2 Number and percent of individuals with reviewed service plans that addressed the individual's ongoing needs. N: Number of individuals with reviewed service plans that addressed the individual's ongoing needs. D: Number of individuals with reviewed service plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Client Assignment and Registration System

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.c.3 Number and percent of individuals with reviewed service plans not cited for failure to address changes in the individual's ongoing needs with changes to the service plan. N: Number of individuals with reviewed service plans not cited for failure to address changes in the individual's ongoing needs with changes to the service plan. D: Number of individuals with reviewed service plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Client Assignment and Registration System

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

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
D.d.1 Number and percent of individuals with records that reflected services were delivered according to their service plan, including type, scope, amount, duration, and frequency. N: Number of individuals with records that reflected that services were delivered according to their service plan, including type, scope, amount, duration, and frequency. D: Number of individuals with reviewed records.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Client Assignment and Registration System

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

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

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.e.2 Number and percent of individuals with reviewed records who were afforded choice among waiver providers. N: Number of individuals with reviewed records who were afforded choice among waiver providers. D: Number of individuals with reviewed records.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Contract Accountability and Oversight Performance Contract reviews

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

		For the first 200 people enrolled for a LIDDA, the agency reviews records of 3 persons receiving TxHmL. For each additional 100 persons enrolled, the agency looks at 1 additional record.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.e.3 Number and percent of individuals with reviewed records who were afforded choice between and among waiver services. N: Number of individuals with reviewed records who were afforded choice between and among waiver services. D: Number of

individuals with reviewed records.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Contract Accountability and Oversight Performance Contract reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: For the first 200 people enrolled for a LIDDA, the agency reviews records of 3 persons receiving TxHmL. For each additional 100 persons enrolled, the agency looks at 1 additional record.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

The State uses findings from the National Core Indicators survey for use in trending and analysis.

b. Methods for Remediation/Fixing Individual Problems

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

Certification Survey
If HHSC determines after an initial or annual survey that the TxHmL provider is in compliance with all certification principles, HHSC certifies the TxHmL provider. If HHSC determines based on a survey that the TxHmL provider is not in compliance with the certification principles, HHSC may take one or more of the follow actions: request a plan of correction, impose an administrative penalty; request written evidence of correction; conduct a survey or onsite visit; impose a vendor hold; or deny certification.

Plan of correction
A TxHmL provider's plan of correction must specify the date by which corrective action will be completed for each violation, and such date must for a violation that is a condition of a serious nature, as stated in the preliminary survey report be no later than 30 calendar days after the date of the survey exit conference, and for a violation, that is not a condition of a serious nature be no later than 45 calendar days after the date of the survey exit conference.

If HHSC approves the plan of correction; the TxHmL provider must complete the corrective action in accordance with the plan of correction. If HHSC does not approve the plan of correction, the TxHmL provider must submit a revised plan of correction

Verification of corrective action:
HHSC may:
- request that the TxHmL provider submit written evidence of correction to HHSC; or
- conduct a survey or an on-site visit for a violation that is:
- a condition of a serious nature that is determined by HHSC to be a critical violation no sooner than 31 calendar days after the survey exit conference; and
- not a condition of a serious nature that is determined by HHSC to be a non-critical violation, no sooner than 46 calendar days after the survey exit conference.

Administrative Penalties
HHSC may impose and collect an administrative penalty against a TxHmL provider for a violation of a certification principle contained in the Texas Administrative Code pertaining to the TxHmL program. HHSC may also impose and collect an administrative penalty against a TxHmL provider for any of the following actions: making a false statement of a material fact the program provider knows or should know is false with respect to a matter under investigation by HHSC; falsifying documentation; or willfully interfering with the work of a representative of HHSC.

Vendor Hold
If HHSC implements a vendor hold against the TxHmL provider, HHSC conducts a second on-site follow-up review between 30 and 45 calendar days after the effective date of the vendor hold. Based on the results of the review, HHSC may certify the TxHmL provider and remove the vendor hold or may deny certification of the TxHmL provider and initiate termination of the Medicaid provider agreement.

Contracts Monitoring Review: Financial Management Services Agencies
Throughout the HHSC review of financial management services agencies, technical assistance is shared with providers. If during a contract monitoring review, a financial management services agency is discovered to not have met Medicaid provider agreement requirements the agency is required to submit a corrective action plan to HHSC. The corrective action plan must contain the following elements: the title of the person responsible for the action; the description of the action to be accomplished; the date the action will be implemented; and the action to ensure compliance.

Corrective action plan
Upon submittal, HHSC reviews the corrective action plan and either approves or, if the submitted plan does not include all of the required elements, requests revisions and resubmission of the plan. Financial management services agencies are informed that their failure to ensure HHSC receives an acceptable corrective action plan by the date specified by HHSC may result in HHSC taking adverse action against the agency, up to and including termination of the Medicaid provider agreement. HHSC monitors the corrective action plan until the financial management services agency is in compliance.

Sanction Action Review Committee
HHSC staff submits Medicaid provider agreement/contract action recommendations for financial management services agencies to the Sanction Action Review Committee when a complaint investigation against a financial management services agency substantiates a reported allegation or staff recommend the agency receive a contract action/sanction greater than a corrective action plan. Sanction Action Review Committee members review the monitoring review results and, if applicable, review complaint investigation findings to ensure the circumstances support the recommended provider agreement/contract action. The Sanction Action Review Committee makes a decision on the appropriate action to take, including submission of a corrective action plan; placing a hold on individual referrals for new clients; placing a hold on provider payments; financial recoupment; involuntary contract termination; and debarment.

Annual monitoring by HHSC includes reviewing data from the quarterly quality measures and annual CMS 372 reports and implementing the Quality Review Team processes. The Quality Review Team meets quarterly and reviews comprehensive quality reports from each waiver at least annually. These reports include data on all of the waiver's quality improvement strategy measures. These reports also include remediation activities and outcomes. Improvement plans are developed as issues are identified by HHSC, and the Quality Review Team reviews, modifying if needed, and approves all improvement plans. All active improvement plans for all waivers are monitored at each quality review team meeting.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Participation in the consumer directed services option provides the individual or the legally authorized representative the opportunity to be the employer of persons providing waiver services chosen for self-direction. Each individual or legally authorized representative electing the consumer directed services option must receive support from a Financial Management Services provider referred to as a financial management service agency chosen by the individual or legally authorized representative. The individual or the legally authorized representative is the employer and may appoint a designated representative to assist with employer responsibilities. The individual or legally authorized representative may choose to receive Support Consultation provided by a support advisor.

An individual or the individual's legally authorized representative may choose to direct any service component provided through the waiver as listed in Appendix C except Extended State Plan Services: Prescription Medications.

The traditional agency option is available to provide authorized services that the individual or legally authorized representative elects not to self-direct. Under the traditional agency option, individuals choose a certified and contracted TxHmL program provider capable of delivering the full array of TxHmL program service components.

When choosing to self-direct authorized waiver services, the individual receiving those services or his legally authorized representative is the common-law employer of service providers and has decision-making authority over providers of those services. The employer or designated representative, with the assistance and final approval of the financial management service agency, budgets authorized funds for those services to be delivered through the consumer directed services option. HHSC authorizes the funds for the services allocated for the consumer directed services option on the service plan.

Support Consultation is an optional service available to provide assistance and skills training for the individual, legally authorized representative, or designated representative in meeting employer responsibilities and succeeding in the consumer directed services option. If Support Consultation is authorized by the individual's service planning team, the individual may receive this service from a support advisor associated with a financial management services agency or from a qualified independent support advisor.

The service coordinator informs the individual and legally authorized representative of the option to self-direct available waiver services at the time of enrollment in the waiver and at least annually thereafter. The individual or legally authorized representative may elect at any time to choose the consumer directed services option, terminate participation in the consumer directed services option, or to change financial management services agencies.

The consumer directed services option is available statewide to all TxHmL program participants or their legally authorized representatives.

Entities/individuals involved in supporting participants or participants' legally authorized representatives who are directing services and supports include.

- The individual or legally authorized representative, as the employer, may appoint an adult as a designated representative to assist in meeting employer responsibilities to the extent directed by the employer;
- The individual's service coordinator provides information about the consumer directed services option and monitors service delivery. The case management functions provided by service coordinators are more global than those of the support advisor and apply to self-directed as well as agency-directed waiver services and non-waiver services. Support Consultation is specific to the individual's responsibilities as an employer and successful participation in the consumer directed services option.
- A third-party entity, a financial management services agency, chosen by the individual or legally authorized representative, provides Financial Management Services. The financial management services agency holds a Medicaid provider agreement.
- The individual employer has the option to receive Support Consultation from a certified support advisor of his choice, when authorized in the individual's service plan, to assist in learning and performing employer responsibilities.

To participate in the consumer directed services option, an individual or legally authorized representative must:

- Select a financial management services agency;
- Participate in orientation and ongoing training conducted by the financial management services agency;
- Perform all employer tasks that are required for self-direction or designate a designated representative capable of performing these tasks on the individual's behalf; and
- Maintain a service backup plan for provision of services determined by the service planning team to be critical to the

individual’s health and welfare.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

A service coordinator employed by the local intellectual and developmental disability authority provides the individual and legally authorized representative with a written and oral explanation of the consumer directed services option initially and at least annually to the individual or the legally authorized representative, and it is also provided at any time on request of the individual or the legally authorized representative.

Each individual or legally authorized representative is provided information sufficient to assure informed decision-making and understanding of the consumer directed services option and of the traditional agency option. The information includes the responsibilities and choices individuals can make with the election of the consumer directed services option.

Information provided orally and in writing to the individual and the legally authorized representative by the service coordinator includes:
- An overview of the consumer directed services option;
- Explanation of responsibilities in the consumer directed services option for the individual or individual's legally authorized representative, service coordinator, the financial management services agency, and a support advisor;
- Explanation of benefits and risks of participating in the consumer directed services option;
- Self-assessment for participation in the consumer directed services option;
- Explanation of required minimum qualifications of service providers through the consumer directed services option; and
- Explanation of employee/employer relationships that prohibit employment under the consumer directed services option.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☐ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The waiver participant or the legally authorized representative serving as the employer may appoint a non-legal representative adult as a designated representative to assist in performance of employer responsibilities to the extent desired by the individual or legally authorized representative. The individual/employer documents the employer responsibilities that the designated representative may perform and those that the designated representative may not perform on the individuals/employers behalf. The individual/employer provides this documentation to the financial management services agency. The financial management services agency monitors performance of employer responsibilities performed by the individual/employer and, when applicable, the designated representative in accordance with the individuals/employers documented directions. Neither the designated representative nor the spouse of the designated representative may be employed by, receive compensation from, or be the provider of waiver services for the individual.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Minor Home Modifications	☒	☒
Physical Therapy Services	☒	☒
Behavioral Support	☒	☒
Occupational Therapy Services	☒	☒
Dental Treatment	☒	☒
Support Consultation	☒	☒
Audiology Services	☒	☒
Day Habilitation	☒	☒
Adaptive Aids	☒	☒
Nursing	☒	☒
Respite	☒	☒
Community Support	☒	☒
Dietary Services	☒	☒
Supported Employment	☒	☒
Employment Assistance	☒	☒
Speech-Language Pathology	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

Financial Management Service

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Private entities called financial management services agencies provide Financial Management Services pursuant to contracts that are procured through an open enrollment process. In addition, financial management services agencies must enroll in Medicaid under a state Medicaid provider agreement.

Financial management services agencies are prohibited from providing service coordination to an individual who has chosen the consumer directed services option

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Entities are compensated with a flat monthly fee per individual. Financial management services agencies provide Financial Management Services, not administrative activities.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☐ **Other**

Specify:

Supports furnished when the participant exercises budget authority:

☒ **Maintain a separate account for each participant's participant-directed budget**

☒ **Track and report participant funds, disbursements and the balance of participant funds**

☒ **Process and pay invoices for goods and services approved in the service plan**

☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other services and supports**

Specify:

Additional functions/activities:

☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

HHSC conducts monitoring reviews of each financial management services agency to determine compliance with the Medicaid provider agreement and with program rules and requirements. These reviews are conducted at the location where the financial management service agencies are providing Financial Management Services. Texas monitors 100 percent of the financial management services agencies at a minimum of every three years.
HHSC assesses a financial management services agency's performance by:
1. Measuring adherence to rules as described in Title 40 of the Texas Administrative Code, Part 1, Chapter 41and 49;
2. Matching payroll, optional benefits and tax deposits to time sheets;
3. Ensuring that the hours worked and the rate of pay are consistent with individual budgets;
4. Reviewing administrative payments; and
5. Reviewing the provider agreements.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Minor Home Modifications	☐
Physical Therapy Services	☐
Behavioral Support	☐
Occupational Therapy Services	☐
Dental Treatment	☐
Support Consultation	☒
Audiology Services	☐
Day Habilitation	☐
Adaptive Aids	☐
Nursing	☐
Respite	☐
Community Support	☐
Dietary Services	☐
Supported Employment	☐
Financial Management Services	☒
Prescription Medications	☐
Employment Assistance	☐
Speech-Language Pathology	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

An individual or legally authorized representative may voluntarily terminate participation in the consumer directed services option at any time. The individual's service coordinator assists the individual in revising the service plan for the transition of services previously delivered through the consumer directed services option to be delivered by the TxHmL program provider chosen by the individual or legally authorized representative. The TxHmL program provider assists the individual as necessary to ensure continuity of all waiver services through the traditional agency option and maintenance of the individual's health and welfare during the transition from the consumer directed services option. The financial management services agency closes the employer's payroll and payable accounts and completes all deposits and filings of required reports with governmental agencies on behalf of the individual.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Involuntary termination of the consumer directed services option may occur when:

- The individual's service planning team, in conjunction with the financial management services agency or HHSC, determines that continued participation in the consumer directed services option would not permit the individual's health and welfare needs to be met; or
- The individual's service planning team, in conjunction with the financial management services agency or HHSC determines that the individual or the individual's representative, when provided with additional support from the financial management services agency or through Support Consultation, has not carried out employer responsibilities in accordance with requirements of the option.

The individual's service coordinator and service planning team assist the individual to ensure continuity of all waiver services through the traditional agency option and maintenance of the individual's health and welfare during the transition from the consumer directed services option. The financial management services agency closes the employer's payroll and payable accounts and completes all deposits and filing of required reports with governmental agencies on behalf of the individual.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		552
Year 2		552
Year 3		552
Year 4		552
Year 5		552

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law

employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

- ☒ **Recruit staff**
- ☐ **Refer staff to agency for hiring (co-employer)**
- ☐ **Select staff from worker registry**
- ☒ **Hire staff common law employer**
- ☒ **Verify staff qualifications**
- ☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Funds available in the individual's consumer directed services budget are used for this purpose.

- ☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

The state's method to conduct background checks does not vary from Appendix C-2-a.

- ☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- ☒ **Determine staff wages and benefits subject to state limits**
- ☒ **Schedule staff**
- ☒ **Orient and instruct staff in duties**
- ☒ **Supervise staff**
- ☒ **Evaluate staff performance**
- ☒ **Verify time worked by staff and approve time sheets**
- ☒ **Discharge staff (common law employer)**
- ☐ **Discharge staff from providing services (co-employer)**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☐ **Reallocate funds among services included in the budget**

☒ **Determine the amount paid for services within the state's established limits**

☒ **Substitute service providers**

☒ **Schedule the provision of services**

☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☒ **Identify service providers and refer for provider enrollment**

☒ **Authorize payment for waiver goods and services**

☒ **Review and approve provider invoices for services rendered**

☒ **Other**

Specify:

Reallocate funds among services included in the budget by requesting a service planning team meeting and revision to the individual plan of care.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The service plan is developed in the same manner for the individual who elects the consumer directed services option as it is for the individual who elects to have services delivered through the traditional agency option. The service plan must be approved by HHSC. The consumer-directed budget is the estimated cost of the self-directed services in the approved service plan based on the adopted consumer directed services reimbursement rates. The consumer-directed budget is developed by the individual or legally authorized representative with assistance from the financial management services agency.

The consumer-directed budget is allocated to each self-directed service based on the approved service plan. The budget for each service, and any revisions, must be approved by the financial management services agency prior to implementation. The financial management services agency must ensure that projected expenditures are within the authorized budget for each service, are allowable and reasonable, and are projected over the effective period of the plan to ensure that sufficient funds will be available to the end date of the service plan. With approval of the financial management services agency, the individual or legally authorized representative may make revisions to a specific service budget that does not change the amount of funds available for the service based on the approved service plan.

Employer-related costs are paid for using the consumer-directed budget and include costs for equipment, supplies or activities that will provide direct benefit to the individuals who self-direct services to support specific outcomes related to being an employer including: recruiting expenses, fax machine for sending employee time sheets to the financial management services agency, criminal conviction history checks from the Texas Department of Public Safety, acquiring other background checks of a potential service provider, purchased employee job-specific training, cardio-pulmonary resuscitation training, first-aid training, and Hepatitis B vaccination if elected by an employee. An individual may use up to a maximum of $600 of the consumer-directed budget for employer support services, including employment-related expenses.

Support Consultation has a specific reimbursement rate and is a component of the individual's service budget. In conjunction with the service planning team, the individual or legally authorized representative determines the level of Support Consultation necessary for inclusion in the individual's service plan.

Revisions to the budget for a particular service or a request to shift funds from one service to another is a service plan change and must be justified by the service planning team and authorized by the State. With assistance of the financial management services agency, the individual or legally authorized representative revises the consumer-directed budget to reflect the revision in the service plan.

Information concerning budget methodology for the consumer-directed budget is in rule at 40 Texas Administrative Code §§41.215, §41.313 and §41.501.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The individual or legally authorized representative participates as a member of the service planning team that develops the individual's person-directed plan upon which the service plan is based. They are apprised of the budget as it is developed. The individual develops the consumer directed services budget based on the finalized service plan and authorized budget.

The financial management services agency and the local intellectual and developmental disability authority service coordinator inform the individual of the amount authorized for the particular service before the budget is finalized and when the total budget is finalized.

The individual may request an adjustment to the budget at any time, subject to the individual cost limit as indicated in Appendix B-2-a of $17,000.

If HHSC denies an individual's request for an adjustment to the budget or reduces the budget, the individual is entitled to a fair hearing. The procedures for a fair hearing are provided in Appendix F, Participant Rights.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

An individual's consumer directed services budget is calculated and monitored based on projected utilization and frequency of the service as determined by the service planning team. The financial management services agency is required to monitor payroll every pay period (two weeks) and expenditures (as processed for payment) and report over- and under-utilization to the employer and the service coordinator. When an over- or under-utilization is not corrected by the employer (individual or legally authorized representative), the financial management services agency notifies the service coordinator and the employer. The service coordinator and the individual identify the cause of continuing deviation from projected utilization and develop a plan to correct the deviation or revise the service plan.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

At the time of enrollment, at least annually and upon request, a local intellectual and developmental disability authority gives the individual a copy of the handbook “Your Rights in a Texas Home Living Program” to the individual or legally authorized representative. The handbook includes information about an individual’s right to request a fair hearing in the Texas Home Living Program.

If Texas Home Living services are reduced, denied, suspended, or terminated, an individual is entitled to a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A.

HHSC sends a letter to the individual at least 10 days prior to the effective date of action in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A, §357.11, except as permitted in situations described in Title 42, Code of Federal Regulations §431.213 and §431.214. The HHSC letter describes the action HHSC will take and explains the right to request a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A, § 357.3 and §357.11. HHSC retains a copy of the letter in the individual’s record. If an individual or legally authorized representative elects to request a fair hearing, HHSC retains a copy of the written request for a hearing in the individual’s record.

An individual may not be eligible to receive or continue to receive services while the fair hearing process is pending, in the following circumstances:
(1) Situations described in Title 42, Code of Federal Regulations, §431.213 and §431.214 and for one of the following situations:
-Denial of waiver enrollment;
-Denial of service not previously authorized on the individual's service plan; and
(2) If an individual has not requested a hearing before the effective date of action (in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A, §357.11).

If an individual requests a fair hearing, HHSC enters the information into the Texas Integrated Eligibility Redesign System for notification to the HHSC Fair Hearings Office that conducts fair hearings. HHSC maintains a hard copy folder of all appeals it conducts. Fair hearing requests are tracked in the TxHmL Database and in the Texas Integrated Eligibility Redesign System creating an electronic record of the request.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

HHSC as the State Medicaid Agency operates the grievance/complaint system.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

To facilitate an efficient consumer response system, HHSC has identified the Intellectual and Developmental Disability Ombudsman (IDD Ombudsman) as its centralized source for the receipt of complaints by individuals, legally authorized representatives, family members, and the general public, as well as concerns and questions regarding the facilities/agencies regulated by HHSC, services, programs, or staff. HHSC IDD Ombudsman ensures that all contacts are handled in a timely, professional manner and are addressed by the proper authorities. All complaints received are acknowledged. HHSC advises complainants that the formal filing of a complaint is not required and is not a substitute for the applicant/individual to request a fair hearing if enrollment is denied or services are denied or suspended. The individual's service coordinator also advises the individual or legally authorized representative that filing a complaint is not a pre-requisite or substitute for requesting a fair hearing.

Grievances or complaints can be submitted by telephone by calling a toll-free line, by e-mail, or by written correspondence. In-office employees answer the toll-free line from 8 a.m. to 5 p.m. Monday through Friday. Voice mail is available 24 hours a day, seven days a week. Voice mail messages are monitored between 8 a.m. and 5 p.m., Central time, including weekends and holidays. Complaints may be anonymous. The identity of all complainants and individuals is protected by law. HHSC, IDD Ombudsman investigates the complaint and attempts resolution within 10 business days of the initiation of the investigation, unless the complaint involves abuse, neglect, or exploitation of an individual receiving services. Complaints involving allegations of abuse, neglect, or exploitation are referred immediately to the Texas Department of Family and Protective Services, the agency with statutory responsibility for investigation of such allegations. Resolution of complaints not referred to Department of Family and Protective Services are tracked and recorded in the IDD Ombudsman complaint database. The status of all complaints unresolved in 90 days are documented in follow-up letters to the complainant unless doing so places the complainant in jeopardy. When IDD Ombudsman staff determines HHSC has no jurisdiction to investigate, complaints are referred to other agencies, boards or entities as required.

Created by the 78th Texas Legislature, the HHSC Office of the Ombudsman assists the public when the normal complaint process cannot, or does not, satisfactorily resolve an issue. The Office of the Ombudsman includes the following services:

- conducting independent reviews of complaints concerning agency policies or practices;
- ensuring that policies and practices are consistent with the goals of HHSC;
- ensuring that individuals are treated fairly, respectfully, and with dignity; and
- making referrals to other agencies as appropriate.

The process to assist with complaints and issues is as follows:

- A member of the public, an individual, or a provider makes first contact with HHSC to request assistance with an issue or complaint;
- If not able to resolve the issue or complaint, the Office of the Ombudsman may be contacted;
- The Office of the Ombudsman will provide an impartial review of actions taken by the program or department; and
- The Office of the Ombudsman will seek a resolution and may use mediation if appropriate.

Often it is necessary for the Office of the Ombudsman to refer an issue to another appropriate department. If so, the Office of the Ombudsman will follow up with the complainant to determine if a resolution has been achieved, or to refer the complainant to other available known resources.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All program provider personnel, individuals, legally authorized representatives, and financial management services agencies are provided the Texas Department of Family and Protective Services toll-free telephone number in writing and are instructed to report to the Department of Family and Protective Services immediately, but not later than one hour after having knowledge or suspicion, that an individual has been or is being abused, neglected, or exploited.

The program provider must report the death of an individual to the local intellectual and developmental disability authority and HHSC by the end of the next business day following the death of the individual or the program provider's knowledge of the death. If the program provider reasonably believes that the individual's legally authorized representative or family does not know of the individual's death, the program provider notifies the individual's legally authorized representative as soon as possible, but not later than 24 hours after the program provider learns of the individual's death.

On a monthly basis, TxHmL program providers are required to enter any of the following critical incidents that occurred during the preceding month in the automated Critical Incident Reporting System.

•• Medication errors committed by program provider staff or occurring under the supervision of program provider staff;
- Serious physical injuries;
- Total number of deaths;
- Unusual deaths;
- Total number and types of restraints;
- Number of 911 calls made by staff;
- Number of emergency room and hospital admissions;
- Number of allegations of abuse, neglect and exploitation;
- Number of confirmed allegations of abuse, neglect and exploitation;
- The number of unauthorized departures; and
- The total number of arrests of individuals by law enforcement.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

At the time an individual is enrolled in TxHmL, a local intellectual and developmental disability authority must assure that an individual and legally authorized representative is informed orally and in writing of the processes for reporting allegations of abuse, neglect, or exploitation. The toll free number for the Department of Family and Protective Services must be provided.

In addition to information provided to all individuals in the waiver, the financial management services agency provides individuals electing the consumer directed services option, the individual's legally authorized representative and, if applicable, the designated representative, training and written information related to reporting allegations of abuse, neglect, or exploitation.

The program providers must ensure the continuous availability of trained and qualified service providers to deliver the required services as determined by the individual's needs. The training is provided as needed.

The informal caregivers are unpaid natural supports and are outside the scope of waiver services. However, the individual/primary caregiver is responsible for training people who provide non-waiver natural support activities, such as informal caregivers.

Evidence supporting compliance with these requirements is reviewed during the State's annual certification reviews of TxHmL program providers who are serving at least one individual, annual contract reviews of local intellectual and developmental disability authorities and biennial contract reviews of financial management services agencies.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Texas Department of Family and Protective Services receives allegations of abuse, neglect and exploitation of individuals enrolled in the TxHmL program and is statutorily responsible for review, investigation and response to those reports. Depending on the severity of the allegation, the Department of Family and Protective Services investigations must be completed within 14 to 21 days. HHSC receives monthly reports of all other critical incidents directly from program providers. HHSC also receives reports of participant deaths directly from program provider within one business day of the death.

In accordance with rules governing the operation of the TxHmL program, an individual's program provider must inform the individual, legally authorized representative, and the individual's service coordinator of the findings of the investigation no later than five calendar days from the program provider's receipt of the investigation report and the corrective action taken by the program provider if the Department of Family and Protective Services confirms that abuse, neglect, and exploitation occurred.

The program provider must inform the individual and legally authorized representatives of the process to appeal the investigation finding, and the process for requesting a copy of the investigative report.

Additionally, HHSC Intellectual and Developmental Disability Ombudsman (IDD Ombudsman) will conduct an investigation of all complaints received, other than those for abuse, neglect and exploitation. Within 10 business days of the complaint, IDD Ombudsman will document their findings. Any unresolved complaints will be forwarded to the appropriate department for additional follow-up.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Department of Family and Protective Services forwards to HHSC a report of each of its investigations along with its determination that the allegation was confirmed or not confirmed or that results of the investigation were inconclusive. HHSC reviews all investigation reports completed by the Department of Family and Protective Services. Based on the content of the report, HHSC may conduct an on-site review of the provider or require the provider to submit evidence of follow-up action on the incident. The investigative findings and HHSC follow up on
those findings are entered into the abuse, neglect and exploitation database by HHSC. HHSC also records deaths in a database. Reports of critical incidents are compiled on a monthly basis for each program provider. In preparation for initial and annual certification reviews and some onsite visits, HHSC compiles data related to all critical incidents reported by or involving the program provider. The information may be used during certification reviews or onsite visits in determining individuals whose records will be reviewed and who may be interviewed during the certification review and to ensure appropriate follow-up was conducted by the program provider.

Unresolved issues that IDD Ombudsman forwards to HHSC will result in a review of any evidence submitted pertaining to the issue. Steps to resolve issues will be taken immediately, if necessary, or up to seven days from the time Waiver Survey and Certification receives the referral from IDD Ombudsman taken for follow-up will include a desk review of the available evidence, the request for additional evidence and/or an on-site visit to further investigate the issue. Findings related to the issues are documented in the Waiver Survey and Certification database and shared with IDD Ombudsman .

Oversight activities occur on an ongoing basis. Information regarding confirmed instances of abuse, neglect or exploitation are monitored, tracked, and trended for purposes of training the provider base to reduce the risk of recurrence.

HHSC annually aggregates the data, discusses any significant findings, and prepares a remediation plan or improvement plan as needed.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State allows the use of personal restraints, drugs used as restraints, and mechanical restraints. The State prohibits the use of seclusion. The following safeguards apply to all restraints used.

In addition to requiring program providers to report the behavior intervention plans authorizing restraints as well as any emergency restraints, the rules governing the TxHmL program also require the program provider's compliance with certification principles prohibiting the use of unnecessary restraints during the provision of waiver services. In the event a restraint is used, the program provider must report the use of a restraint to the individual's service coordinator so that any necessary changes may be made to the individual's service plan. If restrictive or intrusive techniques, including restraint, are used as part of a behavioral support plan, then the program provider must assure that the implementation of such techniques includes:
(1) Approval by the individual's service planning team that includes the service coordinator;
(2) Written consent of the individual or legally authorized representative;
(3) Verbal and written notification to the individual or legally authorized representative of the right to discontinue participation in the behavioral support plan at any time;
(4) Assessment of the individual's needs and current level/severity of the behavior(s) targeted by the plan;
(5) Use of techniques appropriate to the level/severity of the behavior(s) targeted by the plan;
(6) A written behavior support plan developed by a psychologist or behavior analyst with input from the individual, legally authorized representative, the individual's service planning team, and other professional personnel;
(7) Collection and monitoring of behavioral data concerning the targeted behavior(s);
(8) Allowance for the decrease in the use of intervention techniques based on behavioral data;
(9) Allowance for revision of the behavioral support plan when desired behavior(s) are not displayed or techniques are not effective;
(10) Consideration of the effects of the techniques in relation to the individual's physical and psychological well-being; and
(11) At least annual review by the individual or legally authorized representative, local intellectual and developmental disability authority service coordinator and TxHmL program provider to determine the effectiveness of the program and the need to continue the techniques.

The program certification principles also require provider personnel to report allegations of abuse, neglect, or exploitation within one hour.

A restraint may be used in a behavioral emergency as part of a behavioral support plan to address inappropriate behavior exhibited voluntarily by an individual, during a medical or dental procedure to protect the individual or others, to protect the individual from involuntary self-injury, or to provide postural support in obtaining and maintaining normative bodily functioning. The TxHmL program provider must ensure the continuous availability of trained and qualified service providers to deliver the required services as determined by the individual's needs.

Program provider personnel who are involved in the administration of restraints must receive initial and periodic training in the safe use of the specific intervention, when the intervention should be used, and criteria for discontinuing the intervention. While the use of seclusion is prohibited in the TxHmL program, it is important for program provider personnel to know what constitutes seclusion.

At least annual on-site certification reviews conducted by HHSC evaluate program provider's compliance with these principles.

Complaints concerning unnecessary/unapproved use of restraint can be made to the local intellectual and developmental disability authority, HHSC, or the Department of Family and Protective Services. The service coordinator must assure that an individual or legally authorized representative is informed orally and in writing of the processes for filing complaints about the provision of TxHmL program services including:
(A) the telephone number of the local intellectual and developmental disability authority to file a complaint;
(B) the toll-free telephone number of HHSC Consumer Rights and Services to file a complaint; and
(C) the toll-free telephone number of the Department of Family and Protective Services to file a complaint of abuse, neglect, or exploitation.

Restraints are reviewed as a result of a certification review and/or as a follow-up to a complaint from Consumer Rights and Services. During a review of the TxHmL provider, critical incident data is obtained from restraint data from the State database system, incident reports/service records from the program provider or interviews from individuals receiving TxHmL services, legally authorized representatives, staff, and other informants.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

HHSC completes program provider reviews on an annual basis and in response to unresolved complaints or indications of misuse of restraints documented in the Department of Family and Protective Services investigative findings.

Deficiencies related to misuse of restraint or seclusion observed during on-site provider reviews are entered into the HHSC Client Assignment and Registration System. Quarterly reports allow HHSC to identify trends or patterns across the provider-base as well as trends or patterns in the performance of an individual provider agency. This information is used to guide the development of provider training and also guide certification review staff in providing technical assistance to provider agencies in developing systemic corrections to their operations.

Annually, HHSC reports aggregate data on critical incidents including use of restraints, serious injuries, and deaths. TxHmL providers also enter the number of participants with a behavior intervention program. HHSC discusses any significant findings and prepares a remediation plan or improvement plan as needed.

HHSC reviews the data for trends and patterns. Improvement strategies are developed and implemented to reverse adverse trends and address patterns of concern.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

If a behavioral support plan includes techniques that involve restriction of individual rights or intrusive techniques, including restraints, the program provider must assure that the implementation of such techniques includes:
(A) Approval by the individual's service planning team;
(B) Written consent of the individual or legally authorized representative;
(C) Verbal and written notification to the individual or legally authorized representative of the right to discontinue participation in the behavioral support plan at any time;
(D) Assessment of the individual's needs and current level/severity of the behavior(s) targeted by the plan;
(E) Use of techniques appropriate to the level/severity of the behavior(s) targeted by the plan;
(F) A written behavior support plan developed by a psychologist or behavior analyst with input from the individual, the individual's legally authorized representative, the individual's service planning team, and other professional personnel;
(G) Collection and monitoring of behavioral data concerning the targeted behavior(s);
(H) Allowance for the decrease in the use of intervention techniques based on behavioral data;
(I) Allowance for revision of the behavioral support plan when desired behavior(s) are not displayed or techniques are not effective;
(J) Consideration of the effects of the techniques in relation to the individual's physical and psychological well-being; and
(K) At least annual review by the individual's service planning team to determine the effectiveness of the program and the need to continue the techniques.

Any restrictive intervention must be appropriate to the current frequency or severity of the behavior displayed by a participant. Restrictive interventions that would be permitted include restricting privileges such as having access to recreational activities, access to other participants, or certain locations. Interventions that are not permitted include restrictions that endanger health or welfare or prevent access to basic human necessities such as food or water. Restrictive interventions are only allowed when a behavioral support plan that meets the above criteria is in place.

Complaints concerning unnecessary/unapproved restriction of rights can be made to the local intellectual and developmental disability authority, HHSC or the Department of Family and Protective Services. The local intellectual and developmental disability authority must assure that an individual or legally authorized representative is informed orally and in writing of the processes for filing complaints about the provision of TxHmL program services including:
(A) the telephone number of the local intellectual and developmental disability authority to file a complaint;
(B) the toll-free telephone number of HHSC Consumer Rights and Services to file a complaint; and
(C) the toll-free telephone number of the Department of Family and Protective Services to file a complaint of abuse, neglect, or exploitation.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

HHSC completes certification reviews of each program provider on an annual basis and in response to unresolved complaints indicating unnecessary/unapproved restriction of rights documented in the Department of Family and Protective Services investigative findings.

HHSC annually aggregates the data and reports to discuss with any significant findings and prepares a remediation plan or improvement plan as needed.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The State prohibits the use of seclusion in TxHmL programs.

At least annual on-site certification reviews conducted by HHSC evaluate program provider's compliance with this prohibition.

Program provider personnel who are involved in the administration of restraint must receive initial and periodic training in the safe use of the specific intervention, when the intervention should be used, and criteria for discontinuing the intervention. While the use of seclusion is prohibited in the TxHmL program, it is important for program provider personnel to know what constitutes seclusion.

Complaints concerning unapproved use of seclusion can be made to the local intellectual and developmental disability authority, HHSC, or the Department of Family and Protective Services. The service coordinator must assure that an individual or legally authorized representative is informed orally and in writing of the processes for filing complaints about the provision of TxHmL program services including:
(A) the telephone number of the local intellectual and developmental disability authority to file a complaint;
(B) the toll-free telephone number of HHSC Consumer Rights and Services to file a complaint; and
(C) the toll-free telephone number of the Department of Family and Protective Services to file a complaint of abuse, neglect, or exploitation.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

◉ **No. This Appendix is not applicable** *(do not complete the remaining items)*

○ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ○ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

- ○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
  Complete the following three items:

  (a) Specify state agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
G.a.1 Number and percent of individuals who were free from confirmed allegations of

abuse. N: Number of individuals who were free from confirmed allegations of abuse. D: Number of enrolled individuals.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Salesforce Abuse Neglect and Exploitation Database

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

Data Aggregation and Analysis:

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

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

Performance Measure:
G.a.2 Number and percent of individuals who were free from confirmed allegations of neglect. N: Number of individuals who were free from confirmed allegations of neglect. D: Number of enrolled individuals.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Salesforce Abuse Neglect and Exploitation Database

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G.a.3 Number and percent of individuals who were free from confirmed allegations of exploitation. N: Number of individuals who were free from confirmed allegations of exploitation. D: Number of enrolled individuals.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Salesforce Abuse Neglect and Exploitation Database

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

Data Aggregation and Analysis:

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

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

Performance Measure:
G.a.4 Number and percent of individuals with reviewed records who received information on how to report abuse, neglect, and exploitation. N: Number of individuals with reviewed records who received information on how to report abuse, neglect, and exploitation. D: Number of individuals with reviewed records.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Client Assignment and Registration System

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.a.5 Number and percent of individuals free from allegations of abuse, neglect, or exploitation. N: Number of individuals free from allegations of abuse, neglect, or exploitation. D: Number of enrolled individuals.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Salesforce Abuse Neglect and Exploitation Database

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
G.a.6 Number and percent of individuals with reviewed records who were informed of procedures for filing a complaint. N: Number of individuals with reviewed records who were informed of procedures for filing a complaint. D: Number of individuals with reviewed records.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Survey and Certification database

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

Data Aggregation and Analysis:

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

Performance Measure:
G.a.7 Number and percent of provider-reported deaths reviewed. N: Number of provider-reported deaths reviewed. D: Number of provider-reported deaths.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Salesforce Abuse Neglect and Exploitation Database

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

		Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.a.8 Number and percent of provider-reported deaths of individuals free from

previous confirmed allegations of abuse, neglect, or exploitation within the last three months. N: Number of provider-reported deaths of individuals free from previous confirmed allegations of abuse, neglect, or exploitation within the last three months. D: Number of provider-reported deaths.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Quality Assurance and Improvement Data Mart

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
G.b.1 Number and percent of surveyed contracts for which the provider addressed critical incidents that occurred during the reporting period. N: Number of surveyed contracts for which the provider addressed critical incidents that occurred during the reporting period. D: Number of surveyed contracts.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Client Assignment and Registration System

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

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
G.b.2 Number and percent of complaints addressed according to HHSC policies and procedures. N: Number of complaints addressed according to HHSC policies and procedures. D: Number of complaints.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Consumer Rights and Services Database

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
G.c.1 Number and percent of surveyed contracts that were not cited for the use of unnecessary restrictive interventions. N: Number of surveyed contracts that were not cited for the use of unnecessary restrictive interventions. D: Number of surveyed contracts.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Client Assignment and Registration System

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

Data Aggregation and Analysis:

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

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

Performance Measure:
G.c.2 Number and percent of surveyed contracts that were not cited for the use of unnecessary restraint. N: Number of surveyed contracts that were not cited for the use of unnecessary restraint. D: Number of surveyed contracts.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Client Assignment and Registration System

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.c.3 Number and percent of surveyed contracts that were not cited for the use of seclusion. N: Number of surveyed contracts that were not cited for the use of seclusion. D: Number of surveyed contracts.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Client Assignment and Registration System

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

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

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
G.d.1 Number and percent of individuals with reviewed records who received Nursing services according to state rule. N: Number of individuals with reviewed records who received Nursing services according to state rule. D: Number of individuals with reviewed records.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Client Assignment and Registration System

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

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

Data Aggregation and Analysis:

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

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

In accordance with state law, HHSC maintains an Employee Misconduct Registry that includes the names of persons HHSC or Texas Department of Family and Protective Services has confirmed to have abused, neglected, or exploited an individual receiving services from any of the following entities:

- licensed intermediate care facility;
- nursing facilities;
- assisted living facilities;
- adult foster care facilities;
- day activity and health services facilities;
- home and community support services agencies, which include hospice and home health agencies; and
- persons exempt from licensing under the Health and Safety Code, §142.003(a)(19), which include TxHmL Program providers.

In addition, in accordance with federal law, the State maintains a Nurse Aide Registry that lists certified nurse aides. The Nurse Aide Registry indicates if an aide has been confirmed to have abused, neglected, or exploited a resident of a licensed nursing facility. Program providers and local authorities must consult these registries prior to offering employment to a non-licensed service provider and refrain from employing that person if either registry indicated the person was confirmed to have abused, neglected, or exploited an individual receiving services.

Texas state law prohibits program providers and local intellectual and developmental disability authorities from employing a person whose criminal background indicates the person has been convicted of certain felonies. Program providers and local intellectual and developmental disability authorities are required to complete pre-employment criminal background checks for each non-licensed applicant that will provide services to an individual enrolled in the TxHmL program.

The Quality Assurance and Improvement unit of HHSC will continue its National Core Indicators survey project with the individuals who participate in home and community-based service programs operated by the State. Individuals receiving TxHmL are included in the sample at least every three years. As a part of the National Core Indicators survey, individuals who receive services in the TxHmL program may respond to indicators regarding health, welfare and rights. Some of the topics in the survey tool include protection from abuse and neglect, the ability to secure needed health services, medication management, protection of and respect for individual rights, and support to maintain health habits. Discovery findings from the National Core Indicators survey project will be routinely evaluated to assess the status of remediation and improvement activities. In addition, the State will use findings to update the TxHmL Quality Improvement Strategy as necessary. Findings from the National Core Indicators survey will be provided to HHSC each year the survey is administered.

b. Methods for Remediation/Fixing Individual Problems

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

When HHSC detects provider non-compliance with the program certification principles the agency requires the provider to implement corrective action. Following certification reviews, all providers receive a written certification review report that details the specific areas of non-compliance found during the review and includes instruction regarding the provider's responsibility with regard to the areas of deficiency. The State then conducts follow-up activities in accordance with TxHmL program provider review procedures. When appropriate a referral will be made to the Department of Family and Protective Services.

Certification Survey
If HHSC determines after an initial or annual survey that the TxHmL provider is in compliance with all certification principles, HHSC certifies the TxHmL provider. If HHSC determines based on a survey that the TxHmL provider is not in compliance with the certification principles, HHSC may take one or more of the follow actions: request a plan of correction, impose an administrative penalty request written evidence of correction; conduct a survey or onsite visit; impose a vendor hold; or deny certification.

Plan of correction
A TxHmL provider's plan of correction must specify the date by which corrective action will be completed for each violation, and such date must for a violation that is a condition of a serious nature, as stated in the preliminary survey report be no later than 30 calendar days after the date of the survey exit conference, and for a violation, that is not a condition of a serious nature be no later than 45 calendar days after the date of the survey exit conference.

Plan of correction approved or not approved: Within 10 business days after the date HHSC receives the plan of correction HHSC notifies the TxHmL provider of whether the plan is approved or not approved. If HHSC approves the plan of correction, the TxHmL provider must complete the corrective action in accordance with the plan of correction. If HHSC does not approve the plan of correction, the TxHmL provider must submit a revised plan of correction within 10 calendar days after the date of HHSC written notice that the plan of correction was not approved.

Revised plan of correction approved or not approved: Within 10 business days after the date HHSC receives the revised plan of correction, HHSC notifies the TxHmL provider of whether the plan is approved.
- If HHSC approves the revised plan of correction, the TxHmL provider must complete the corrective action in accordance with the revised plan of correction.
- If the TxHmL provider does not submit a plan of correction or HHSC notifies the TxHmL provider that the revised plan of correction is not approved, HHSC may impose a vendor hold against the TxHmL provider until the TxHmL provider submits a plan of correction that is approved by HHSC, or deny or terminate certification of the TxHmL provider.

Verification of corrective action: HHSC may take one or more of the following actions to determine if the TxHmL provider has completed its corrective action in accordance with an approved plan of correction. HHSC may:
- request that the TxHmL provider submit written evidence of correction to HHSC; or
- conduct a survey or an on-site visit for a violation that is:

a condition of a serious nature that is determined by HHSC to be a critical violation no sooner than 31 calendar days after the survey exit conference; and

not a condition of a serious nature that is determined by HHSC to be a non-critical violation, no sooner than 46 calendar days after the survey exit conference.

Administrative Penalties
HHSC may impose and collect an administrative penalty against a TxHmL provider for a violation of a certification principle contained in the Texas Administrative Code pertaining to the TxHmL program. HHSC may also impose and collect an administrative penalty against a TxHmL provider for any of the following actions: making a false statement of a material fact the program provider knows or should know is false with respect to a matter under investigation by HHSC; falsifying documentation; or willfully interfering with the work of a representative of HHSC.

Vendor Hold
If HHSC implements a vendor hold against the TxHmL provider, HHSC conducts a second on-site follow-up

review between 30 and 45 calendar days after the effective date of the vendor hold. Based on the results of the review, HHSC may certify the TxHmL provider and remove the vendor hold or may deny certification of the TxHmL provider and initiate termination of the Medicaid provider agreement.

Administrative Penalty and Vendor Hold
If HHSC imposes an administrative penalty against a program provider for a violation or action, HHSC does not, at the same time, impose a vendor hold or otherwise withhold contract payments from the program provider for the same violation or action.

Annual monitoring by HHSC includes reviewing data from the quarterly quality measures and annual CMS- 372 reports and implementing the Quality Review Team processes, the key formal mechanism for monitoring HHSC' performance. The Quality Review Team meets quarterly and reviews comprehensive quality reports from each waiver at least annually. These reports include data on all of the waiver's quality improvement strategy measures. These reports also include remediation activities and outcomes. Improvement plans are developed as issues are identified by HHSC, and the Quality Review Team reviews, modifying if needed, and approves all improvement plans. All active improvement plans for all waivers are monitored at each quality review team meeting.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Quality Oversight Plan utilizes numerous quality indicators that are tracked and reported on a quarterly basis. The TxHmL system data is aggregated on no less than an annual basis. The State analyzes trends and identifies and prioritizes areas for improvement. These findings are reported to the Quality Review Team.

The Quality Review Team, which consists of representatives from several departments within HHSC reviews TxHmL data to establish priorities and directs the improvement activities for the waiver. The Quality Review Team oversees implementation of the quality oversight plan and related processes. This includes making recommendations for new or revised quality measures, identifying and facilitating access to new data sources, identifying new intra- and interagency processes impacting any and all phases of the quality program, and other actions needed to assure continued improvement of TxHmL waiver program.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The Quality Review Team meets quarterly and reviews comprehensive quality reports from each waiver program at least annually. These quarterly and annual reports include data for all of the waiver's quality improvement strategy measures, along with applicable remediation activities and outcomes. HHSC present the reports and recommendations for system improvements to the Quality Review Team, which establishes priorities for quality improvement initiatives. Improvement plans are developed as issues are identified and the Quality Review Team reviews, modifies (if needed), and approves all improvement plans. All active improvement plans for all waivers are monitored at each Quality Review Team meeting. This includes updates to determine whether or not improvement activities have had the intended effect.

To facilitate communication with external stakeholders, the agency has implemented Texas Quality Matters, which is a web-based medium that provides external stakeholders with an increased ability to access quality reporting information. Texas Quality Matters provides the State with the ability to conduct online surveys related to quality improvement. A link to the Long Term Care Quality Reporting System can be found on the Texas Quality Matters web-page.

Stakeholders have the opportunity to provide testimony on policies and rules governing the delivery of services in the TxHmL program in writing and at meetings of the Medical Care Advisory Committee and the HHSC Advisory Council. Stakeholders may also provide feedback and comments anytime to the TxHmL mailbox.

The Promoting Independence Advisory Committee is comprised of member representatives from all departments of the State Medicaid Agency and external stakeholders. The Promoting Independence Advisory Council, Texas's Olmstead implementation committee, studies and makes recommendations to the State regarding appropriate care settings for persons with disabilities. The Promoting Independence Advisory Council is another venue stakeholders can use to provide input and feedback about the TxHmL waiver program.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

HHSC will evaluate the Quality Oversight Plan at least every three years. State staff will evaluate the processes and indicators of the quality oversight plan. HHSC will examine issues such as whether or not the indicators are providing substantive information about each subassurance; whether the Quality Review Team can be made more effective through changes to its composition or meeting framework; and whether the processes for involving external stakeholders can be improved. Where improvement is needed, staff will make recommendations for changes to the Quality Review Team, and the Quality Review Team will approve or revise recommended changes.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ◉ **Other** *(Please provide a description of the survey tool used):*

Texas deployed the NCI Adult Consumer Survey and the Participant Experience Survey (PES) in 2019. Texas deployed the NCI Child Family Survey in 2018. The three surveys are organized across five general topics – health and welfare, choice and respect, community inclusion, systems performance, and services satisfaction.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

HHSC uses a fiscal monitoring process, billing and payment reviews, to ensure that Texas Home Living program providers are complying with program requirements. HHSC conducts fiscal monitoring of TxHmL program providers on-site and desk reviews at least every four years and typically reviews a three month sample of the provider's records, but may lengthen that sample period, if deemed necessary. Financial management services agencies are monitored at a minimum of every three years. Typically, a six-month sample of financial management services agencies' records are reviewed.

The methods used in the monitoring process include:
Review of the provider's or agency's existing billing system and internal controls;
Comparison of the provider or agency's service delivery records with its billing records to verify that payments HHSC made to provider or agency were appropriate ;
Review of service plans and records; and
Comparison of service delivery and other supporting documentation with service plans.

HHSC may perform desk and on-site compliance reviews associated with claims the provider or agency submits under. HHSC recovers improper payments, without extrapolation, if HHSC verifies that the provider or agency has been overpaid because of improper billing or accounting practices or failure to comply with the provider agreement.

The provider or agency must provide the documentation HHSC requests to support the provider's or agency's submitted claims. If the provider or agency fails to provide the requested information, HHSC may take adverse action based on the terms of the Medicaid provider agreement.

HHSC may withhold payments and apply them to the payments the provider agency owes HHSC. Corrective action may be required for findings based upon the billing and payment or contract and fiscal compliance monitoring results.

TxHmL providers and financial management services agencies are not required to conduct independent financial audits.

The HHSC's Cost Report Review Unit is responsible for the statewide financial and compliance audit. The HHSC Inspector General is responsible for performing audits of Medicaid provider agreements between HHSC and providers or financial management services agencies.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the

reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
I.a.1 Total dollar amount and percent of total dollar amount of reviewed claims that were coded and paid for according to the reimbursement methodology specified in the approved waiver. N: Total dollar amount of reviewed claims that were coded and paid for according to the reimbursement methodology specified in the approved waiver. D: Total dollar amount of reviewed claims.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Billing and Payment database

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

		Sample size is based upon prior error rate, total contract census, and whether a routine review was conducted. Samples consist of 5 - 10 individuals plus 5 - 10% of individuals provided services.
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

Performance Measure:
I.a.2 Number and percent of paid claims that reflect only the services listed in the service plan. N: Number of paid claims that reflect only the services listed in the service plan. D: Number of paid claims.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
I.a.3 Number and percent of reviewed providers not requiring a corrective action plan due to billing and payment error rates greater than 15 percent. N: Number of reviewed providers not requiring a corrective action plan due to billing and payment error rates greater than 15 percent. D: Number of reviewed providers.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Billing and Payment database

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

		Reviews are conducted cyclically in order based on oldest review and staff availability.
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
I.b.1 Number and percent of provider payment rates that are consistent with the rate methodology in the approved waiver. N: Number of provider payment rates that are consistent with the rate methodology in the approved waiver. D: Number of provider payment rates.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Health and Human Services Commission Rate Analysis Department

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

Data Aggregation and Analysis:

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

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

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

TxHmL program providers enter billing claims into the Client Assignment and Registration System, which assigns the correct reimbursement rate associated with the billing code entered by a program provider. The Client Assignment and Registration System automatically rejects any claim that is entered with an unauthorized billing code or for a service not included in an individual's authorized service plan. A report on this assurance will be prepared annually and reviewed by the Quality Review Team.

b. Methods for Remediation/Fixing Individual Problems

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

If the State detects provider non-compliance with the program billing guidelines, the agency requires the provider to implement corrective action. Following billing and payment reviews, all providers receive a written review report that details the specific areas of non-compliance found during the review and includes instruction regarding the provider's responsibility with regard to the areas of deficiency. The State then conducts follow-up activities in accordance with TxHmL program provider review procedures and Financial Management Services agency review procedures to ensure corrective action has been implemented. The State recoups funds when claims for services provided to individuals were found in error.
HHSC has the responsibility of executing Medicaid provider agreements, including day-to-day operations, of Financial Management Services and monitoring of financial management services agencies. Texas monitors 100 percent of financial management services agencies at a minimum of every three years. These reviews are conducted via desk review or at the location where the financial management services agency is providing Financial Management Services. HHSC assesses a financial management services agency's performance by:

1. *Measuring adherence to rules in Title 40 of the Texas Administrative Code, Part 1, Chapters 41 and 49;*
2. *Matching payroll, optional benefits, and tax deposits to time-sheets;*
3. *Ensuring that the hours worked and the rate of pay are consistent with individual budgets;*
4. *Reviewing administrative payments; and*
5. *Reviewing the provider agreements.*

HHSC recovers improper payments, without extrapolation and verifies that the provider or agency has been overpaid because of improper billing or accounting practices or failure to comply with the provider agreement terms. HHSCS staff prepares a written report itemizing claims found in error during each review. A summary of each review, including the name of the financial management services agency, the dollar amount to be subtracted from pending or future payments to the financial management services agency, if applicable, and any follow-up action to be taken is scanned and sent electronically on a monthly basis to HHSC. HHSC staff enters the monitoring information into the Health and Human Services Contract Administration and Tracking System. HHSC staff uses the data entered into this system to track monitoring and billing disallowances.

HHSC staff conducts intermittent monitoring reviews to ensure that the financial management services agency has taken the necessary steps to attain and maintain compliance at the required performance level. HHSC staff recommends further action or possible sanctions if the financial management services agency remains out of compliance.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- (●) ***No***
- ( ) ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. *Rate Determination Methods.* *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

HHSC, the single State Medicaid agency, determines payment rates every two years, coincident with the State's legislative biennium. Payment rates are determined for each service. The rates for services are prospective and uniform statewide. HHSC reimburses providers for contracted client services through reimbursement amounts determined as described in Title 1 of the Texas Administrative Code, Part 15, Chapter 355, and in reimbursement methodologies for each program. HHSC determines payment rates after analysis of financial and statistical information, and the effect of the payment rates on achievement of program objectives, including economic conditions and budgetary considerations. Statewide, uniform reimbursements and reimbursement ceilings are approved by HHSC. Methodology rules are developed and adopted by HHSC. HHSC has oversight authority with respect to the state's reimbursement methodology and cost determination rules. The rates for the TxHmL waiver are available on the HHSC Rate Analysis Department webpage.

In order to ensure adequate financial and statistical information upon which to base reimbursement, HHSC requires each contracted provider to submit a periodic cost report or supplemental report. The cost report contains information on direct service costs, including direct service wages, benefits, contracted services and staffing information; facility costs; operations costs; and administrations costs of the providers. Providers are responsible for eliminating all unallowable expenses from the cost report prior to submission of the cost report. HHSC conducts a desk review of all cost reports. HHSC removes any unallowable costs and corrects any errors detected on the cost report in the course of the review. Reviewed cost reports are used in the determination of statewide prospective rates.

Costs reported on the cost reports are projected to the applicable rate period. HHSC determines reasonable methods for projecting each provider's costs to allow for significant changes in cost-related conditions anticipated as occurring between the historical cost reporting period and the prospective rate period.

HHSC uses the projected costs from the latest, desk-reviewed cost reports to rebase modeled rates for the following services: Day Habilitation, Respite, Supported Employment, Audiology Services, Behavioral Support, Community Support, Dietary Services, Employment Assistance, Occupational Therapy Services, Physical Therapy Services, Nursing and Speech-Language Pathology. The initial model-based rates for these services were determined using cost, financial, statistical and operational information collected during site visits performed by an independent consultant. The data was collected from cost reports and the service providers' accounting systems. Additionally, the state fiscal year (SFY) 1996 state wage data, the SFY 1994 cost data and the SFY 1995 data from service providers was reviewed and analyzed. The base model rate year was calendar year 1997. Data from SFY 1994-1996 were used to develop the current rate structure; rates are rebased every biennium from the most recent projected cost report data, within available appropriations.

Supported Employment, Audiology, Behavioral Support, Dietary, Employment Assistance, Occupational Therapy, Physical Therapy, Nursing and Speech/Language Pathology are provided under more than one Home and Community-based 1915(c) waiver. The rates for these services are determined by combining the allowable costs per unit of service for the providers with Medicaid provider agreements in all the waivers offering these services into an array. The array is weighted by the number of units of service and the median cost per unit of service is calculated.

When historical costs are unavailable, such as in the case of changes in program requirements, payment rates may be based on a pro forma approach. This approach involves using historical costs of delivering similar services, where appropriate data are available, and estimating the basic types and costs of products and services necessary to deliver services meeting federal and state requirements. The rate for support consultation is modeled using a pro forma approach.

Prescription Medications, Adaptive Aids, Dental Treatment and Minor Home Modifications, are paid at cost.

The TxHmL providers are given additional payments for their efforts in acquiring Adaptive Aids, Dental Treatment and Minor Home Modifications for individuals; these payments are called requisition fees. The rates for the requisition fees are modeled using a pro forma approach that uses the historical data of provider’s costs to deliver services.

In setting the rates for Financial Management Services provided under the consumer directed services option, the reimbursement rate to the financial management services provider, the financial management services agency, is a flat monthly fee, determined by modeling the estimated cost to carry out the financial management responsibilities of the financial management services agency. The payment rate available for the individual's budget for the self-directed service is modeled based on the payment rate to the traditional agency less an adjustment for the traditional agency's

indirect costs.

The financial management services agency is responsible for providing rate information to the consumer directed services option employer. For individuals not in the consumer directed services option, the document created during the service planning team meeting, the individual plan of care, contains the rates for each service. This form is reviewed and signed by the individual and/or legally authorized representative.

HHSC publishes notice of proposed adjustments at the earliest feasible date but not later than ten state working days before the effective date of the adjustment, in the Texas Register. HHSC holds a public hearing before it approves rates, to allow interested persons to present comments relating to the proposed rates, and HHSC provides notice of the hearing to the public. The notice of the public hearing includes the location, date, and time for the hearing; information about the proposed rate changes and identifies the name, address, and telephone number of the staff member to contact for the materials pertinent to the proposed rates. At least ten working days before the public hearing takes place, material pertinent to the proposed statewide uniform rates is made available to the public. The public may present comments at the hearing or submit written comments regarding the proposed rates. Information about payment rates is made available to waiver participants through HHSC websites as well as through the Texas Register via a public notice.

Providers of Day Habilitation, Respite, Supported Employment, Community Support and Employment Assistance services have the option of participating in the Attendant Compensation Rate Enhancement. The 81st Texas Legislature directed HHSC to provide incentives for increased wages and benefits for community care attendants. In response, HHSC adopted rules in Title 1 of the Texas Administrative Code, Part 15, Chapter 355, Section 112 to establish procedures for community care providers to obtain additional funds for increased attendant wages, benefits, insurance, and mileage reimbursement. Community care providers who choose to participate in Attendant Compensation Rate Enhancement and receive additional funds must demonstrate compliance with enhanced spending requirements. For providers who choose not to participate in Attendant Compensation Rate Enhancement, the attendant compensation rate will remain constant over time, except for adjustments necessitated by increases in the federal minimum wage.

Participation in the Attendant Compensation Rate Enhancement is voluntary. Enrollment in Attendant Compensation Enhancement Rate is held in July prior to the rate year. Providers may choose to participate in Attendant Compensation Rate Enhancement by submitting to HHSC an electronic Enrollment Contract Amendment choosing to enroll and indicating the level of enhanced add-on rate they desire to receive. Requested add-on rate levels will be granted beginning with the lowest level and granting successive levels until requested enhancements are granted within available funds. Funding for the enhancement add-on rate levels is limited by biennial legislative appropriations.

Providers participating in the Attendant Compensation Rate Enhancement agree to spend approximately 90 percent of their total attendant revenues, including their enhanced add-on rate revenues, on attendant compensation. Attendant compensation includes salaries, payroll taxes, benefits, and mileage reimbursement. Participating providers must submit reports to HHSC documenting their spending on attendant compensation.

Determination of each provider's compliance with the attendant compensation spending requirement will be made based on reports submitted to HHSC on a biennial basis. Participants failing to meet their spending requirement for the reporting period will have their enhanced add-on revenues associated with the unmet spending requirements recouped. At no time will a participating provider's attendant care rate after their spending recoupment be less than the rate paid to providers not participating in receiving the enhanced add-on rates.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

TxHmL program providers and financial management services agencies enter individual service usage information (billing claims) into the HHSC electronic billing system. TxHmL program provider agencies and financial management services agencies submit appropriate receipts for Adaptive Aids, Minor Home Modifications, and Dental Treatment that are authorized for payment by HHSC staff. Following authorization, the TxHmL program providers and financial management services agencies submit electronic claims for the Adaptive Aids, Minor Home Modifications, or Dental Treatment.

Whether delivered through the traditional agency option or the consumer directed services option, providers and employers electronically submit claims for reimbursement for waiver services that were provided to individuals to the CMS-approved State Medicaid Management Information System.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

TxHmL program providers and financial management services agencies may enter electronic billing claims weekly. A claim includes the total units of each service component delivered to an individual, the date of delivery, and the amount due the program provider. HHSC electronic billing system verifies the following before a billing claims is approved:

- *The individual meets level of care and financial eligibility requirements on the date of service;*
- *The service components billed are included on the individual's current, approved service plan;*
- *The amount of units and unit costs do not exceed the most current, approved service plan; and*
- *The billing claim is complete, accurate, and is received by HHSC no later than 12 months after the last day of the month in which the service component was provided.*

TxHmL program providers and financial management services agencies submit appropriate receipts for Adaptive Aids, Minor Home Modifications, and Dental Treatment that are authorized for payment by HHSC. Following authorization, the provider agencies and financial management services agencies submit electronic claims for the Adaptive Aids, Minor Home Modifications or Dental Treatment.

HHSC uses a fiscal monitoring process to ensure that reimbursement to TxHmL program providers and financial management services agencies are for services actually provided in compliance with program requirements. The methods used in the fiscal monitoring process and outcomes of the process are described in Appendix I-1.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☒ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

HHSC contracts with local community centers, established in accordance with Chapter 534 of the Texas Health and Safety Code, and with a local Council of Government, established in accordance with Chapter 391 of the Texas Local Government Code, which have all been designated by HHSC as local intellectual and developmental disability authorities.

Local intellectual and developmental disability authorities contract as TxHmL program providers, and must provide all TxHmL services and receive payment for services provided. Local intellectual and developmental disability authorities may also contract to provide Financial Management Services under the consumer directed services option.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***

○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***

○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***

○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***

○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state***

Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☐ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☒ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

The non-federal share of TxHmL funds are appropriated by the Texas State Legislature to HHSC for the TxHmL program. There are no IGTs or CPEs. The non-federal share is exclusively from state general revenue appropriations.

- *There are no local sources of funds.*
- *There are no certified public expenditures.*
- *TxHmL non-federal share funds are appropriated to HHSC as a specific line item for the provision of TxHmL services.*
- *If another agency was designated to operate the TxHmL program, those funds would be removed from HHSC and appropriated to that agency.*

HHSC TxHmL appropriations remain in the state comptrollers account designated for the TxHmL program. Once the Medicaid agency has approved a claim via the Health and Human Services Accounting System (HHSAS), federal funds are drawn and combined with the state appropriation to make payments to the provider.

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

Check each that applies:

- [ ] ***Health care-related taxes or fees***
- [ ] ***Provider-related donations***
- [ ] ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ( ) ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- (●) ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Payment of the cost for room and board is the responsibility of the individual except when room and board are provided under the waiver as part of out-of-home Respite service.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ( ) ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to

the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- (●) ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ( ) ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] ***Nominal deductible***
- [ ] ***Coinsurance***
- [ ] ***Co-Payment***
- [ ] ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	6878.38	20538.75	27417.13	121259.96	2746.14	124006.10	96588.97
2	6850.73	20550.10	27400.83	123806.42	2803.81	126610.23	99209.40
3	6851.82	20790.30	27642.12	126406.35	2868.30	129274.65	101632.53
4	6860.67	21046.70	27907.37	129060.88	2937.14	131998.02	104090.65
5	6869.73	21309.20	28178.93	131771.16	3007.63	134778.79	106599.86

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	*Total Unduplicated Number of Participants (from Item B-3-a)*	*Distribution of Unduplicated Participants by Level of Care (if applicable)*
		Level of Care:
		ICF/IID
Year 1	*6540*	*6540*
Year 2	*6540*	*6540*
Year 3	*6540*	*6540*
Year 4	*6540*	*6540*
Year 5	*6540*	*6540*

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

For (current) waiver year five, the estimate was based upon actual enrollment data (using claims payment information) through December 2016 and assumed attrition with only partial replacement for the remainder of the waiver year. For renewal year one, the estimate assumes attrition with only partial replacement of attrition for the first six months of the waiver year, and then attrition with full replacement of attrition for the last six months of the year. For renewal years two through five, the estimate assumes attrition with full replacement of attrition throughout the year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Factor D estimates are based upon cost per unit and utilization information obtained from claims payment data used to prepare the CMS 372 for Waiver Year 2015 (service period March 2014 - February 2015).

For services that do not have a set rate established (adaptive aids, dental, home modification), the following Personal Consumption Expenditures (PCE) – Health Care Consumption deflators (Chained Price Deflators 2009 = 100) as forecasted by IHS Global Insight, September 2016 were used to inflate cost: renewal year one - 1.7%; renewal year two - 2.1%; renewal year three - 2.1%, renewal year four - 2.1 %, renewal year five - 2.1%.

Two key changes have been made to state plan services which significantly impact the Texas Home Living waiver service array.

Since September 1, 2014, unlimited prescription drugs have been provided to all Texas Home Living waiver individuals through managed care. It is estimated that after September 1, 2014, 90% of the costs associated with "Extended State Plan: Prescriptions" were reported as D' costs, and only 10% of the costs associated with "Extended State Plan: Prescriptions" remained under the waiver for and are included as D costs. Therefore, the utilization of "Extended State Plan: Prescriptions" was assumed to be only 10% of the utilization rate reported in the CMS 372 for Waiver Year 2015. The following Personal Consumption Expenditures (PCE) – Health Care Consumption deflators (Chained Price Deflators 2009 = 100) as forecasted by IHS Global Insight, September 2016 were used to inflate drug cost: current year five - 1.7%, renewal year one - 1.8%, renewal year two - 2.1%, renewal year three - 2.3%, renewal year four - 2.4 %, renewal year five - 2.4%.

Effective June 1, 2015, the State implemented the Community First Choice (CFC) state plan program. As a result, "Community Support" service hours are now provided as a state plan service and have been removed from the waiver service array for current waiver year five as well as subsequent years. The impact of this change was $225.26 per enrollee per month. Additionally, "Community Support" service hours related to transportation were added back into the service array. Based upon claims payment information for the period August 2016 - October 2016, 25.76% of the population will use an average of 9 hours of this service in a given month, at a cost of $22.86 per unit.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The Factor D' estimates are based on the D' cost from the CMS 372 Report for Waiver Year 2015 (March 2014 - February 2015). For renewal years one through five, the following Personal Consumption Expenditures (PCE) – Health Care Consumption deflators (Chained Price Deflators 2009 = 100) as forecasted by IHS Global Insight, September 2016 were used to inflate cost: current year four - 1.6%; current year five - 1.7%; renewal year one - 1.8%; renewal year two - 2.1%; renewal year three - 2.3%, renewal year four - 2.4 %, renewal year five - 2.5%.

Two key changes have been made to state plan services which significantly impact the Texas Home Living waiver service array as well as the D' cost.

Since September 1, 2014, unlimited prescription drugs have been provided to all Texas Home Living waiver individuals through managed care. It is estimated that after September 1, 2014, 90% of the costs associated with "Extended State Plan: Prescriptions" will be reported as D' costs. Since the CMS 372 for waiver year 2015 was for the period March 2014 - February 2015, it is assumed that the CMS 372 only picked up half of the annual impact. As a result, the D value was adjusted by adding one-half of 90% of the drug costs reported under D to the D' cost, which equates to an increase of $17.60 per enrollee per month. The following Personal Consumption Expenditures (PCE) – Health Care Consumption deflators (Chained Price Deflators 2009 = 100) as forecasted by IHS Global Insight, September 2016 were used to inflate drug costs: current year five - 1.7%, renewal year one - 1.8%, renewal year two - 2.1%, renewal year three - 2.3%, renewal year four - 2.4 %, renewal year five - 2.4%.

Effective June 1, 2015, the State implemented the Community First Choice (CFC) state plan program. As a result, "Community Support" service hours are now provided as a state plan service and have been removed from the waiver service array for current waiver year five as well as subsequent years and are now reported as D'. The impact of this change was $225.26 per enrollee per month. In addition, the implementation of CFC as a state plan service resulted in a dramatic increase in the number of habilitation service hours being utilized. Based upon claims payment information from August 2016 – October 2016, the additional D' cost associated with the increased habilitation service hours is estimated to be $785.56 per enrollee per month.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The Factor G estimates were based upon costs for State Fiscal year 2015, and the following Personal Consumption Expenditures (PCE) – Health Care Consumption deflators (Chained Price Deflators 2009 = 100) as forecasted by IHS Global Insight, September 2016 were used to inflate cost: renewal year one - 1.7%, renewal year two - 2.1%, renewal year three - 2.1%, renewal year four - 2.1 %, renewal year five - 2.1%.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The Factor G' estimates were based upon costs for State Fiscal year 2015. For Renewal years one through five, the following Personal Consumption Expenditures (PCE) – Health Care Consumption deflators (Chained Price Deflators 2009 = 100) as forecasted by IHS Global Insight, September 2016 were used to inflate cost: current year five - 1.7%, renewal year one - 1.8%, renewal year two - 2.1%, renewal year three - 2.3%, renewal year four - 2.4 %, renewal year five - 2.5%.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Day Habilitation	
Respite	
Supported Employment	

Waiver Services	
Prescription Medications	
Financial Management Services	
Support Consultation	
Adaptive Aids	
Audiology Services	
Behavioral Support	
Community Support	
Dental Treatment	
Dietary Services	
Employment Assistance	
Minor Home Modifications	
Nursing	
Occupational Therapy Services	
Physical Therapy Services	
Speech-Language Pathology	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**11039843.88**
Day Habilitation	Daily	2861	135.00	28.08	**10845478.80**	
Day Habilitation, CDS	Daily	78	102.00	24.43	**194365.08**	
Respite Total:						**25361622.11**
Respite, CDS	Hourly	625	440.00	17.89	**4919750.00**	
Respite	Hourly	2577	407.00	19.49	**20441872.11**	
Supported Employment Total:						**199732.80**
Supported Employment, CDS	Hourly	8	115.00	32.10	**29532.00**	
Supported Employment	Hourly	120	42.00	33.77	**170200.80**	
				GRAND TOTAL:		**44984607.64**
				Total Estimated Unduplicated Participants:		**6540**
				Factor D (Divide total by number of participants):		**6878.38**
				Average Length of Stay on the Waiver:		307

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prescription Medications Total:						**302502.60**
Prescription Medications	Per Rx	162	10.00	186.73	**302502.60**	
Financial Management Services Total:						**1317262.90**
Financial Management	Monthly	851	10.00	154.79	**1317262.90**	
Support Consultation Total:						**1168.12**
Support Consultation	Hourly	38	2.00	15.37	**1168.12**	
Adaptive Aids Total:						**111816.72**
Adaptive Aids	Per Item	156	3.00	236.23	**110555.64**	
Adaptive Aids, CDS	Per Item	2	2.00	315.27	**1261.08**	
Audiology Services Total:						**263.65**
Audiology, CDS	Hourly	0	0.00	0.01	**0.00**	
Audiology Services	Hourly	1	5.00	52.73	**263.65**	
Behavioral Support Total:						**319086.48**
Behavioral Support, CDS	Hourly	9	34.00	78.53	**24030.18**	
Behavioral Support	Hourly	371	10.00	79.53	**295056.30**	
Community Support Total:						**3528898.20**
Community Support	Hourly	1795	86.00	22.86	**3528898.20**	
Community Support, CDS	Hourly	0	0.00	0.01	**0.00**	
Dental Treatment Total:						**1721805.22**
Dental Treatment	Per Visit	2620	2.00	314.44	**1647665.60**	
Dental, CDS	Per Visit	109	2.00	340.09	**74139.62**	
Dietary Services Total:						**10447.92**
Dietary, CDS	Hourly	0	0.00	0.01	**0.00**	
Dietary Services	Hourly	63	3.00	55.28	**10447.92**	

GRAND TOTAL:	**44984607.64**
Total Estimated Unduplicated Participants:	**6540**
Factor D (Divide total by number of participants):	**6878.38**
Average Length of Stay on the Waiver:	307

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Assistance Total:						**54999.00**
Employment Assistance	Hourly	81	20.00	33.95	**54999.00**	
Employment Assistance, CDS	Hourly	0	0.00	0.01	**0.00**	
Minor Home Modifications Total:						**220876.36**
Minor Home Modifications	Per Item	46	1.00	4801.66	**220876.36**	
Nursing Total:						**367010.16**
Nursing	Hourly	2279	4.00	40.26	**367010.16**	
Nursing, CDS	Hourly	0	0.00	0.01	**0.00**	
Occupational Therapy Services Total:						**9848.25**
Occupational Therapy, CDS	Hourly	0	0.00	0.01	**0.00**	
Occupational Therapy Services	Hourly	45	3.00	72.95	**9848.25**	
Physical Therapy Services Total:						**35540.37**
Physical therapy, CDS	Hourly	1	0.00	76.43	**0.00**	
Physical Therapy Services	Hourly	51	9.00	77.43	**35540.37**	
Speech-Language Pathology Total:						**381882.90**
Speech-Language Pathology	Hourly	195	24.00	76.29	**357037.20**	
Speech and Language Pathology, CDS	Hourly	11	30.00	75.29	**24845.70**	
				GRAND TOTAL:		**44984607.64**
				Total Estimated Unduplicated Participants:		**6540**
				Factor D (Divide total by number of participants):		**6878.38**
				Average Length of Stay on the Waiver:		307

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**11036032.80**
Day Habilitation	Daily	2861	135.00	28.08	**10845478.80**	
Day Habilitation, CDS	Daily	78	100.00	24.43	**190554.00**	
Respite Total:						**25177401.17**
Respite, CDS	Hourly	625	437.00	17.89	**4886206.25**	
Respite	Hourly	2577	404.00	19.49	**20291194.92**	
Supported Employment Total:						**199732.80**
Supported Employment, CDS	Hourly	8	115.00	32.10	**29532.00**	
Supported Employment	Hourly	120	42.00	33.77	**170200.80**	
Prescription Medications Total:						**308853.00**
Prescription Medications	Per Rx	162	10.00	190.65	**308853.00**	
Financial Management Services Total:						**1317262.90**
Financial Management	Monthly	851	10.00	154.79	**1317262.90**	
Support Consultation Total:						**584.06**
Support Consultation	Hourly	38	1.00	15.37	**584.06**	
Adaptive Aids Total:						**113520.70**
Adaptive Aids	Per Item	156	3.00	241.19	**112876.92**	
Adaptive Aids, CDS	Per Item	2	1.00	321.89	**643.78**	
Audiology Services Total:						**263.65**
Audiology, CDS	Hourly	0	0.00	0.01	**0.00**	
Audiology Services	Hourly	1	5.00	52.73	**263.65**	
Behavioral Support Total:						**319086.48**
Behavioral Support, CDS	Hourly	9	34.00	78.53	**24030.18**	
Behavioral Support	Hourly	371	10.00	79.53	**295056.30**	

GRAND TOTAL:	**44803790.94**
Total Estimated Unduplicated Participants:	**6540**
Factor D (Divide total by number of participants):	**6850.73**
Average Length of Stay on the Waiver:	304

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Support Total:						**3487864.50**
Community Support	Hourly	1795	85.00	22.86	**3487864.50**	
Community Support, CDS	Hourly	0	0.00	0.01	**0.00**	
Dental Treatment Total:						**1757945.74**
Dental Treatment	Per Visit	2620	2.00	321.04	**1682249.60**	
Dental, CDS	Per Visit	109	2.00	347.23	**75696.14**	
Dietary Services Total:						**10447.92**
Dietary, CDS	Hourly	0	0.00	0.01	**0.00**	
Dietary Services	Hourly	63	3.00	55.28	**10447.92**	
Employment Assistance Total:						**54999.00**
Employment Assistance	Hourly	81	20.00	33.95	**54999.00**	
Employment Assistance, CDS	Hourly	0	0.00	0.01	**0.00**	
Minor Home Modifications Total:						**225514.54**
Minor Home Modifications	Per Item	46	1.00	4902.49	**225514.54**	
Nursing Total:						**367010.16**
Nursing	Hourly	2279	4.00	40.26	**367010.16**	
Nursing, CDS	Hourly	0	0.00	0.01	**0.00**	
Occupational Therapy Services Total:						**9848.25**
Occupational Therapy, CDS	Hourly	0	0.00	0.01	**0.00**	
Occupational Therapy Services	Hourly	45	3.00	72.95	**9848.25**	
Physical Therapy Services Total:						**35540.37**
Physical therapy, CDS	Hourly	1	0.00	76.43	**0.00**	
Physical Therapy Services	Hourly	51	9.00	77.43	**35540.37**	
Speech-Language Pathology Total:						**381882.90**
Speech-Language					**357037.20**	

GRAND TOTAL:	**44803790.94**
Total Estimated Unduplicated Participants:	**6540**
Factor D (Divide total by number of participants):	**6850.73**
Average Length of Stay on the Waiver:	304

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Pathology	Hourly	195	24.00	76.29		
Speech and Language Pathology, CDS	Hourly	11	30.00	75.29	24845.70	
				GRAND TOTAL:		44803790.94
				Total Estimated Unduplicated Participants:		6540
				Factor D (Divide total by number of participants):		6850.73
				Average Length of Stay on the Waiver:		304

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						11036032.80
Day Habilitation	Daily	2861	135.00	28.08	10845478.80	
Day Habilitation, CDS	Daily	78	100.00	24.43	190554.00	
Respite Total:						25177401.17
Respite, CDS	Hourly	625	437.00	17.89	4886206.25	
Respite	Hourly	2577	404.00	19.49	20291194.92	
Supported Employment Total:						199732.80
Supported Employment, CDS	Hourly	8	115.00	32.10	29532.00	
Supported Employment	Hourly	120	42.00	33.77	170200.80	
Prescription Medications Total:						315948.60
Prescription Medications	Per Rx	162	10.00	195.03	315948.60	
Financial Management Services Total:						1317262.90
Financial Management					1317262.90	
				GRAND TOTAL:		44810886.54
				Total Estimated Unduplicated Participants:		6540
				Factor D (Divide total by number of participants):		6851.82
				Average Length of Stay on the Waiver:		304

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Monthly	851	10.00	154.79		
Support Consultation Total:						**584.06**
Support Consultation	Hourly	38	1.00	15.37	**584.06**	
Adaptive Aids Total:						**113520.70**
Adaptive Aids	Per Item	156	3.00	241.19	**112876.92**	
Adaptive Aids, CDS	Per Item	2	1.00	321.89	**643.78**	
Audiology Services Total:						**263.65**
Audiology, CDS	Hourly	0	0.00	0.01	**0.00**	
Audiology Services	Hourly	1	5.00	52.73	**263.65**	
Behavioral Support Total:						**319086.48**
Behavioral Support, CDS	Hourly	9	34.00	78.53	**24030.18**	
Behavioral Support	Hourly	371	10.00	79.53	**295056.30**	
Community Support Total:						**3487864.50**
Community Support	Hourly	1795	85.00	22.86	**3487864.50**	
Community Support, CDS	Hourly	0	0.00	0.01	**0.00**	
Dental Treatment Total:						**1757945.74**
Dental Treatment	Per Visit	2620	2.00	321.04	**1682249.60**	
Dental, CDS	Per Visit	109	2.00	347.23	**75696.14**	
Dietary Services Total:						**10447.92**
Dietary, CDS	Hourly	0	0.00	0.01	**0.00**	
Dietary Services	Hourly	63	3.00	55.28	**10447.92**	
Employment Assistance Total:						**54999.00**
Employment Assistance	Hourly	81	20.00	33.95	**54999.00**	
Employment Assistance, CDS	Hourly	0	0.00	0.01	**0.00**	

GRAND TOTAL:	**44810886.54**
Total Estimated Unduplicated Participants:	**6540**
Factor D (Divide total by number of participants):	**6851.82**
Average Length of Stay on the Waiver:	304

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Minor Home Modifications Total:						**225514.54**
Minor Home Modifications	Per Item	46	1.00	4902.49	**225514.54**	
Nursing Total:						**367010.16**
Nursing	Hourly	2279	4.00	40.26	**367010.16**	
Nursing, CDS	Hourly	0	0.00	0.01	**0.00**	
Occupational Therapy Services Total:						**9848.25**
Occupational Therapy, CDS	Hourly	0	0.00	0.01	**0.00**	
Occupational Therapy Services	Hourly	45	3.00	72.95	**9848.25**	
Physical Therapy Services Total:						**35540.37**
Physical therapy, CDS	Hourly	1	0.00	76.43	**0.00**	
Physical Therapy Services	Hourly	51	9.00	77.43	**35540.37**	
Speech-Language Pathology Total:						**381882.90**
Speech-Language Pathology	Hourly	195	24.00	76.29	**357037.20**	
Speech and Language Pathology, CDS	Hourly	11	30.00	75.29	**24845.70**	

GRAND TOTAL:	**44810886.54**
Total Estimated Unduplicated Participants:	**6540**
Factor D (Divide total by number of participants):	**6851.82**
Average Length of Stay on the Waiver:	304

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**11036032.80**

GRAND TOTAL:	**44868769.62**
Total Estimated Unduplicated Participants:	**6540**
Factor D (Divide total by number of participants):	**6860.67**
Average Length of Stay on the Waiver:	304

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation	Daily	2861	135.00	28.08	10845478.80	
Day Habilitation, CDS	Daily	78	100.00	24.43	190554.00	
Respite Total:						25177401.17
Respite, CDS	Hourly	625	437.00	17.89	4886206.25	
Respite	Hourly	2577	404.00	19.49	20291194.92	
Supported Employment Total:						199732.80
Supported Employment, CDS	Hourly	8	115.00	32.10	29532.00	
Supported Employment	Hourly	120	42.00	33.77	170200.80	
Prescription Medications Total:						323530.20
Prescription Medications	Per Rx	162	10.00	199.71	323530.20	
Financial Management Services Total:						1317262.90
Financial Management	Monthly	851	10.00	154.79	1317262.90	
Support Consultation Total:						584.06
Support Consultation	Hourly	38	1.00	15.37	584.06	
Adaptive Aids Total:						116245.88
Adaptive Aids	Per Item	156	3.00	246.98	115586.64	
Adaptive Aids, CDS	Per Item	2	1.00	329.62	659.24	
Audiology Services Total:						263.65
Audiology, CDS	Hourly	0	0.00	0.01	0.00	
Audiology Services	Hourly	1	5.00	52.73	263.65	
Behavioral Support Total:						319086.48
Behavioral Support, CDS	Hourly	9	34.00	78.53	24030.18	
Behavioral Support	Hourly	371	10.00	79.53	295056.30	
Community Support Total:						3487864.50

GRAND TOTAL:	44868769.62
Total Estimated Unduplicated Participants:	6540
Factor D (Divide total by number of participants):	6860.67
Average Length of Stay on the Waiver:	304

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Support	Hourly	1795	85.00	22.86	3487864.50	
Community Support, CDS	Hourly	0	0.00	0.01	0.00	
Dental Treatment Total:						1800109.68
Dental Treatment	Per Visit	2620	2.00	328.74	1722597.60	
Dental, CDS	Per Visit	109	2.00	355.56	77512.08	
Dietary Services Total:						10447.92
Dietary, CDS	Hourly	0	0.00	0.01	0.00	
Dietary Services	Hourly	63	3.00	55.28	10447.92	
Employment Assistance Total:						54999.00
Employment Assistance	Hourly	81	20.00	33.95	54999.00	
Employment Assistance, CDS	Hourly	0	0.00	0.01	0.00	
Minor Home Modifications Total:						230926.90
Minor Home Modifications	Per Item	46	1.00	5020.15	230926.90	
Nursing Total:						367010.16
Nursing	Hourly	2279	4.00	40.26	367010.16	
Nursing, CDS	Hourly	0	0.00	0.01	0.00	
Occupational Therapy Services Total:						9848.25
Occupational Therapy, CDS	Hourly	0	0.00	0.01	0.00	
Occupational Therapy Services	Hourly	45	3.00	72.95	9848.25	
Physical Therapy Services Total:						35540.37
Physical therapy, CDS	Hourly	1	0.00	76.43	0.00	
Physical Therapy Services	Hourly	51	9.00	77.43	35540.37	
Speech-Language Pathology Total:						381882.90
Speech-Language Pathology	Hourly	195	24.00	76.29	357037.20	

GRAND TOTAL:	44868769.62
Total Estimated Unduplicated Participants:	6540
Factor D (Divide total by number of participants):	6860.67
Average Length of Stay on the Waiver:	304

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech and Language Pathology, CDS	Hourly	11	30.00	75.29	24845.70	
				GRAND TOTAL:		44868769.62
				Total Estimated Unduplicated Participants:		6540
				Factor D (Divide total by number of participants):		6860.67
				Average Length of Stay on the Waiver:		304

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						11036032.80
Day Habilitation	Daily	2861	135.00	28.08	10845478.80	
Day Habilitation, CDS	Daily	78	100.00	24.43	190554.00	
Respite Total:						25177401.17
Respite, CDS	Hourly	625	437.00	17.89	4886206.25	
Respite	Hourly	2577	404.00	19.49	20291194.92	
Supported Employment Total:						199732.80
Supported Employment, CDS	Hourly	8	115.00	32.10	29532.00	
Supported Employment	Hourly	120	42.00	33.77	170200.80	
Prescription Medications Total:						331290.00
Prescription Medications	Per Rx	162	10.00	204.50	331290.00	
Financial Management Services Total:						1317262.90
Financial Management	Monthly	851	10.00	154.79	1317262.90	
Support Consultation						584.06
				GRAND TOTAL:		44928065.70
				Total Estimated Unduplicated Participants:		6540
				Factor D (Divide total by number of participants):		6869.73
				Average Length of Stay on the Waiver:		304

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Support Consultation	Hourly	38	1.00	15.37	584.06	
Adaptive Aids Total:						119036.94
Adaptive Aids	Per Item	156	3.00	252.91	118361.88	
Adaptive Aids, CDS	Per Item	2	1.00	337.53	675.06	
Audiology Services Total:						263.65
Audiology, CDS	Hourly	0	0.00	0.01	0.00	
Audiology Services	Hourly	1	5.00	52.73	263.65	
Behavioral Support Total:						319086.48
Behavioral Support, CDS	Hourly	9	34.00	78.53	24030.18	
Behavioral Support	Hourly	371	10.00	79.53	295056.30	
Community Support Total:						3487864.50
Community Support	Hourly	1795	85.00	22.86	3487864.50	
Community Support, CDS	Hourly	0	0.00	0.01	0.00	
Dental Treatment Total:						1843312.82
Dental Treatment	Per Visit	2620	2.00	336.63	1763941.20	
Dental, CDS	Per Visit	109	2.00	364.09	79371.62	
Dietary Services Total:						10447.92
Dietary, CDS	Hourly	0	0.00	0.01	0.00	
Dietary Services	Hourly	63	3.00	55.28	10447.92	
Employment Assistance Total:						54999.00
Employment Assistance	Hourly	81	20.00	33.95	54999.00	
Employment Assistance, CDS	Hourly	0	0.00	0.01	0.00	
Minor Home Modifications Total:						236468.98
Minor Home Modifications					236468.98	

GRAND TOTAL:	44928065.70
Total Estimated Unduplicated Participants:	6540
Factor D (Divide total by number of participants):	6869.73
Average Length of Stay on the Waiver:	304

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Per Item	46	1.00	5140.63		
Nursing Total:						**367010.16**
Nursing	Hourly	2279	4.00	40.26	**367010.16**	
Nursing, CDS	Hourly	0	0.00	0.01	**0.00**	
Occupational Therapy Services Total:						**9848.25**
Occupational Therapy, CDS	Hourly	0	0.00	0.01	**0.00**	
Occupational Therapy Services	Hourly	45	3.00	72.95	**9848.25**	
Physical Therapy Services Total:						**35540.37**
Physical therapy, CDS	Hourly	1	0.00	76.43	**0.00**	
Physical Therapy Services	Hourly	51	9.00	77.43	**35540.37**	
Speech-Language Pathology Total:						**381882.90**
Speech-Language Pathology	Hourly	195	24.00	76.29	**357037.20**	
Speech and Language Pathology, CDS	Hourly	11	30.00	75.29	**24845.70**	

GRAND TOTAL:	**44928065.70**
Total Estimated Unduplicated Participants:	**6540**
Factor D (Divide total by number of participants):	**6869.73**
Average Length of Stay on the Waiver:	304