# 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:**
**Deaf Blind with Multiple Disabilities**

**C. Waiver Number:TX.0281**
**Original Base Waiver Number: TX.0281.R1.03**

**D. Amendment Number:**

**E. Proposed Effective Date:** (mm/dd/yy)
03/09/20
**Approved Effective Date of Waiver being Amended: 03/01/18**

## 2. Purpose(s) of Amendment

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

Appendix B
Changing interest list procedures for individuals who lose eligibility for the Medically Dependent Children Program, to comply with Senate Bill 1207 of the 86th Texas Legislature.

Appendix C
Correcting the licensing chapter for Behavioral Support service providers.

Correcting the licensing chapter for dentists as Dental service providers and adding dental hygienists as Dental service providers.

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

## 3. Nature of the Amendment

**A. Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following

component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

| Component of the Approved Waiver | Subsection(s) |
|---|---|
| ☐ **Waiver Application** | |
| ☐ **Appendix A Waiver Administration and Operation** | |
| ☒ **Appendix B Participant Access and Eligibility** | B-3.f |
| ☒ **Appendix C Participant Services** | C-1 |
| ☐ **Appendix D Participant Centered Service Planning and Delivery** | |
| ☒ **Appendix E Participant Direction of Services** | E-2.b |
| ☐ **Appendix F Participant Rights** | |
| ☐ **Appendix G Participant Safeguards** | |
| ☐ **Appendix H** | |
| ☐ **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
Changing interest list procedures for individuals who lose eligibility for the Medically Dependent Children Program, to comply with Senate Bill 1207 of the 86th Texas Legislature.

Appendix C
Correcting the licensing chapter for Behavioral Support service providers.

Correcting the licensing chapter for dentists as Dental service providers and adding dental hygienists as Dental service providers.

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

# 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*):

Deaf Blind with Multiple Disabilities

**C. Type of Request: amendment**

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

○ **3 years** ◉ **5 years**

**Original Base Waiver Number: TX.0281**
**Draft ID: TX.018.05.04**

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

Regular Waiver

**E. Proposed Effective Date of Waiver being Amended: 03/01/18**
**Approved Effective Date of Waiver being Amended: 03/01/18**

## 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:

Enrollment in the waiver is limited to individuals qualifying for an intermediate care facility level of care 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 Deaf Blind with Multiple Disabilities (DBMD) waiver, first authorized March 1, 1995, provides community based services and supports to individuals with legal blindness, deafness, or a condition that leads to deafblindness, and at least one additional disability that limits functional abilities. The goals of the DBMD waiver are to assist an individual to live in his/her own home, parent's or guardian's home, or in a small group home setting. These goals are intended to enhance quality of life, functional independence, health, and well-being. Services are intended to enhance, rather than replace, existing informal or formal supports and resources. Residential habilitation, respite, intervener, supported employment, and employment assistance are available through both the consumer directed option and the traditional agency option.

Individuals enrolling in the waiver choose a DBMD provider agency from a list of all agencies in the region where services will be provided. Once an agency is chosen, a case manager from the chosen agency facilitates the applicants enrollment and arranges for an initial service planning team meeting to determine needed services. The single State Medicaid Agency, the Health and Human Service Commission (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 applicants; 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 Uniform Fair Hearing Rules).

HHSC maintains all functions necessary to the operation of the waiver. These functions include participant waiver enrollment; waiver enrollment managed against approved limits; waiver expenditures managed against approved levels; level of care evaluation; review participant service plans; prior authorization of waiver services; utilization management; qualified provider enrollment; execution of Medicaid provider agreements; development of rules policies, procedures and information development governing the waiver program; and quality assurance and quality improvement activities.

## 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 DBMD Amendment Tribal Notification to the tribal representatives on October 1, 2018, in compliance with the 60-day federal and state requirements. Amended tribal notices were distributed on October 2, 2018, and October 11, 2018. The Tribal Notification provided contact information to request copies of the amendment, provide comments, and request information from the State via email, mail, or telephone. The State provides copies free of charge. The State did not receive any comments from the tribal representatives.

The Public Notice of Intent (PNI) for the DBMD Amendment was published in the Texas Register (https://www.sos.state.tx.us/texreg/archive/October122018/In%20Addition/In%20Addition.html#172) on October 12, 2018, 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.

HHSC also sent a request to the HHSC Office of Social Services to distribute notice of the amendment to 290 local eligibility offices with instructions to post the notice in public areas on October 16, 2018. HHSC received confirmation of HHSC Office of Social Services distribution and local office posting of the notice on October 16, 2018.

The State posted the amendment on the HHSC website on October 16, 2018, at https://hhs.texas.gov/laws-regulations/policies-rules/waivers/dbmd-waiver-applications. The public comment period expired on November 15, 2018. During the public comment period, 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) 730-7409 **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:**

State Medicaid Director or Designee

**Submission Date:**

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

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:** **Texas**

**Zip:**

**Phone:**

**Ext:** **TTY**

**Fax:**

**E-mail:**

## 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.*

The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

D-1-b Continued:

Case managers participate in the development and approval of the individual's service plan. The case manager supports the individual 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 Deaf Blind with Multiple Disabilities program, as well as through other non-waiver resources for which the individual may be qualified. Only in rare circumstances necessary to ensure health and safety, would a case manager also deliver direct attendant or other services such as intervenor to an individual. This ensures the administrative separation of case management and direct delivery of services to the greatest extent possible while ensuring the individual's health and safety. The case manager may only bill for the case management activities outlined in Title 40 of the Texas Administrative Code , Part 1, Chapter 42, Subchapter F, Division 3, §42.623 (relating to Case Management). If a service provider is providing a service other than case management, the service provider must bill separately for the specific service provided.

In addition, the service planning team process ensures that there is not a conflict of interest when a provider who monitors and assists in development of the service plan also provides other direct services. This team consists of the individual, legally authorized representative, case manager, nurse or program director, and staff providing direct services. The individual, legally authorized representative or both may designate direct service staff to be involved in the service planning and other persons such as family members, friends or advocates as well. All of the various team members contribute to development of the service plan based on the individual's interests, needs, strengths, likes and dislikes. The team assists in determining the types and amounts of services necessary for the plan and must approve of the service plan. Identifying the services and supports is not solely left up to the case manager or direct service provider.

Once complete the case manager submits the service plan and supporting documentation to HHSC who authorizes the requested services, conducts utilization review and has final approval on program enrollment and levels of service. HHSC reviews 100 percent of the Deaf Blind with Multiple Disabilities service plans to ensure that the services are necessary to protect the individual's health and welfare in the community, address at least one of the individual's related conditions or the additional disability that impairs independent functioning, supplement rather than replace the individual's natural supports and other non-waiver services and supports for which the individual is eligible, prevent the individual's admission to an institution, are the most appropriate type and amount of DBMD Program services and CFC services to meet the individual's needs, and are cost effective. HHSC Program Enrollment and Utilization Review staff remand service plans that do not meet program standards for corrections and additional clarification/justification. HHSC Program Enrollment and Utilization Review staff may make referrals to the Ombudsman if they identify any concerns for further investigation and follow up.

During monitoring reviews, HHSC monitors all DBMD provider agencies to ensure that the DBMD agency implements service planning requirements, including that the individual's needs are being met and that their service plan changes as their needs change.

Additionally, HHSC sends nurses to conduct face-to-face utilization reviews of individuals in the DBMD program each year. These reviews provide an extra assurance that DBMD recipients are receiving appropriate services and adequate care. Face-to-face reviews can result in the addition or reduction of services based on the nurse's review of documentation, observations and their professional opinion. If serious concerns are found referrals to 9-1-1, the Department of Family and Protective Services, the Ombudsman, Consumer Rights, Office of Inspector General, Board of Nursing, HHSC Contracts, Billing, or Consumer Directed Services are made.

## 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** | ☒ |
| **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**<br>Specify:<br>N/A | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☒ **Other**<br>Specify:<br>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** | | | ☐ |
| | ☐ | **Disabled (Physical)** | | | |
| | ☐ | **Disabled (Other)** | | | |
| ☐ **Aged or Disabled, or Both - Specific Recognized Subgroups** | | | | | |
| | ☐ | **Brain Injury** | | | ☐ |
| | ☐ | **HIV/AIDS** | | | ☐ |
| | ☐ | **Medically Fragile** | | | ☐ |
| | ☐ | **Technology Dependent** | | | ☐ |
| ☒ **Intellectual Disability or Developmental Disability, or Both** | | | | | |
| | ☐ | **Autism** | | | ☐ |
| | ☒ | **Developmental Disability** | 0 | | ☒ |
| | ☐ | **Intellectual Disability** | | | ☐ |
| ☐ **Mental Illness** | | | | | |
| | ☐ | **Mental Illness** | | | ☐ |
| | ☐ | **Serious Emotional Disturbance** | | | |

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

An eligible individual must:

1. be an individual with deafblindness or function as a person with deafblindness as defined in Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter B, 42.103;
2. have one or more additional disabilities that result in impairment to independent functioning;
3. qualify for an Intermediate Care Facility for Individuals with an Intellectual Disability level of care VIII;
4. not be enrolled in another Medicaid waiver program;
5. not be residing in an Intermediate Care Facility for Individuals with an Intellectual Disability, nursing facility, jail or hospital; and
6. comply with the mandatory participation requirements outlined in Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter B, §42.252.

**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:*

The cost limit is $114,736.07. The cost limit is determined by legislative direction. All individuals have access to services up to the cost ceiling if they have an identified need that is supported and justified.

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

○ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

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

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

○ **The following dollar amount:**

Specify dollar amount:

**The dollar amount** *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

*Specify:*

## Appendix B: Participant Access and Eligibility

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

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

The service planning team includes the individual, the individual's legally authorized representative, or both as appropriate; this team reviews assessments and other information related to the individual's service needs and develops a service plan that includes non-waiver services and supports as well as waiver services. The service planning team must have a reasonable expectation that the service plan will adequately meet the needs of the individual in the community setting. The service planning team members sign the service plan prior to implementation and certify that the waiver services are appropriate to meet the needs of the individual.

An individual is entitled to request a fair hearing if an individual's request for enrollment into the DBMD program is denied or is not acted upon with reasonable promptness. If a request for enrollment is denied, HHSC program staff send a letter to the provider that describes the action and explains the right to request a fair hearing. The provider is responsible for providing a copy of the letter to the individual, legally authorized representative, or both, as appropriate.

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

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

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

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

☒ **Other safeguard(s)**

Specify:

All waiver individuals must have a service plan at a cost within the cost limit. For individuals with needs that exceed the cost limit, HHSC has a process to ensure their needs are met. The process includes examining non-waiver resources, transitioning the individual to another waiver, possible use of state funds to cover costs above the cost limit, or transition to institutional services when necessary and appropriate.
During the enrollment process, at least annually, and during service review meetings held throughout the year or as needs are identified, the case manager informs the individual of other options and makes referrals as appropriate. If HHSC denies or suspends a service, proposes to reduce a service, or proposes to terminate the individual's program services, HHSC gives the individual or legally authorized representative the opportunity to request a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A.

## Appendix B: Participant Access and Eligibility

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

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

**Table: B-3-a**

| Waiver Year | Unduplicated Number of Participants |
|---|---|
| **Year 1** | 381 |
| **Year 2** | 378 |
| **Year 3** | 378 |
| **Year 4** | 378 |
| **Year 5** | 378 |

**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** | 345 |
| **Year 2** | 347 |

| Waiver Year | Maximum Number of Participants Served At Any Point During the Year |
|---|---|
| Year 3 | 342 |
| Year 4 | 342 |
| Year 5 | 342 |

## 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 | |
|---|---|
| Promoting Independence/Money Follows the Person | |

## Appendix B: Participant Access and Eligibility

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

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

Promoting Independence/Money Follows the Person

**Purpose** *(describe):*

Texas Promoting Independence/Money Follows the Person allows individuals residing in an institutional setting to return to the community and receive long-term services and supports without being placed on an interest list. The target population for the program is individuals who reside in an institution and are enrolled in Medicaid.

If the person is transitioning from a nursing facility, the relocation specialist, under contract with the MCO, provides relocation support. Some other institutions employ specialists who assist in transition from the institution to the community. If an individual chooses to relocate from an institution to the community, the transition specialist coordinates the relocation with the resident, provider case manager, and other applicable parties such as the resident's family, legally authorized representative, and the institution. In addition, representatives from the following organizations provide information and assistance to individuals residing in an institution interested in returning to a community setting:
• MCO Service Coordinator
• Local Area Agencies on Aging;
• Local Long-Term Care Ombudsmen;
• Institution Social Workers;
• Institution Family Councils;
• Local Long-Term Services and Supports Providers;
• Community Transition Teams; and
• Aging and Disability Resource Centers.

**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 | 1 |
| Year 2 | 1 |
| Year 3 | 1 |
| Year 4 | 1 |
| Year 5 | 1 |

## 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:

When appropriations do not support demand, HHSC maintains a DBMD interest list that contains the names of individuals interested in receiving DBMD Program services. Placement on the interest list is based on the chronological date of the request for DBMD services. Anyone may request for an individual's name to be added to the list by calling or submitting a written request to HHSC. When an individual is placed on the interest list, HHSC requests that the individual provide contact information, including a Texas mailing address, with the exception of individuals who are temporarily out of the state due to military assignments. If an applicant is a military family member living outside of Texas and claimed Texas as his or her state of residency prior to joining the military, he or she cannot be denied an interest list offer while he or she is living outside Texas during his or her 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.

HHSC offers a vacancy to individuals on a first-come, first-served basis as funding is available and according to the chronological date of the registration on the DBMD interest list. If an individual seeking entrance into DBMD meets the criteria for a reserved capacity group, he or she bypasses the interest list, as long as there are reserved waiver capacity slots available. If there are no slots remaining in the Promoting Independence/Money Follows the Person reserved capacity group, the State will request an increase in slots for the reserved capacity group to accommodate additional individuals. Promoting Independence/Money Follows the Person assists individuals living in an institution to return to the community to receive their long-term services and supports without having to be placed on an interest list.

Once an offer to apply for DBMD is made, the individual must choose a DBMD provider from a list of contracted DBMD providers and notify HHSC of the choice of provider. HHSC then notifies the chosen provider. The provider case manager must schedule and conduct a face-to-face contact with the individual to begin the eligibility process. The individual must meet DBMD eligibility requirements including level of care which is documented on the Intellectual Disability/Related Condition assessment. Once the assessment is completed, a physician must review and sign to attest to the accuracy of the information in the assessment. HHSC staff authorizes or denies the assignment of level of care based on the assessment and supporting documentation. Once this is complete, the provider case manager schedules a service planning team meeting to determine the services to be included in the service plan and the date for services to begin.

In addition to the individual's right to a fair hearing, 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 program's interest list, 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 place the individual's name on the program's interest list, using his or her original interest list request date.

An individual who is enrolled in the medically dependent children waiver program (MDCP) but becomes ineligible for services under MDCP because the individual no longer meets the level of care criteria for medical necessity for nursing facility care or the age requirement for the program may request to be placed on the DBMD interest list.
(1) If the individual's name is not on DBMD interest list and never has been, the DBMD interest list date will be the date of the request.
(2) If the individual's name is not on the DBMD interest list but was previously, the DBMD interest list date will be the date the individual's name was placed on the MDCP interest list.
(3) If the individual's name is on the DBMD interest list, the DBMD interest list date will be the earlier of: (A) the date the individual's name was placed on the MDCP interest list; or (B) the date the individual's name was placed on the DBMD interest list.

## 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:*

Children's Medicaid (§435.118)
Medicaid for Pregnant Women (§435.116)
Medicaid for Transitioning Foster Care Youth (1902(a)(10)(A)(ii)(XVII), 42 CFR §435.226)
Former Foster Care Children (§1902(a)(10)(A)(i)(IX), 42 CFR §435.150)
Earnings Transitional Medical Assistance (§1902(e)(1), §1925, 42 CFR §435.112)
Spousal Support Transitional (42 CFR §435.115(f))
Pickle (1939(a)(5)(E); (42 CFR 435.135; Sec 503 of P.L. 94-566))
Disabled Adult Children §1634(c); §1939(a)(2)(D)
Disabled Widow(er) §1634(b), 42 CFR §435.137; §1939(a)(2)(C)
Early Aged Widow(er) §1634(d), 42 CFR §435.138; §1939(a)(2)(E)
Foster Care and Adoption Assistance (§1902(a)(10)(A)(i)(I), §473(b)(3), 42 CFR §435.145)
Reasonable Classification Children Under 21 §1902(a)(10)(A)(ii)(I) and (IV), 42 CFR 435.222
Children with Non-IV-E Adoption Assistance (§1902(a)(10)(A)(ii)(VIII), 42 CFR §435.227)
Parent and Caretaker Relatives (§435.110)

***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:

*Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.*

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
*Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).*

*Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).*

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

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

*Select one*:

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

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

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

*Specify:*

○ **The following dollar amount**

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

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

*Specify:*

○ **Other**

*Specify:*

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

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

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

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

*Specify:*

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

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

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

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

*Specify:*

○ **Other**

*Specify:*

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

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

Select one:

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

*Specify:*

Texas uses the following limits:
• Covered services beyond the amount, duration, and scope of the Medicaid State Plan that are medically necessary are limited to the Medicaid State Plan rates;
• Services available from Medicaid providers, but recipient elects a non-Medicaid provider, are limited to zero;
• A deduction for incurred medically necessary non-covered medical or remedial care expenses will be allowed when the bill is incurred during a period which is no more than three months prior to the month of current application;
• A deduction for incurred medical expenses for durable medical equipment is based on the Medicare fee schedule for durable medical equipment. If an item is not listed on the schedule, the item is cleared through a Medicare contact at the CMS Regional Office; and,
• Expenses incurred as the result of imposition of a transfer of assets penalty period are limited to zero.

## Appendix B: Participant Access and Eligibility

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

*Select one*:

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

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

- ○ **Other standard included under the state Plan**

*Specify:*

- ○ **The following dollar amount**

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

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

*Specify:*

- ○ **Other**

*Specify:*

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

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

*Specify:*

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

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

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

  *Specify:*

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

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

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

  *Specify:*
- ○ **Other**

  *Specify:*

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

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

Select one:

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

*Specify:*

Texas uses the following limits:
• Covered services beyond the amount, duration, and scope of the Medicaid State Plan that are medically necessary are limited to the Medicaid State Plan rates;
• Services available from Medicaid providers, but recipient elects a non-Medicaid provider are limited to zero;
• A deduction for incurred medically necessary non-covered medical or remedial care expenses will be allowed when the bill is incurred during a period which is no more than three months prior to the month of current application;
• A deduction for incurred medical expenses for durable medical equipment is based on the Medicare fee schedule for durable medical equipment. If an item is not listed on the schedule, the item is cleared through a Medicare contact at the CMS Regional Office; and,
• Expenses incurred as the result of imposition of a transfer of assets penalty period are limited to zero.

## Appendix B: Participant Access and Eligibility

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

**i. Allowance for the personal needs of the waiver participant**

(*select one*):

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

  Specify percentage: 300

- ○ **The following dollar amount:**

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

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

  *Specify formula:*

○ **Other**

*Specify:*

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

Select one:

◉ **Allowance is the same**

○ **Allowance is different.**

*Explanation of difference:*

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

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

Select one:

○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

○ **The state does not establish reasonable limits.**

◉ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

## Appendix B: Participant Access and Eligibility

### B-6: Evaluation/Reevaluation of Level of Care

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

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

**i. Minimum number of services.**

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

1

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

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

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

**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:

Must have a bachelor's degree in a health and human services related field plus two years of experience in the delivery of services to individuals with disabilities; or be a qualified intellectual disability professional who meets the requirements outlined in 42 CFR 483.430(a); or have an associate's degree in a health and human services related field plus four years of experience in the delivery of services to individuals with disabilities.

**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.

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

HHSC assigns the level of care based on the Intellectual Disability/Related Condition Assessment submitted by the case manager through an online system that allows secure submission of electronic documentation, rather than submission of paper documentation. The Intellectual Disability/Related Condition Assessment, which must be signed by a physician at enrollment or when a diagnosis changes. This document includes all factors that are considered in evaluating a level of care determination: diagnostic information that includes age of onset of the qualifying conditions, names of qualifying conditions, the appropriate International Classification of Diseases codes, the name of adaptive behavior assessment tool, and the adaptive behavior level.

**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:

For initial evaluation, the case manager or the nurse employed by the provider completes the level of care assessment for an individual. The physician reviews the information contained in the Intellectual Disability/Related Condition assessment and attests to the onset of the primary diagnosis and additional diagnostic information by signing the form. The case manager submits the assessment to HHSC through an online system that allows secure submission of electronic documentation, rather than submission of paper documentation. Based on the assessment information submitted, HHSC staff authorizes or denies the assignment of level of care and notifies the program provider in writing of the decision. If the level of care is denied by HHSC, the DBMD provider must notify the individual of the denial, his or her right to request a fair hearing, and the process for requesting a fair hearing. With the exception of a physician's signature on the level of care assessment form, the process for reevaluation of level of care is the same as an initial evaluation.

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

- ( ) **Every three months**
- ( ) **Every six months**
- (●) **Every twelve months**
- ( ) **Other schedule**

  *Specify the other schedule:*

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

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**

○ **The qualifications are different.**
*Specify the qualifications:*

**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):*

HHSC requires DBMD provider agencies to annually resubmit the level of care assessment along with the annual service plan. HHSC has implemented an online portal system that allows secure submission of electronic documentation, rather than submission of paper documentation.. This allows for improved secure document transmission, reduced need for follow-up calls, emails, and faxes, and the ability to check submission status at any time. Providers will receive status updates on submissions, including if a submission needs additional information or documentation and when a submission reaches a final status. HHSC reviews each level of care assessment for accuracy. If HHSC discovers errors in submission, the DBMD provider agency is notified and instructed to correct the errors. If the DBMD provider does not submit a level of care reassessment prior to the expiration of the previously approved level of care, HHSC requires the DBMD provider to submit the level of care reassessment as soon as possible after the expiration. However, if granted, reinstatement will only be effective for up to 180 calendar days before the date HHSC receives the current Intellectual Disability/Related Condition Assessment, or the first day of the new IPC period, whichever is more recent. HHSC does not reimburse a provider for services provided during the time HHSC has not approved the level of care assessment.

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

Program providers are required to have policies and procedures in place to ensure timely submission of the level of care to HHSC and rules with specific time frames for completion of level of care requirements. HHSC monitors to ensure policies are in place and that level of care documentation is completed in line with program rules. HHSC reviews the level of care effective periods during on-site monitoring reviews.

**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 by HHSC, the State Medicaid Agency, and DBMD 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 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**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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.*

**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 new enrollees with initial LOCs completed prior to receipt of first service using approved processes and instruments. N: Number of new enrollees with initial LOCs completed prior to receipt of first service using approved processes and instruments. D: Number of new enrollees requiring initial LOC determinations who received at least one service.**

**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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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.

One hundred percent of level of care submissions are reviewed by HHSC through desk reviews. HHSC staff who are qualified intellectual disability professionals review the assessment information used to determine level of care and assure the accuracy of the level of care value for every individual in the DBMD waiver program.

One hundred percent of Deaf Blind with Multiple Disabilities providers are reviewed by HHSC Contracts staff at least every two years. This monitoring includes a review of the case records to ensure each individual in the sample has correctly completed level of care documentation.

**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.

HHSC staff who are qualified intellectual disability professionals review the assessment information used to determine level of care and ensure the accuracy of the level of care value for every individual in the DBMD waiver program. Any level of care forms completed incorrectly or developed using instruments and processes that are not approved are returned to the provider through the online portal system for correction prior to approval. The provider is responsible for correcting identified errors and returning level of care forms to HHSC. HHSC does not reimburse a provider for services provided during the time HHSC has not approved the level of care assessment.

HHSC Contract staff's monitoring procedure includes a review of each individual case record in the sample to ensure that each record includes documentation of an approved level of care. This monitoring reviews: whether the level of care forms were approved by HHSC, whether the level of care forms and supporting documentation were submitted to HHSC within the required timeframes, and whether providers have policies and procedures in place to ensure these documents were completed in line with the required timeframes.

Technical assistance is shared with providers throughout the monitoring reviews. The monitoring review culminates in an exit conference, during which the provider is informed of all findings and is given the opportunity to ask questions. Further technical guidance related to the findings is provided during the exit conference. If a corrective action plan is requested from the provider, the provider is informed that they may contact HHSC staff with questions or requests for clarification of what constitutes an acceptable corrective action plan. This provides further opportunity for the provider to receive technical assistance relating to the specific area of deficiency. If the findings necessitate action beyond a corrective action plan, HHSC Contracts staff refer the provider and the related recommendations to the Sanction Action Review Committee, which is responsible for determining what further action, if any, is needed. These actions range from placing a hold on new referrals up to contract termination. Upon submission, 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. Corrective action plans remain in effect for the duration of the contract and are monitored at each subsequent review.

**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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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).

During the initial meeting with an individual and annually thereafter, the case manager informs the individual of services available through DBMD and of any alternatives available including available third party resources. Additionally, the choice of institutional care versus home and community-based waiver services is explained and the individual or legally authorized representative signs the Waiver Program Verification of Freedom of Choice form to indicate choice of waiver services over institutional care. During the initial meeting and annually, the provider case manager must also address living arrangements, choice of providers, and the option to self-direct certain waiver services using HHSC forms.

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

The forms are maintained by HHSC and by the DBMD provider in the case 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 commission’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 HHS Translation Services Unit coordinates translations for HHSC. HHSC routinely provides Spanish translation of forms and letters and is responsive to other translation needs.

DBMD 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** | **Case Management** | | |
| **Statutory Service** | **Day Habilitation** | | |
| **Statutory Service** | **Residential Habilitation** | | |
| **Statutory Service** | **Respite** | | |
| **Statutory Service** | **Supported Employment** | | |
| **Extended State Plan Service** | **Prescribed Drugs** | | |
| **Supports for Participant Direction** | **Financial Management Services** | | |
| **Supports for Participant Direction** | **Support Consultation** | | |
| **Other Service** | **Adaptive Aids and Medical Supplies** | | |
| **Other Service** | **Assisted Living** | | |
| **Other Service** | **Audiology Services** | | |
| **Other Service** | **Behavioral Support Services** | | |
| **Other Service** | **Chore Service** | | |
| **Other Service** | **Dental Treatment** | | |
| **Other Service** | **Dietary Services** | | |
| **Other Service** | **Employment Assistance** | | |
| **Other Service** | **Intervener** | | |
| **Other Service** | **Minor Home Modifications** | | |
| **Other Service** | **Nursing** | | |
| **Other Service** | **Occupational Therapy Services** | | |
| **Other Service** | **Orientation and Mobility** | | |
| **Other Service** | **Physical Therapy Services** | | |
| **Other Service** | **Speech, Hearing, and Language Therapy Services** | | |
| **Other Service** | **Transition Assistance Services** | | |

# Appendix C: Participant Services

## C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Case Management

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

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

01 Case Management | 01010 case management

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

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

**Service Definition** *(Scope):*

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

Services which assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of service plans at enrollment, annually and as needed. Case managers observe the individual in his or her home and determine the intent and level of the individual's communication. If necessary, they determine from non-verbal communication the likes and dislikes of the individual. They lead the service planning team in development of a service plan that optimizes the opportunities for the individual to use his or her abilities and to integrate in community settings. They use the individual's knowledge of sign language and other communication systems to make the individual as aware as possible of his or her service plan and options. They communicate with service planning team members to ensure that the service plan is carried out appropriately. They monitor the success of the service plan by observing the individual at home and in the community. Case managers are responsible for ongoing monitoring of the provision of services included in the service plan.

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

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

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

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Home and community support services agency |

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Case Management**

**Provider Category:**

Agency

**Provider Type:**

Home and community support services agency

**Provider Qualifications**

**License** *(specify):*

Licensed as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97

**Certificate** *(specify):*

Current documentation of completion and certification of hands-on skills training in:
(1) cardiopulmonary resuscitation (CPR);
(2) first aid; and
(3) choking prevention.

**Other Standard** *(specify):*

The case manager must meet one of the following criteria:

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

- have an associate's degree in a health and human services related field and a minimum of four years of experience in the delivery of direct services to individuals with disabilities; or

- have a high school diploma or certificate recognized by a state as the equivalent of a high school diploma and a minimum of six years of experience in the delivery of services to individuals with disabilities.

The case manager must be fluent in the communication methods used by the individual or become fluent within six months after being assigned to work with an individual. The case manager must complete HHSC case management training and other training and orientation as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter D, §42.403.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The home and community support services agency is responsible for reviewing and documenting that the service provider meets the qualifications for that service. HHSC is responsible for verifying the qualifications based on the documentation provided by the home and community support services agency during monitoring reviews.

**Frequency of Verification:**

HHSC verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows:

HHSC Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 15 months of the contract term and every two years thereafter.

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

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

HHSC follows the internal policy of coordinating communications and operations between all involved HHSC departments when action is taken in regard to licensure violations. This policy ensures that authorized services are provided by Home and Community Support Services Agencies that are appropriately licensed and contracted.

## 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):**

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 04 Day Services | 04020 day habilitation |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Day habilitation services provide individuals with assistance in acquiring, retaining, or improving the 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 consistent with achieving the outcomes identified in the individual's service plan. Activities are also designed to reinforce therapeutic outcomes targeted by other waiver services, school, or other support providers.

Day habilitation is furnished in a setting other than the individual's residence on a regularly scheduled basis.

This service includes transportation necessary for the individual's participation in day habilitation activities, such as shopping, swimming, going to the park, or other community activities.

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

Day habilitation may not be provided to an individual at the same time as the following services: employment assistance, supported employment, residential habilitation, 24-hour assisted living, respite, or state plan Community First Choice Personal Assistance Services/Habilitation .

**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 | Home and community support services agency |

## 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:**

Home and community support services agency

**Provider Qualifications**

**License** *(specify):*

Licensed as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

**Certificate** *(specify):*

Current documentation of completion and certification of hands-on skills training in:
(1) cardiopulmonary resuscitation (CPR);
(2) first aid; and
(3) choking prevention.

**Other Standard** *(specify):*

The day habilitation provider must be 18 years of age or older and have:

- a high school diploma;
- a certificate recognized by a state as the equivalent of a high school diploma; or
- documentation of a proficiency evaluation of experience and competence to perform job tasks including an ability to provide the required services needed by the individual as demonstrated through a written competency-based assessment and at least three personal references from persons not related by blood that evidence the person's ability to provide a safe and healthy environment for the individual.

The provider must be fluent in the communication methods used by the individual or have the ability to become fluent in the communication methods used by the individual within three months after assignment to that individual. The provider of day habilitation must complete orientation and training as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter D, §42.403. If providing transportation, the provider of day habilitation must have a valid Texas driver's license with proof of insurance. Tasks delegated by a registered nurse must be performed in accordance with state law.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The home and community support services agency is responsible for reviewing and documenting that the service provider meets the qualifications for this service. HHSC is responsible for verifying the qualifications based on the documentation provided by the home and community support services agency during monitoring reviews.

**Frequency of Verification:**

HHSC verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows:

HHSC Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 15 months of the contract term and every two years thereafter.

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

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

HHSC follows the internal policy of coordinating communications and operations between all involved HHSC departments when action is taken regarding licensure violations. This policy ensures that authorized services the are provided by appropriately licensed and contracted Home and Community Support Services Agencies.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Residential Habilitation

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 08 Home-Based Services | 08010 home-based habilitation |
| **Category 2:** | **Sub-Category 2:** |
| 08 Home-Based Services | 08030 personal care |
| **Category 3:** | **Sub-Category 3:** |
| 08 Home-Based Services | 08040 companion |
| **Category 4:** | **Sub-Category 4:** |
| 15 Non-Medical Transportation | 15010 non-medical transportation |

**Service Definition** *(Scope):*

Habilitation services assist an individual in acquiring, retaining, and improving socialization and adaptive skills related to activities of daily living to enable the individual to live successfully in the community and participate in home and community life, including day habilitation and residential habilitation. Residential habilitation is provided to individuals living in their own home or family home. Residential Habilitation is not provided to individuals receiving licensed assisted living or licensed home health assisted living.

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

The DBMD residential habilitation waiver service may include:
- transportation necessary for the individual to participate in community activities or assistance in securing such transportation;
- assistance with ambulation and mobility;
- reinforcement of behavioral support or therapy activities;
- assistance with medications and the performance of tasks delegated by a registered nurse in accordance with state law;
- supervision of the individual's safety and security;
- assistance with acquisition, retention, or improvement of skills related to activities of daily living, including: personal grooming and cleanliness; bed making and household chores; and preparation and consumption of food;
- use of natural supports and typical community services; and
- social interaction and participation in leisure activities.

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

Payment will not be rendered for the routine care and supervision that a family member is legally obligated to provide or for activities or supervision for which a payment is made by a source other than Medicaid.

This service does not include payment for room or board and may not be provided at the same time as the following services: respite, day habilitation, employment assistance, supported employment, licensed assisted living, licensed home health assisted living, or state plan Community First Choice Personal Assistance Services/Habilitation.

**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 | Home and community support services 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: Residential Habilitation**

**Provider Category:**

Agency

**Provider Type:**

Home and community support services agency

**Provider Qualifications**

**License** *(specify):*

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

**Certificate** *(specify):*

Current documentation of completion and certification of hands-on skills training in:
(1) cardiopulmonary resuscitation (CPR);
(2) first aid; and
(3) choking prevention.

**Other Standard** *(specify):*

The residential habilitation provider must be 18 years of age or older and have:
- a high school diploma;
- a certificate recognized by a state as the equivalent of a high school diploma; or
- documentation of a proficiency evaluation of experience and competence to perform job tasks including an ability to provide the required services needed by the individual as demonstrated through a written competency-based assessment and at least three personal references from persons not related by blood that evidence the person's ability to provide a safe and healthy environment for the individual.

Residential habilitation can be provided by a family member if they are not the individual's spouse or the parent of an individual who is a minor child.

The provider must have the ability to learn the functional language of the individual within three months of serving the individual or be fluent in the communication methods used by the individual. The provider must complete orientation and training as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter D, §42.403. If providing transportation, the residential habilitation provider must have a valid Texas driver's license with proof of insurance. Tasks delegated by a registered nurse must be performed in accordance with state law.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The home and community support services agency is responsible for reviewing and documenting that the service provider meets the qualifications for that service. HHSC is responsible for verifying the qualifications based on the documentation provided by the home and community support services agency during monitoring reviews.

**Frequency of Verification:**

HHSC verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows:

HHSC Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 15 months of the contract term and every two years thereafter.

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

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

HHSC follows the internal policy of coordinating communications and operations between all involved HHSC departments when action is taken regarding licensure violations. This policy ensures that authorized services are provided by appropriately licensed and contracted Home and Community Support Services Agencies.

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Residential Habilitation**

**Provider Category:**

Individual

**Provider Type:**

Consumer directed services direct service provider

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Current documentation of completion and certification of hands-on skills training in:
(1) cardiopulmonary resuscitation (CPR);
(2) first aid; and
(3) choking prevention.

**Other Standard** *(specify):*

The residential habilitation provider must be 18 years of age or older and have:

- a high school diploma;
- a certificate recognized by a state as the equivalent of a high school diploma; or
- documentation of a proficiency evaluation of experience and competence to perform job tasks including an ability to provide the required services needed by the individual as demonstrated through a written competency-based assessment and at least three personal references from persons not related by blood that evidence the person's ability to provide a safe and healthy environment for the individual.

The provider must complete orientation and training as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter D, §42.403.

The consumer directed services direct service provider must be fluent in the communication methods used by the individual or have the ability to become fluent in the communication methods used by the individual within three months after assignment to the individual. The consumer directed services direct service provider must complete orientation and training as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter D, §42.403. If providing transportation, the provider of residential habilitation must have a valid Texas driver's license with proof of insurance. Tasks delegated by a registered nurse must be performed in accordance with state law.

In the consumer directed services option, the residential habilitation provider must not be the employer, the employer's spouse, the designated representative, the designated representative's spouse, legally authorized representative, or the spouse of the legally authorized representative.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The individual/employer or legally authorized representative is responsible for reviewing and documenting that the service provider meets the qualifications for that service. The financial management services agency legal entity is responsible for verifying the qualifications based on the documentation collected by the individual/employer or legally authorized representative.

During monitoring reviews, HHSC ensures that the financial management services agency legal entity has verified that each potential participant employer's service provider meets the required qualifications prior to being hired by the participant employer.

**Frequency of Verification:**

For individual providers, the financial management services agency legal entity and the individual/employer verify that each potential employee meets the required qualifications prior to being hired by the individual/employer.

Each new financial management services agency legal entity that must be monitored according to HHSC policy, is monitored within the first 15 months of the contract term. Thereafter, HHSC monitors financial management services agency legal entities at least every three years. Financial management services agency legal entities are monitored more frequently if the need is indicated or if there is a complaint filed against the financial management services agency legal entity. As a result of reviews, HHSC will recoup the financial management services agency monthly fees for service providers who were unqualified at the time they provided the service. Findings from monitoring reviews and complaint investigations may result in a corrective action plan and may go to the Sanction Action Review Committee to determine whether actions should be taken against the financial management services agency, including referral hold, vendor hold and involuntary contract termination.

Contracts staff must conduct intermittent monitoring for financial management services agency legal entities that do not meet an acceptable compliance level during formal monitoring reviews. Contracts staff responds to complaints received against a financial management services agency legal entity for failure to maintain provider qualifications. HHSC levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity.

## 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: |
|---|---|
| 09 Caregiver Support | 09011 respite, out-of-home |
| **Category 2:** | **Sub-Category 2:** |
| 09 Caregiver Support | 09012 respite, in-home |
| **Category 3:** | **Sub-Category 3:** |
| | |

**Service Definition** *(Scope):*

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

Respite is provided on a short-term basis to address a need caused by the absence or need for relief of persons normally providing unpaid care for the individual. This service must not be provided by the individual's spouse or a paid caregiver of residential habilitation with whom the individual resides. This service provides the individual with 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 therapy 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 service includes activities that facilitate the individual's inclusion in community activities, use of natural supports and typical community services, social interaction and participation in leisure activities, and daily and functional living skills.

Respite may be provided in the following locations: the individual's home or place of residence, the private residence of the respite provider, Intermediate Care facility for Individuals with Intellectual Disabilities with a certified capacity of six or less, an Assisted Living Facility with a licensed capacity of six or less, a home, or an outdoor camp accredited by the American Camping Association.

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

Respite is not provided to an individual receiving assisted living. This service may not be provided at the same time that supported employment, day habilitation, residential habilitation or state plan Community First Choice Personal Assistance Services/Habilitation is provided. The respite service is limited to 720 hours or 30 calendar days per service plan year.

**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 | Intermediate Care Facility for Individuals with Intellectual Disabilities |
| Agency | Assisted Living Facility |
| Agency | Outdoor Camp |
| Agency | Home and community support services 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: Respite**

**Provider Category:**
Agency

**Provider Type:**

Intermediate Care Facility for Individuals with Intellectual Disabilities

**Provider Qualifications**

**License** *(specify):*

Licensed by HHSC as an Intermediate Care facility for Individuals with Intellectual Disabilities in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 90;
Licensed or subject to being licensed in accordance with Texas Health and Safety Code, Chapter 252.

**Certificate** *(specify):*

Current documentation of completion and certification of hands-on skills training in:
(1) cardiopulmonary resuscitation (CPR);
(2) first aid; and
(3) choking prevention.

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The Intermediate Care Facility for Individuals with Intellectual Disabilities is responsible for reviewing and documenting that the service provider meets the qualifications for that service. HHSC is responsible for verifying the qualifications based on the documentation provided by the Intermediate Care Facility for Individuals with Intellectual Disabilities during monitoring reviews.

**Frequency of Verification:**

HHSC verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows:

HHSC Regulatory Services licenses Intermediate Care Facilities for Individuals with Intellectual Disabilities according to Title 40 of the Texas Administrative Code, Part 1, Chapter 90. Intermediate Care Facilities for Individuals with Intellectual Disabilities have annual recertification health and life safety code surveys every 12-15 months, per CMS Survey & Certification memorandum S&C: 13-11-ICF/IID. HHSC Regulatory staff verify the Qualified Intellectual Disability Professional qualifications during annual recertification surveys.

HHSC has an internal policy to coordinate communications and operations between all involved HHSC departments when action is taken regarding licensure violations. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers.

Licensed Intermediate Care Facilities for Individuals with Intellectual Disabilities also have an annual licensing inspection. All Intermediate Care Facilities for Individuals with Intellectual Disabilities have an annual State Standards of Participation inspection.

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Assisted Living Facility

**Provider Qualifications**

**License** *(specify):*

Assisted living homes serving four to six residents must have an Assisted Living Facility license in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 92.

**Certificate** *(specify):*

Current documentation of completion and certification of hands-on skills training in:
(1) cardiopulmonary resuscitation (CPR);
(2) first aid; and
(3) choking prevention.

**Other Standard** *(specify):*

The assisted living service provider must be 18 years of age or older and have:
- a high school diploma;
- a certificate recognized by a state as the equivalent of a high school diploma; or
- documentation of a proficiency evaluation of experience and competence to perform job tasks

including an ability to provide the required services needed by the individual as demonstrated through a written competency-based assessment and at least three personal references from persons not related by blood that evidence the person's ability to provide a safe and healthy environment for the individual.

Assisted living cannot be provided by the individual's spouse or the parent of an individual who is a minor child.

The provider must be fluent in the communication methods used by the individual or have the ability to become fluent in the communication methods used by the individual within three months after being assigned to the individual. The provider must have received orientation and training specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter D, §42.403. If providing transportation, the provider must have a valid Texas driver's license with proof of insurance. Tasks delegated by a registered nurse must be performed in accordance with state law.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The Assisted Living Facility is responsible for reviewing and documenting that the service provider meets the qualifications for that service. HHSC is responsible for verifying the qualifications based on the documentation provided by the Assisted Living Facility during monitoring reviews.

**Frequency of Verification:**

HHSC verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows:

HHSC Regulatory Services licenses Assisted Living Facilities, and is responsible for ensuring that providers meet licensing requirements, in accordance with Texas Health and Safety Code, Chapter 247 (relating to Assisted Living Facilities); and Title 40 of the Texas Administrative Code, Part 1, Chapter 92 (relating to Licensing Standards for Assisted Living Facilities).

Type A and Type B Assisted Living Facility licenses are valid for two years and facilities are inspected at least every two years. The inspection includes observation of the care of a sample of residents. HHSC Regulatory Services staff ensure operational and building requirements for Type A and Type B Assisted Living Facilities are met as described in Title 40 of the Texas Administrative Code, Part 1, Chapter 92.

In addition to the HHSC Regulatory Services licensure reviews, HHSC Contract staff conduct at least biennial on-site monitoring reviews of DBMD providers. Each new DBMD contract is monitored within the first 15 months of the contract and every two years thereafter.

Contracts staff must conduct intermittent monitoring for providers that do not meet an acceptable compliance level during formal monitoring reviews. HHSC investigates complaints received against a DBMD provider for failure to maintain provider qualifications. HHSC follows up on the investigation by assessing appropriate Medicaid provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity. Complaint investigations involving staff qualifications and services rendered are conducted according to the priority of the allegations.

Regulatory Services licenses Assisted Living Facilities according to Title 40 of the Texas Administrative Code, Part 1, Chapter 92, and is responsible for ensuring that providers meet qualifications. Type A and Type B Assisted Living Facility licenses are valid for two years and facilities are inspected every two years. Regulatory Services staff ensure operational and building requirements for Type A and Type B Assisted Living Facilities are met as described in Title 40 of the Texas Administrative Code, Part 1, Chapter 92.

HHSC follows the internal policy of coordinating communications and operations between all involved HHSC departments when action is taken regarding licensure violations. This policy ensures that authorized services are provided by the appropriate licensed and contracted providers .

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Outdoor Camp

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Current documentation of completion and certification of hands-on skills training in:
(1) cardiopulmonary resuscitation (CPR);
(2) first aid; and
(3) choking prevention.

**Other Standard** *(specify):*

Must be accredited by the American Camping Association and have experience serving individuals with disabilities.
The American Camp Association has multiple standards related to staff requirements including criminal background checks, cardiopulmonary resuscitation (CPR), experience and education requirements, personal references, and training.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The American Camp Association is responsible for ensuring the camp and their staff meet their accreditation standards.

The home and community support services agency is responsible for reviewing and documenting that the outdoor camp has current documentation of the American Camp Association accreditation. HHSC is responsible for verifying the qualifications based on the documentation provided by the home and community support services agency during monitoring reviews.

**Frequency of Verification:**

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

## Appendix C: Participant Services

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

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Home and community support services agency

**Provider Qualifications**

**License** *(specify):*

Title 40 of the Texas Administrative Code, Part 1, Chapter 97

**Certificate** *(specify):*

Current documentation of completion and certification of hands-on skills training in:
(1) cardiopulmonary resuscitation (CPR);
(2) first aid; and
(3) choking prevention.

**Other Standard** *(specify):*

The home and community support services agency employee providing respite must be 18 years of age or older and have:

- a high school diploma;
- a certificate recognized by a state as the equivalent of a high school diploma; or
- documentation of a proficiency evaluation of experience and competence to perform job tasks including an ability to provide the required services needed by the individual as demonstrated through a written competency-based assessment and at least three personal references from persons not related by blood that evidence the person's ability to provide a safe and healthy environment for the individual. Respite cannot be provided by the individual's spouse, the parent of an individual who is a minor child, or a residential habilitation or state plan community First Choice Personal Assistance Services/Habilitation provider with whom the individual resides.

The provider must be fluent in the communication methods used by the individual or have the ability to become fluent in the communication methods used by the individual within three months after being assigned to the individual. The provider must have received orientation and training specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter D, §42.403. If providing transportation, the provider must have a valid Texas driver's license with proof of insurance. Tasks delegated by a registered nurse must be performed in accordance with state law.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The home and community support services agency is responsible for reviewing and documenting that the service provider meets the qualifications for that service. HHSC is responsible for verifying the qualifications based on the documentation provided by the home and community support services agency during monitoring reviews.

**Frequency of Verification:**

HHSC verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows:

HHSC Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 15 months of the contract and every two years thereafter.

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

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

HHSC follows the internal policy of coordinating communications and operations between all involved HHSC departments when action is taken regarding licensure violations. This policy ensures that authorized services are provided by appropriately licensed and contracted Home and Community Support Services Agencies.

## 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):*

**Certificate** *(specify):*

Current documentation of completion and certification of hands-on skills training in:
(1) cardiopulmonary resuscitation (CPR);
(2) first aid; and
(3) choking prevention.

**Other Standard** *(specify):*

The consumer directed services direct service provider must be at least 18 years of age or older and have:

-a high school diploma;
-a certificate recognized by a state as the equivalent of a high school diploma; or
-documentation of a proficiency evaluation of experience and competence to perform job tasks including an ability to provide the required services needed by the individual as demonstrated through a written competency-based assessment and at least three personal references from persons not related by blood that evidence the person's ability to provide a safe and healthy environment for the individual.

The consumer directed services direct service provider must complete training and orientation as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter D, §42.403. The direct service provider must be fluent in the communication methods used by the individual or have the ability to become fluent in the communication methods used by the individual within three months after being assigned to the individual. If providing transportation, the direct service provider must have a valid Texas driver's license with proof of insurance. Tasks delegated by a registered nurse must be performed in accordance with state law. The provider cannot be the individual's spouse, legal guardian, or paid caregiver of residential habilitation with whom the individual resides.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The individual/-employer or legally authorized representative is responsible for reviewing and documenting that the service provider meets the qualifications for that service. The financial management services agency is responsible for verifying the qualifications based on the documentation collected by the individual/employer or legally authorized representative.

During monitoring reviews, HHSC ensures that the financial management services agency has verified that each potential participant employer's service provider meets the required qualifications prior to being hired by the participant employer.

**Frequency of Verification:**

The financial management services agency and the individual/employer verify that each potential employee meets the required qualifications prior to being hired by the individual/employer.

Each new financial management services agency legal entity that must be monitored according to HHSC policy is monitored within the first 15 months of the contract term. Thereafter, HHSC monitors financial management services agency legal entities at least every three years. Financial management services agencies are monitored more frequently if the need is indicated or if there is a complaint filed against the financial management services agency. A key part of that monitoring is to ensure that the financial management services agency has verified that each potential participant employer's service provider meets the required qualifications prior to being hired by the participant employer. As a result of reviews, HHSC will recoup the financial management services agency monthly fees for service providers who were unqualified at the time they provided the service. Findings from monitoring reviews and complaint investigations may result in a corrective action plan and may go to the Sanction Action Review Committee to determine whether actions should be taken against the financial management services agency, including referral hold, vendor hold, and involuntary contract termination.

Contracts staff must conduct intermittent monitoring for financial management services agency legal entities that do not meet an acceptable compliance level during formal monitoring reviews. Contracts staff responds to complaints received against a financial management services agency legal entity for failure to maintain provider qualifications. HHSC levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity.

## 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: |
|---|---|
| 03 Supported Employment | 03021 ongoing supported employment, individual |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |

**Service Definition** *(Scope):*

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

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

A provider of supported employment may bill for such services as: (1) transporting the individual to and from the worksite; (2) activities related to supporting the individual to be self-employed, work from home, or perform in a work setting; and (3) participating in the service planning team meetings.

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

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

Supported employment does not include sheltered work or other similar types of vocational services furnished in specialized facilities, or using Medicaid funds paid to the program provider for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
(A) paying an employer to encourage the employer to hire an individual, or for supervision, training, and adaptations for an individual that the employer typically makes available to other workers without disabilities filling similar positions in the business; or
(B) paying the individual as an incentive to participate in supported employment activities, or for expenses associated with the start-up costs or operating expenses of an individual's business.

This service may not be provided to an individual with the individual present at the same time that one of the following DBMD services is provided: day habilitation, residential habilitation, employment assistance, or respite.

**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 | Home and community support services 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: Supported Employment**

**Provider Category:**

Agency

**Provider Type:**

Home and community support services agency

**Provider Qualifications**

**License** *(specify):*

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

**Certificate** *(specify):*

Current documentation of completion and certification of hands-on skills training in:
(1) cardiopulmonary resuscitation (CPR);
(2) first aid; and
(3) choking prevention.

**Other Standard** *(specify):*

The provider must be at least 18 years of age, not be the individual's legally responsible person, and satisfy one of these options:
Option 1:
- have a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and
- one year's paid or unpaid experience providing employment services to people with disabilities.

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

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

The provider must be fluent in the communication methods used by the individual or have the ability to become fluent in the communication methods used by the individual within three months after assignment to the individual. The provider must complete orientation and training as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter D, §42.403. If providing transportation, the provider must have a valid Texas driver's license with proof of insurance. Tasks delegated by a registered nurse must be performed in accordance with state law.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The home and community support services agency is responsible for reviewing and documenting that the service provider meets the qualifications for that service. HHSC is responsible for verifying the qualifications based on the documentation provided by the home and community support services agency during monitoring reviews.

**Frequency of Verification:**

HHSC verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows:
HHSC Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 15 months of the contract term and every two years thereafter.

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

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

HHSC follows the internal policy of coordinating communications and operations between all involved HHSC departments when action is taken regarding licensure violations. This policy ensures that authorized services are provided by appropriately licensed and contracted Home and Community Support Services Agencies.

## 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):*

Current documentation of completion and certification of hands-on skills training in:
(1) cardiopulmonary resuscitation (CPR);
(2) first aid; and
(3) choking prevention.

**Other Standard** *(specify):*

The provider must be at least 18 years of age, not be the individual's legally responsible person, and satisfy one of these options:
Option 1:
- have a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and
- one year's paid or unpaid experience providing employment services to people with disabilities.
Option 2:
- have an associate's degree in rehabilitation, business, marketing, or a related human services field; and
- two years' paid or unpaid experience providing employment services to people with disabilities.
Option 3:
- have a high school diploma or Certificate of High School Equivalency (GED credentials); and
- three years' paid or unpaid experience providing employment services to people with disabilities.

The consumer directed services direct service provider must be fluent in the communication methods used by the individual or have the ability to become fluent in the communication methods used by the individual within three months after being assigned to the individual. The provider must complete orientation and training as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter D, §42.403. If providing transportation, the consumer directed services direct service provider must have a valid Texas driver's license with proof of insurance. Tasks delegated by a registered nurse must be performed in accordance with state law.

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The individual/employer or legally authorized representative is responsible for reviewing and documenting that the service provider meets the qualifications for that service. The financial management services agency is responsible for verifying the qualifications based on the documentation collected by the individual/employer or legally authorized representative.

During monitoring reviews, HHSC ensures that the financial management services agency has verified that each potential participant employer's service provider meets the required qualifications prior to being hired by the participant employer.

**Frequency of Verification:**

For individual providers, the financial management services agency and the individual/employer or legally authorized representative verify that each potential employee meets the required qualifications prior to being hired by the individual/employer.

Each new financial management services legal entity that must be monitored according to HHSC policy, is monitored within the first 15 months of the contract term. Thereafter, HHSC monitors financial management services agency legal entities at least every three years. Financial management services agencies are monitored more frequently if the need is indicated or if there is a complaint filed against the financial management services agency. A key part of that monitoring is to ensure that the financial management services agency legal entity has verified that each potential participant employer's service provider meets the required qualifications prior to being hired by the participant employer. As a result of reviews, HHSC will recoup the financial management services monthly fees for service providers who were unqualified at the time they provided the service. Findings from monitoring reviews and complaint investigations may result in a corrective action plan and may go to the Sanction Action Review Committee to determine whether actions should be taken against the financial management services agency legal entity, including referral hold, vendor hold, and involuntary contract termination.

Contracts staff must conduct intermittent monitoring for financial management services agency legal entities that do not meet an acceptable compliance level during formal monitoring reviews. Contracts staff responds to complaints received against a financial management services agency legal entity for failure to maintain provider qualifications. HHSC levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Extended State Plan Service

**Service Title:**

Prescribed Drugs

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 11 Other Health and Therapeutic Services | 11060 prescription drugs |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |

**Service Definition** *(Scope):*

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

This service provides unlimited prescription medications to individuals 21 or older enrolled in the waiver who are eligible for both Medicaid and Medicare (dually eligible). An individual who is dually eligible and 21 or older must obtain prescribed medications through the Medicare Prescription Drug Plan or through the Texas Medicaid State Plan (for certain medications excluded from Medicare), before using the waiver to obtain the medications. Individuals not dually eligible for Medicare and Medicaid who are receiving acute care services through managed care receive unlimited prescription medications through their managed care plan.

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

Individuals under the age of 21 who are Medicaid eligible continue to have access to unlimited prescriptions under the current Medicaid State Plan service pursuant to the Early Periodic Screening, Diagnosis, and Treatment benefit.

Individuals in the waiver who are enrolled in managed care for their acute care services receive unlimited prescription medications through their managed care plan and therefore do not qualify for prescriptions through the waiver. Dual eligible individuals 21 or older are excluded from enrollment into managed care and are still eligible for prescription medications through the waiver if they meet the requirements above.

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

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

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Pharmacies holding a Vendor Drug Medicaid Provider Agreement with HHSC |

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**
**Service Name: Prescribed Drugs**

**Provider Category:**

Agency

**Provider Type:**

Pharmacies holding a Vendor Drug Medicaid Provider Agreement with HHSC

**Provider Qualifications**

**License** *(specify):*

The pharmacy must be licensed by the Texas State Board of Pharmacy under Title 22 of the Texas Administrative Code, Part 15, Chapter 291.

**Certificate** *(specify):*

**Other Standard** *(specify):*

Must hold Vendor Drug Provider Agreement with 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: |
|---|---|
| 12 Services Supporting Self-Direction | 12010 financial management services in support of self-directio |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Financial management services provide assistance to individuals with managing funds associated with consumer directed services. The service includes initial orientation and ongoing training related to responsibilities of being an employer and adhering to employer legal requirements. The financial management services agency collects and processes timesheets, processes payroll and payables, and makes withholdings for and payment of applicable federal, state, and local employment-related taxes. The financial management services provider tracks disbursement of funds and provides periodic reports to the individual and case manager of all expenditures and the status of the individual's consumer directed services budget. The financial management services provider, referred to as the financial management services agency, also provides assistance in the development, monitoring, and revision of the individual's budget for each service delivered through the consumer directed services option and must maintain a separate account for each individual's budget. The financial management services agency provides assistance in: determining staff wages and benefits subject to state limits, hiring by verifying employee's citizenship status and qualifications, and conducting required background checks. The financial management services agency verifies and maintains documentation of employee qualifications, including citizenship status and documentation of services delivered.

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

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

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

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | 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):*

Private entities furnish financial management services. These entities, called financial management services agencies, are procured through an open enrollment process. The State has Medicaid provider agreements with multiple financial management services agencies. Through a delegation arrangement, HHSC executes a contract with the required elements of the HHSC Texas Medicaid provider agreement on behalf of HHSC.

Prior to contracting with HHSC to provide financial management services, a financial management services agency must comply with the requirements for delivery of financial management services, including attending a mandatory enrollment training conducted by HHSC. Topics covered in the training include: contracting requirements and procedures; financial management services agency responsibilities; consumer/employer responsibilities; case manager responsibilities; enrollment, transfer, suspension and termination of the consumer directed services option; employer budgets; reporting abuse, neglect, and exploitation allegations; oversight of consumer directed services; contract compliance; and financial monitoring. The required training materials include the definition and responsibilities of a vendor fiscal/ employer agent in accordance with IRS Revenue Procedure and an explanation of fiscal employer agent based on Section 3504 of the IRS code and state tax (unemployment) requirements as a Vendor Fiscal/Employer Agent. The training also covers IRS Forms SS-4 and 2678. The HHSC rules for the consumer directed services option, located in Title 40 of the Texas Administrative Code, Part 1, Chapter 41, require financial management services agencies to act as employer-agents. These state and federal rules also describe additional responsibilities of the financial management services agency.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

HHSC is responsible for verifying the qualifications of Financial Management Services Agencies prior to awarding a contract and during monitoring reviews. HHSC ensures the financial management agencies has policies in place for screening employees.

**Frequency of Verification:**

Each new financial management services legal entity that must be monitored according to HHSC policy is monitored within the first 15 months of the contract term. Thereafter, HHSC monitors financial management services agency legal entities at least every three years. Financial management services agencies are monitored more frequently if the need is indicated or if there is a complaint filed against the financial management services agency legal entity. A key part of that monitoring is to ensure that the financial management services agency legal entity has verified that each potential participant employer's service provider meets the required qualifications prior to being hired by the participant employer. As a result of reviews, HHSC will recoup the financial management services monthly fees for service providers who were unqualified at the time they provided the service. Findings from monitoring reviews and complaint investigations may result in a corrective action plan and may go to the Sanction Action Review Committee to determine if the following actions or sanctions should be taken against the financial management services agency legal entity: referral hold, vendor hold, and involuntary contract termination.

## 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:**

Other Supports for Participant Direction

**Alternate Service Title (if any):**

Support Consultation

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 12 Services Supporting Self-Direction | 12020 information and assistance in support of self-direction |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Support consultation offers practical skills training and assistance to enable an employer to direct those services the individual or the legally authorized representative elects to self-direct. This service is provided by a certified support advisor, and 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 back-up plans for services considered critical to the individual's health and welfare in the absence of the regular provider or an emergency situation. Skills training involves such activities as training and coaching the individual or employer regarding how to write an ad, how to interview potential job candidates, and role-playing to prepare to interview potential employees. In addition, the support advisor assists the individual or the employer to determine staff duties, to orient and instruct staff in duties, and to schedule staff. Support advisers also assist the individual with activities related to the supervision, performance evaluation, and discharge of staff. This service provides sufficient information and assistance to ensure that individuals and their representatives understand the responsibilities involved with consumer direction. The State defines support consultation as an optional service provided by a support advisor and provides a level of assistance and training beyond that provided by the consumer directed services agency through financial management services. Support consultation helps an individual or the employer to meet the required employer responsibilities of the consumer directed services option and to deliver program services successfully. Support consultation may be provided by a certified support advisor associated with a financial management services agency selected by the individual or the employer or by an independent certified support advisor.

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

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

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

☐ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| 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):*

**Certificate** *(specify):*

Provider must have a Support Advisor certificate issued by HHSC to indicate successful completion of required training conducted or approved by HHSC.

**Other Standard** *(specify):*

The direct service provider of support consultation 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
-complete any ongoing training if required by and conducted or authorized by HHSC.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The individual/employer or legally authorized representative is responsible for reviewing and documenting that the service provider meets the qualifications for that service. The financial management services agency is responsible for verifying the qualifications based on the documentation collected by the individual/employer or legally authorized representative.

During monitoring reviews, HHSC ensures that the financial management services agency has verified that each potential participant employer's service provider meets the required qualifications prior to being hired by the participant employer.

**Frequency of Verification:**

The financial management services agency legal entity and the individual/employer verify that each potential employee meets the required qualifications prior to being hired by the individual/employer.

Each new financial management services legal entity that must be monitored according to HHSC policy, is monitored within the first 15 months of the contract term. Thereafter, HHSC monitors financial management services agency legal entities at least every three years. Financial management services agency legal entities are monitored more frequently if the need is indicated or if there is a complaint filed against the financial management services agency legal entity. As a result of reviews, HHSC will recoup the financial management services monthly fees for service providers who were unqualified at the time they provided the service. Findings from monitoring reviews and complaint investigations may result in a corrective action plan and may go to the Sanction Action Review Committee to determine whether actions should be taken against the financial management services agency legal entity, including referral hold, vendor hold, and involuntary contract termination.

Contracts staff must conduct intermittent monitoring for financial management services agency legal entities that do not meet an acceptable compliance level during formal monitoring reviews. Contracts staff responds to complaints received against a financial management services agency legal entity for failure to maintain provider qualifications. HHSC levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity.

## 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 and Medical Supplies

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 14 Equipment, Technology, and Modifications | 14010 personal emergency response system (PERS) |
| **Category 2:** | **Sub-Category 2:** |
| 14 Equipment, Technology, and Modifications | 14020 home and/or vehicle accessibility adaptations |
| **Category 3:** | **Sub-Category 3:** |
| 15 Non-Medical Transportation | 15010 non-medical transportation |
| **Category 4:** | **Sub-Category 4:** |

**Service Definition** (Scope):

17 Other Services | 17020 interpreter

Adaptive aids include items that assist an individual with mobility and communication, and the 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 must be in addition to any medical equipment and supplies furnished under the Medicaid state plan. All items must meet applicable standards of manufacture, design, and installation. Temporary Lease/Rental of Medically Necessary Durable Medical Equipment is allowable during repair, purchase, or replacement of essential support system or while non-waiver resources review the medical necessity and shall not exceed 90 days.

An adaptive aid is provided for a specific individual and becomes the exclusive property of that individual. The individual's service planning team must authorize all adaptive aids. Items must be authorized by the service planning team based upon written evaluations and recommendations by a qualified professional able to assess the individual's need for the specific adaptive aid. These qualified professionals include: the individual's physician; a licensed occupational or physical therapist; a psychologist; licensed psychological associate; dentist; optometrist; ophthalmologist; a registered nurse; a licensed dietician; a licensed audiologist, orientation, and mobility specialist; or speech/language pathologist. 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
-Other modifications/additions to primary transportation vehicles
-Respiratory aids
-Sensory adaptations
-Mobility aids
-Positioning devices
-Environmental control units
-Medically necessary supplies or equipment
-Communication aids (including batteries)
-Adaptive or modified equipment for activities of daily living
-Safety devices
-Temporary lease/rental of medically necessary durable medical equipment to allow for repair, purchase, replacement of essential support system
-A full list of adaptive aids may be found at: DBMD, Section 1000, Adaptive Aids/Vehicle Modification Services

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

The maximum amount of funds available for adaptive aids is $10,000 per individual per service plan year. Adaptive aids are provided under this waiver when no other financial resource for such aids is available or when other available resources have been used. 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, other governmental programs, or private insurance. Individuals who are under 21 years of age must purchase adaptive aids through the Texas Health Steps--Comprehensive Care Program Early Periodic Screening, Diagnosis, and Treatment benefit before purchasing adaptive aids through 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 | Home and community support services agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Adaptive Aids and Medical Supplies**

**Provider Category:**

Agency

**Provider Type:**

Home and community support services agency

**Provider Qualifications**

**License** *(specify):*

Licensed by DADS as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

**Certificate** *(specify):*

**Other Standard** *(specify):*

The home and community support services agency must hire or subcontract with an adaptive aid or medical supply provider that complies with the requirements as set by HHSC for delivery of adaptive aids and medical supplies, including requirements such as types of allowed items, time frames for delivery, training on the use of adaptive aids, and follow-up on the purchase of the item.

Adaptive aids and medical supplies must be provided by contractors and suppliers capable of meeting applicable standards of manufacture, design, and installation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The home and community support services agency is responsible for reviewing and documenting that the service provider meets the qualifications for that service. HHSC is responsible for verifying the qualifications based on the documentation provided by the home and community support services agency during monitoring reviews.

**Frequency of Verification:**

HHSC verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows:

HHSC Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 15 months of the contract term and every two years thereafter.

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

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

HHSC follows the internal policy of coordinating communications and operations between all involved HHSC departments when action is taken regarding licensure violations. This policy ensures that authorized services are provided by appropriately licensed and contracted Home and Community Support Services Agencies.

## 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:**

Assisted Living

**HCBS Taxonomy:**

**Category 1:** 02 Round-the-Clock Services

**Sub-Category 1:** 02031 in-home residential habilitation

**Category 2:** 02 Round-the-Clock Services

**Sub-Category 2:** 02011 group living, residential habilitation

**Category 3:**

**Sub-Category 3:**

**Service Definition** *(Scope):*

**Category 4:**

**Sub-Category 4:**

Provides personal assistance with activities of daily living and assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in the community. Services also include homemaker and chore services and therapeutic social and recreational activities. This service includes 18- or 24-hour on-site staff to meet scheduled or unpredictable needs and to provide supervision of safety and security. Personalized services are furnished to individuals in homes with 1 to 3 residents or 4 to 6 residents.

Assisted living may also include assistance with health care maintenance and medication administration provided within the scope of state law, and non-medical transportation as specified in the service plan. Transportation provided within the assisted living service is above and beyond the scope of transportation through the state plan service.

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

Separate payment will not be made for respite, residential habilitation, transition assistance services, chore services, or state plan Community First Choice Personal Assistance/Habilitation services. On days an individual receives 24-hour assisted living, separate payment will not be made for day habilitation. When day habilitation is needed or if the individual is absent for 6 or more hours in a day, services must be claimed as 18-hour assisted living. This prevents duplication of services. Separate payment will not be made for 24-hour skilled nursing care.

**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 | Home and community support services agency |
| Agency | Assisted Living Facility |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Assisted Living**

**Provider Category:**

Agency

**Provider Type:**

Home and community support services agency

**Provider Qualifications**

**License** *(specify):*

Licensed as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

**Certificate** *(specify):*

Current documentation of completion and certification of hands-on skills training in:
(1) cardiopulmonary resuscitation (CPR);
(2) first aid; and
(3) choking prevention.

**Other Standard** *(specify):*

Providers of assisted living must be 18 years of age or older and have:
-a high school diploma;
-a certificate recognized by a state as the equivalent of a high school diploma; or
-documentation of a proficiency evaluation of experience and competence to perform job tasks including an ability to provide the required services needed by the individual as demonstrated through a written competency-based assessment and at least three personal references from persons not related by blood that evidence the person's ability to provide a safe and healthy environment for the individual.

The provider must be fluent in the communication methods used by the individual or have the ability to become fluent in the communication methods used by the individual within three months after being assigned to the individual. The provider must complete orientation and training as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter D, §42.403. If providing transportation, the provider must have a valid Texas driver's license with proof of insurance. Tasks delegated by a registered nurse must be performed in accordance with state law.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The home and community support services agency is responsible for reviewing and documenting that the service provider meets the qualifications for that service. HHSC is responsible for verifying the qualifications based on the documentation provided by the home and community support services agency during monitoring reviews.

**Frequency of Verification:**

HHSC verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows:

HHSC Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 15 months of the contract term and every two years thereafter.

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

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

HHSC follows the internal policy of coordinating communications and operations between all involved HHSC departments when action is taken regarding licensure violations. This policy ensures that authorized services are provided by appropriately licensed and contracted Home and Community Support Services Agencies.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Assisted Living**

**Provider Category:**

Agency

**Provider Type:**

Assisted Living Facility

**Provider Qualifications**

**License** *(specify):*

Homes in which four to six individuals reside must be licensed as an Assisted Living Facility under Title 40 of the Texas Administrative Code, Part 1, Chapter 92.

**Certificate** *(specify):*

Current documentation of completion and certification of hands-on skills training in:
(1) cardiopulmonary resuscitation (CPR);
(2) first aid; and
(3) choking prevention.

**Other Standard** *(specify):*

Providers of assisted living must be 18 years of age or older and have:
-a high school diploma;
-a certificate recognized by a state as the equivalent of a high school diploma; or
-documentation of a proficiency evaluation of experience and competence to perform job tasks including an ability to provide the required services needed by the individual as demonstrated through a written competency-based assessment and at least three personal references from persons not related by blood that evidence the person's ability to provide a safe and healthy environment for the individual.

The provider must be fluent in the communication methods used by the individual or have the ability to become fluent in the communication methods used by the individual within three months after being assigned to the individual. The provider must complete orientation and training as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter D, §42.403. If providing transportation, the provider must have a valid Texas driver's license with proof of insurance. Tasks delegated by a registered nurse must be performed in accordance with state law.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The home and community support services agency is responsible for reviewing and documenting that the service provider meets the qualifications for that service. HHSC is responsible for verifying the qualifications based on the documentation provided by the home and community support services agency during monitoring reviews.

**Frequency of Verification:**

HHSC verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows:

HHSC Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 15 months of the contract term and every two years thereafter.

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

HHSC Regulatory Services licenses Assisted Living Facilities according to Title 40 of the Texas Administrative Code, Part 1, Chapter 92, and is responsible for ensuring that providers meet qualifications. Type A and Type B Assisted Living Facility licenses are valid for two years and facilities are inspected every two years. The inspection includes observation of the care of a sample of residents. HHSC Regulatory Services staff ensure operational and building requirements for Type A and Type B Assisted Living Facilities are met as described in Title 40 of the Texas Administrative Code, Part 1, Chapter 92.

HHSC follows the internal policy of coordinating communications and operations between all involved HHSC departments when action is taken regarding licensure violations. This policy ensures that authorized services are provided by appropriate licensed and contracted providers.

# Appendix C: Participant Services

## C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Audiology Services

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 11 Other Health and Therapeutic Services | 11100 speech, hearing, and language therapy |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Audiology 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;
-Consultation with other service providers and family members; and
-Participation on the service planning team, when appropriate.

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

Audiology services are provided through the waiver when no other financial resources for the service are available or when other available resources have been exhausted. 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 Early Periodic Screening, Diagnosis, and Treatment 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 | Home and community support services agency |

## 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:**

Home and community support services agency

**Provider Qualifications**

**License** *(specify):*

Licensed by HHSC as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

The audiologist must be licensed under Title 22 of the Texas Administrative Code, Part 32, Chapter 741.

**Certificate** *(specify):*

**Other Standard** *(specify):*

The home and community support services agency must hire a person who complies with the requirements for delivery of audiology services in accordance with the service plan, which includes the audiologist duties and credentialing.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The home and community support services agency is responsible for reviewing and documenting that the service provider meets the qualifications for that service. HHSC is responsible for verifying the qualifications based on the documentation provided by the home and community support services agency during monitoring reviews.

**Frequency of Verification:**

HHSC verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows:

HHSC Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 15 months of the contract term and every two years thereafter.

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

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

HHSC follows the internal policy of coordinating communications and operations between all involved HHSC departments when action is taken regarding licensure violations. This policy ensures that authorized services are provided by appropriately licensed and contracted Home and Community Support Services Agencies.

# 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 Services

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 10 Other Mental Health and Behavioral Services | 10040 behavior support |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Behavioral support services provide specialized interventions that assist an individual in increasing adaptive behaviors 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, with a particular emphasis on communication as it affects behavior.

The service includes assessment and analysis of assessment findings of the behavior(s) to be targeted so that an appropriate behavior support or communication plan may be designed; development of an individualized behavioral support plan consistent with the outcomes identified in the individual's service plan; training of and consultation with family members or other support providers on 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. When appropriate, the person providing behavioral support educates the individual in the purpose/objectives, methods and documentation requirements of the plan. The service may also include counseling with and educating a participant's family, friends or other service providers about interacting with a participant whose behaviors may interfere with independent living.

The scope of behavioral support services offered in this waiver exceeds the state plan psychological services benefit and may be provided by a certified behavior analyst or a behavior communications specialist, neither of which is allowed under the state plan service. Under the waiver, behavioral support services will be provided to maintain the individual's optimum condition.

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

Behavioral support services are provided through the waiver when no other financial resources are available or when other available resources have been exhausted.

**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 | Home and community support services agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Behavioral Support Services**

**Provider Category:**

Agency

**Provider Type:**

Home and community support services agency

**Provider Qualifications**

**License** *(specify):*

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

The behavioral support service provider must be:
- a psychologist licensed in accordance with the Texas Occupations Code, Chapter 501;
- a provisional license holder licensed in accordance with the Texas Occupations Code, Chapter 501;
- a psychological associate licensed in accordance the Texas Occupations Code, Chapter 501;
- a licensed clinical social worker licensed in accordance with the Texas Occupations Code, Chapter 505;
- a licensed professional counselor licensed in accordance with the Texas Occupations Code, Chapter 503; or
-a licensed behavior analyst in accordance with the Texas Occupations Code, Chapter 506.

**Certificate** *(specify):*

Certification as Behavior Analyst by the Behavior Analyst Certification Board, Inc.

**Other Standard** *(specify):*

Behavior Communication Specialist with a Masters or Ph.D degree in special education, psychology, or a related human services discipline, and three years of experience providing direct services to individuals who have deafblindness; or

- Bachelor’s degree in psychology or special education and seven years of experience providing direct services to individuals who have deafblindness and multiple disabilities.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The home and community support services agency is responsible for reviewing and documenting that the service provider meets the qualifications for that service. HHSC is responsible for verifying the qualifications based on the documentation provided by the home and community support services agency during monitoring reviews.

**Frequency of Verification:**

HHSC verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows:

HHSC Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 15 months of the contract term and every two years thereafter.

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

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

HHSC follows the internal policy of coordinating communications and operations between all involved HHSC departments when action is taken regarding licensure violations. This policy ensures that authorized services are provided by appropriately licensed and contracted Home and Community Support Services Agencies.

## 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:**

Chore Service

**HCBS Taxonomy:**

**Category 1:** 08 Home-Based Services

**Sub-Category 1:** 08060 chore

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition** *(Scope):*

**Category 4:**

**Sub-Category 4:**

Services needed to maintain the individual's home as a clean, sanitary, and safe environment. In order to provide safe access and egress, this service includes heavy household chores such as washing floors, windows, and walls; securing loose rugs and tiles; and moving heavy items or furniture.

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

These services will be provided only in cases when neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and when no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for the provision of the service. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

These services will not be provided to an individual receiving assisted living.

**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 | Home and community support services agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Chore Service**

**Provider Category:**
Agency

**Provider Type:**

Home and community support services agency

**Provider Qualifications**

**License** *(specify):*

Licensed as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

**Certificate** *(specify):*

**Other Standard** *(specify):*

The chore service provider must be 18 years of age or older and be able to read, write, and follow directions. The chore service provider must demonstrate skills in performing household tasks including cleaning, mopping, buffing, and waxing.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The home and community support services agency is responsible for reviewing and documenting that the service provider meets the qualifications for that service. HHSC is responsible for verifying the qualifications based on the documentation provided by the home and community support services agency during monitoring reviews.

**Frequency of Verification:**

HHSC verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows:

HHSC Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 15 months of the contract term and every two years thereafter.

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

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

HHSC follows the internal policy of coordinating communications and operations between all involved HHSC departments when action is taken regarding licensure violations. This policy ensures that authorized services are provided by appropriately licensed and contracted Home and Community Support Services Agencies.

## 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:** 11 Other Health and Therapeutic Services

**Sub-Category 1:** 11070 dental services

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition** *(Scope):*

**Category 4:**

**Sub-Category 4:**

This service includes the following two elements:

(A) Routine preventive, therapeutic, orthodontic treatment, and emergency dental treatment, to include:
1. 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;
2. Preventive dental treatment: Examinations, X-rays, cleanings, sealants, oral prophylaxes, and topical fluoride applications;
3. Therapeutic dental treatment: Treatment that includes, but is not limited to: fillings, scaling, extractions, crowns, pulp therapy for permanent and primary teeth; restoration of carious permanent and primary teeth; maintenance of space; and limited provision of removable prostheses when masticatory function is impaired, when an existing prosthesis is unserviceable, or when aesthetic considerations interfere with employment or social development;
4. Orthodontic dental treatment: Procedures that include treatment of retained deciduous teeth; cross-bite therapy; facial accidents involving severe traumatic deviations; cleft palates with gross malocclusion that will benefit from early treatment; and severe, handicapping malocclusions affecting permanent dentition with a minimum score of 26 as measured on the Handicapping Labio-lingual Deviation Index; and
5. Administration of routine local anesthesia necessary for dental treatment.

(B) Sedation necessary to perform dental treatment including non-routine anesthesia (e.g., intravenous sedation, general anesthesia, or sedative therapy prior to routine procedures). Sedation does not include administration of routine local anesthesia only.

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

The total amount allowable for the dental treatment service is limited to a maximum expenditure of $2,500.00 per service plan year for routine preventive, therapeutic, orthodontic, or emergency treatment and $2,000.00 per individual per service plan year for sedation.

Cosmetic orthodontia is excluded from the dental treatment service.

Dental treatment is provided through the waiver when no other financial resources for the service are available or when other available resources have been exhausted. This waiver service is only provided to individuals age 21 and over. All medically necessary dental services for children under the age of 21 are covered in the State plan pursuant to the Early Periodic Screening, Diagnosis, and Treatment 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 | Home and community support services agency |

## 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:**

Home and community support services agency

**Provider Qualifications**

**License** *(specify):*

Licensed as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

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

**Certificate** *(specify):*

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The home and community support services agency is responsible for reviewing and documenting that the service provider meets the qualifications for that service. HHSC is responsible for verifying the qualifications based on the documentation provided by the home and community support services agency during monitoring reviews.

**Frequency of Verification:**

HHSC verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows:

HHSC Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 15 months of the contract term and every two years thereafter.

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

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

HHSC follows the internal policy of coordinating communications and operations between all involved HHSC departments when action is taken regarding licensure violations. This policy ensures that authorized services are provided by appropriately licensed and contracted Home and Community Support Services Agencies.

## 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:** 11 Other Health and Therapeutic Services

**Sub-Category 1:** 11040 nutrition consultation

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition** *(Scope):*

**Category 4:**

**Sub-Category 4:**

Dietary services assist individuals in meeting their basic and/or special therapeutic nutritional needs. Dietary 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.

A dietician develops individualized meal plans as appropriate for the individual. A registered, licensed, or provisionally licensed dietitian delivers the service.

Through a nutritional assessment, the dietician evaluates the nutritional needs of an individual based on biochemical, anthropometric, physical, and dietary data to determine nutrient needs and to recommend appropriate nutritional intake through counseling and/or in consultation with the physician.

In the Texas state plan, dietician services are provided only to children or to adults with specific high-risk conditions as defined in Title V. Services provided in the waiver are outside the scope of the state plan.

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

Dietary services are provided through the waiver when no other financial resources are available or when other available resources have been exhausted. 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 Early Periodic Screening, Diagnosis, and Treatment 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 | Home and community support services agency |

## 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:**

Home and community support services agency

**Provider Qualifications**

**License** *(specify):*

Licensed by DADS as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

The dietician must be licensed under Texas Occupations Code, Chapter 701; Title 16 of the Texas Administrative Code, Part 4, Chapter 116.

**Certificate** *(specify):*

**Other Standard** *(specify):*

The home and community support services agency must hire a person who complies with the requirements for delivery of nutritional services in accordance with the service plan, which includes dietician duties and credentialing.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The home and community support services agency is responsible for reviewing and documenting that the service provider meets the qualifications for that service. HHSC is responsible for verifying the qualifications based on the documentation provided by the home and community support services agency during monitoring reviews.

**Frequency of Verification:**

HHSC verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows:

HHSC Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 15 months of the contract term and every two years thereafter.

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

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

HHSC follows the internal policy of coordinating communications and operations between all involved HHSC departments when action is taken regarding licensure violations. This policy ensures that authorized services are provided by appropriately licensed and contracted Home and Community Support Services Agencies.

## 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:**

03 Supported Employment | 03010 job development

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

03 Supported Employment | 03030 career planning

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

**Service Definition** *(Scope):*

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

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

A provider of employment assistance may bill for such services as: (1) transporting the individual to and from the work site; (2) activities related to supporting the individual to be self-employed, work from home, or perform in a work setting; and (3) participating in service planning team meetings.

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

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

Employment assistance does not include using Medicaid funds paid to the program provider for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
(A) Paying for an employer to encourage the employer to hire an individual, or for supervision, training, and adaptations for an individual that the employer typically makes available to other workers without disabilities filling similar positions in the business; or
(B) Paying the individual as an incentive to participate in employment assistance activities, or for expenses associated with the start-up costs or operating expenses of an individual's business.

This service may not be provided in person to an individual at the same time that one of the following DBMD services is provided: day habilitation, residential habilitation, employment assistance, respite, or state plan Community First Choice Personal Assistance Services/Habilitation.

**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 | Home and community support services agency |

## 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):*

Current documentation of completion and certification of hands-on skills training in:
(1) cardiopulmonary resuscitation (CPR);
(2) first aid; and
(3) choking prevention.

**Other Standard** *(specify):*

The provider must be at least 18 years of age, not be the individual's legally responsible person and satisfy one of these options:
Option 1:
- have a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and
- one year's paid or unpaid experience providing employment services to people with disabilities.

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

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

The provider must be fluent in the communication methods used by the individual or have the ability to become fluent in the communication methods used by the individual within three months after assignment to the individual. The provider must complete orientation and training as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter D, §42.403. If providing transportation, the provider must have a valid Texas driver's license with proof of insurance. Tasks delegated by a registered nurse must be performed in accordance with state law.

The provider of employment assistance must not be the individual's employer or an employee of the individual's employer and must have at least one year of experience working with individuals with developmental disabilities. The provider cannot be the individual's legal guardian or the spouse of the legal guardian.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The individual/employer or legally authorized representative is responsible for reviewing and documenting that the service provider meets the qualifications for that service. The financial management services agency legal entity is responsible for verifying the qualifications based on the documentation collected by the individual/employer or legally authorized representative.

During monitoring reviews, HHSC ensures that the financial management services agency legal entity has verified that each potential participant employer's service provider meets the required qualifications prior to being hired by the individual/employer.

**Frequency of Verification:**

For individual providers, the financial management services agency legal entity and the individual/employer verify that each potential employee meets the required qualifications prior to being hired by the individual/employer.

Each new financial management services legal entity that must be monitored according to HHSC policy is monitored within the first 15 months of the contract term. Thereafter, HHSC monitors financial management services agency legal entities at least every three years. Financial management services agency legal entities are monitored more frequently if the need is indicated or if there is a complaint filed against the financial management services agency legal entity. As a result of reviews, HHSC will recoup the financial management services monthly fees for service providers who were unqualified at the time they provided the service. Findings from monitoring reviews and complaint investigations may result in a corrective action plan and may go to the Sanction Action Review Committee to determine whether actions should be taken against the financial management services agency legal entity, including referral hold, vendor hold, and involuntary contract termination.

Contracts staff must conduct intermittent monitoring for financial management services agency legal entities that do not meet an acceptable compliance level during formal monitoring reviews. Contracts staff responds to complaints received against a financial management services agency legal entity for failure to maintain provider qualifications. HHSC levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity.

# 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:**

Home and community support services agency

**Provider Qualifications**

**License** *(specify):*

Licensed as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

**Certificate** *(specify):*

Current documentation of completion and certification of hands-on skills training in:
(1) cardiopulmonary resuscitation (CPR);
(2) first aid; and
(3) choking prevention.

**Other Standard** *(specify):*

The provider must be at least 18 years of age, not be the individual's legally responsible person and satisfy one of these options:
Option 1:
- have a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and
- one year's paid or unpaid experience providing employment services to people with disabilities.

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

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

The provider must be fluent in the communication methods used by the individual or have the ability to become fluent in the communication methods used by the individual within three months after being assigned to the individual. The provider must complete orientation and training as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter D, §42.403. If providing transportation, the provider must have a valid Texas driver's license with proof of insurance. Tasks delegated by a registered nurse must be performed in accordance with state law.

The provider of employment assistance must not be the individual's employer or an employee of the individual's employer and must have at least one year of experience working with individuals with developmental disabilities.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The home and community support services agency is responsible for reviewing and documenting that the service provider meets the qualifications for that service. HHSC is responsible for verifying the qualifications based on the documentation provided by the home and community support services agency during monitoring reviews.

**Frequency of Verification:**

HHSC verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows:

HHSC Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 15 months of the contract term and every two years thereafter.

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

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

HHSC follows the internal policy of coordinating communications and operations between all involved HHSC departments when action is taken in regard to licensure violations. This policy ensures that authorized services are provided by appropriately licensed and contracted Home and Community Support Services Agencies.

## 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:**

Intervener

**HCBS Taxonomy:**

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

17 Other Services | 17990 other

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

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

**Service Definition** *(Scope):*

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

The intervener serves as a facilitator to involve the individual in home and community services and activities. The intervener makes sights, sounds, and activities accessible to the individual by learning the specific communication system of the individual. This system is an individualized combination of expressive and receptive communication forms that may include sign language, speech, tangible symbols, gestures, non-verbal cues, actions, and behaviors.

Intervener services include one-to-one contact to provide communication and information from the environment that would otherwise be available through vision and hearing, periodic development and preparation of activities for the individual, transporting individuals to gain access to community services and resources included in the service plan, and instructing individuals in skills related to community access.

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

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

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

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Home and community support services agency |
| 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: Intervener**

**Provider Category:**

Agency

**Provider Type:**

Home and community support services agency

**Provider Qualifications**

**License** *(specify):*

Licensed as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

**Certificate** *(specify):*

Current documentation of completion and certification of hands-on skills training in:
(1) cardiopulmonary resuscitation (CPR);
(2) first aid; and
(3) choking prevention.

**Other Standard** *(specify):*

The provider must be at least 18 years of age and not be the individual's legally responsible person . There are four levels of intervener qualifications:

• An intervener must meet the following minimum qualifications: be 18 years of age or older; must not be the individual's legal guardian or the spouse of the legal guardian; hold a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma; have a minimum of two years of experience working with individuals with developmental disabilities; and have the ability to proficiently communicate in the functional language of the individual.

• An Intervener I must meet the minimum requirements of an intervener (listed above), and have the following: a minimum of six months of experience working with individuals who have deafblindness or who function as individuals with deafblindness; a minimum of eight semester credit hours in deafblind-related coursework from an accredited college or university, and have completed a one-hour practicum in deafblind-related course work from an accredited college or university.

• An Intervener II must meet the requirements of an intervener and have the following: a minimum of eight semester credit hours in deafblind-related coursework from an accredited college or university, and have completed a one-hour practicum in deafblind-related course work from an accredited college or university, a minimum of nine months of experience working with individuals who have deafblindnes or function as individuals with deafblindness, and have completed an additional 10 semester credit hours in deafblind-related course work from an accredited college or university.

• An Intervener III must meet the criteria of an Intervener II, have a minimum of one year of experience working with an individual with deafblindness, and hold an associate's degree or bachelor's degree in a course of study with a focus on deafblind-related coursework from an accredited college or university.

All levels of intervener must complete the orientation and training required as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter D, §42.403.

If providing transportation, all levels of intervener must have a valid Texas driver's license and proof of insurance that is in accordance with the requirements of state law.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The home and community support services agency is responsible for reviewing and documenting that the service provider meets the qualifications for that service. HHSC is responsible for verifying the qualifications based on the documentation provided by the home and community support services agency during monitoring reviews.

**Frequency of Verification:**

HHSC verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows:

HHSC Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 15 months of the contract term and every two years thereafter.

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

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

HHSC follows the internal policy of coordinating communications and operations between all involved HHSC departments when action is taken regarding licensure violations. This policy ensures that authorized services are provided by appropriately licensed and contracted Home and Community Support Services Agencies.

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Intervener**

**Provider Category:**

Individual

**Provider Type:**

Consumer directed services direct service provider

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Current documentation of completion and certification of hands-on skills training in:
(1) cardiopulmonary resuscitation (CPR);
(2) first aid; and
(3) choking prevention.

**Other Standard** *(specify):*

There are four levels of intervener qualifications.

• An intervener must meet the following minimum qualifications: be 18 years of age or older; must not be the individual's legal guardian or the spouse of the legal guardian; hold a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma; have a minimum of two years of experience working with individuals with developmental disabilities; and, have the ability to proficiently communicate in the functional language of the individual.

• An Intervener I must meet the minimum requirements of an intervener (listed above), and have the following: a minimum of six months of experience working with individuals who have deafblindness or who function as individuals with deafblindness; a minimum of eight semester credit hours in deafblind-related coursework from an accredited college or university, and have completed a one-hour practicum in deafblind-related course work from an accredited college or university.

• An Intervener II must meet the requirements of an intervener and have the following: a minimum of eight semester credit hours in deafblind-related coursework from an accredited college or university, and have completed a one-hour practicum in deafblind-related course work from an accredited college or university, a minimum of nine months of experience working with individuals who have deafblindnes or function as individuals with deafblindness, and have completed an additional 10 semester credit hours in deafblind-related course work from an accredited college or university.

• An Intervener III must meet the criteria of an Intervener II, have a minimum of one year of experience working with an individual with deafblindness, and hold an associate’s degree or bachelor's degree in a course of study with a focus on deafblind-related coursework from an accredited college or university.

All levels of intervener must complete the orientation and training required as specified in Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter D, §42.403.

If providing transportation, all levels of intervener must have a valid Texas driver's license and proof of insurance.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The individual/employer or legally authorized representative is responsible for reviewing and documenting that the service provider meets the qualifications for that service. The financial management services agency legal entity is responsible for verifying the qualifications based on the documentation collected by the individual/employer or legally authorized representative.

During monitoring reviews, HHSC ensures that the financial management services agency legal entity has verified that each potential participant employer's service provider meets the required qualifications prior to being hired by the participant employer.

**Frequency of Verification:**

For individual providers, the financial management services agency legal entity and the individual/employer verify that each potential employee meets the required qualifications prior to being hired by the individual/employer.

Each new financial management services legal entity that must be monitored according to HHSC policy, is monitored within the first 15 months of the contract term. Thereafter, HHSC monitors financial management services agency legal entities at least every three years. Financial management services agency legal entities are monitored more frequently if the need is indicated or if there is a complaint filed against the financial management services agency legal entity. As a result of reviews, HHSC will recoup the financial management services monthly fees for service providers who were unqualified at the time they provided the service. Findings from monitoring reviews and complaint investigations may result in a corrective action plan and may go to the Sanction Action Review Committee to determine whether actions should be taken against the financial management services agency legal entity, including referral hold, vendor hold, and involuntary contract termination.

Contracts staff must conduct intermittent monitoring for financial management services agency legal entities that do not meet an acceptable compliance level during formal monitoring reviews. Contracts staff responds to complaints received against a financial management services agency legal entity for failure to maintain provider qualifications. HHSC levies appropriate provider agreement actions and sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity.

# 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: |
| --- | --- |
| 14 Equipment, Technology, and Modifications | 14020 home and/or vehicle accessibility adaptations |

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

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

**Service Definition** *(Scope):*

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

Minor home modifications are those physical adaptations to the individual's home, required to address specific needs identified in the individual's service plan, that are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Modifications may also include safety adaptations necessary for the welfare of the individual.

All minor home modifications must be authorized by the individual's service planning team. Any modification or combination of modifications must be authorized by the team based on prior written evaluations and recommendations from a professional 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 and local building codes and include installation, maintenance, and repair not covered by warranty. The service includes the following categories:

-Construction or repair of wheelchair ramps and landings, or both to meet ADA specifications
-Protective awnings over ramps
-Modifications to bathroom facilities
-Modifications to kitchen facilities
-Specialized accessibility and safety adaptations
An all-inclusive list of Minor Home Modifications can be located in the DBMD Program Manual.
https://hhs.texas.gov/laws-regulations/handbooks/deaf-blind-multiple-disabilities-dbmd-program-manual/dbmd-section-2000-minor-home-modification-services

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

The maximum lifetime expenditure for this service is $10,000. After the lifetime maximum is reached, $300 is allowed per service plan year per individual for repairs, replacements, or additional modifications. Minor home modifications cannot be provided in alternative living arrangements.

Adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, construction of additional rooms, or adaptations which add to the total square footage of the home are excluded. Swimming pools, saunas, and hot tubs are also excluded.

**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 | Home and community support services agency |

## 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:**

Home and community support services agency

**Provider Qualifications**

**License** *(specify):*

Licensed by DADS as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

**Certificate** *(specify):*

**Other Standard** *(specify):*

The home and community support services agency must comply with the requirements for delivery of minor home modifications, which include requirements such as types of allowed modifications, time frames for completion, specifications for the modification, inspections of the modification, and follow-up on the completion of the modification.

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The home and community support services agency is responsible for reviewing and documenting that the service provider meets the qualifications for that service. HHSC is responsible for verifying the qualifications based on the documentation provided by the home and community support services agency during monitoring reviews.

**Frequency of Verification:**

HHSC verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows:

HHSC Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 15 months of the contract term and every two years thereafter.

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

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

HHSC follows the internal policy of coordinating communications and operations between all involved HHSC departments when action is taken regarding licensure violations. This policy ensures that authorized services are provided by appropriately licensed and contracted Home and Community Support Services Agencies.

## 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:** 05 Nursing

**Sub-Category 1:** 05020 skilled nursing

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition** *(Scope):*

**Category 4:**

**Sub-Category 4:**

Provides services listed in the service plan that are within the scope of the State's Nurse Practice Act. Nursing services provide treatment and monitoring of health care procedures prescribed by a physician/medical practitioner, or as required by standards of professional practice or state law to be performed by licensed nursing personnel.

State plan nursing services are provided for individuals over the age of 21, only for acute conditions or to treat an exacerbation of a chronic condition lasting less than 60 days. Services provided in the waiver cover ongoing chronic conditions such as wound care, medication administration, and supervision of delegated tasks for individuals over the age of 21. This broadens the scope of these services beyond extended state plan services.

**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 Early Periodic Screening, Diagnosis, and Treatment 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 |
|---|---|
| Agency | Home and community support services agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Nursing**

**Provider Category:**

Agency

**Provider Type:**

Home and community support services agency

**Provider Qualifications**

**License** *(specify):*

Licensed as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

The nurse must be licensed by the Texas Board of Nursing under Title 22 of the Texas Administrative Code, Part 11, Chapter 217.

**Certificate** *(specify):*

**Other Standard** *(specify):*

The home and community support services agency must comply with the requirements for delivery of nursing services, which include requirements related to compliance with the Texas Nurse Practice Act and delegation of nursing tasks.

The licensed vocational nurse must practice under the supervision of a registered nurse licensed to practice in the State.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The home and community support services agency is responsible for reviewing and documenting that the service provider meets the qualifications for that service. HHSC is responsible for verifying the qualifications based on the documentation provided by the home and community support services agency during monitoring reviews.

**Frequency of Verification:**

HHSC verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows:

HHSC Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 15 months of the contract term and every two years thereafter.

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

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

HHSC follows the internal policy of coordinating communications and operations between all involved HHSC departments when action is taken regarding licensure violations. This policy ensures that authorized services are provided by appropriately licensed and contracted Home and Community Support Services Agencies.

## 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: |
|---|---|
| 11 Other Health and Therapeutic Services | 11080 occupational therapy |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

The scope of occupational therapy services offered in this waiver exceeds the state plan occupational therapy benefit. Through the waiver, occupational therapy services are provided to maintain the individual's optimum condition. Occupational therapy services include: screening and assessment; development of therapeutic treatment plans; providing direct therapeutic intervention; recommending adaptive aids; training and assisting with adaptive aids and augmentative communication devices; consulting with other providers and family members; and participating on the service planning team, when appropriate.

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

Occupational therapy services are provided through the waiver when no other financial resources for the service are available or when other available resources have been exhausted. Individuals who are under 21 years of age must first access occupational therapy benefits through the Texas Health Steps--Comprehensive Care Program Early Periodic Screening, Diagnosis, and Treatment before occupational therapy may be provided through the waiver.

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

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

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Home and community support services agency |

## 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:**

Home and community support services agency

**Provider Qualifications**

**License** *(specify):*

Licensed by HHSC as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

The occupational therapist and occupational therapy assistant must be licensed by the Texas Board of Occupational Therapy Examiners under Title 3 of the Texas Occupations Code, Chapter 454.

**Certificate** *(specify):*

**Other Standard** *(specify):*

The home and community support services agency must hire a person who complies with the requirements for delivery of occupational therapy services, in accordance with the service plan, which includes occupational therapist and occupational therapist assistant duties and credentialing.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The home and community support services agency is responsible for reviewing and documenting that the service provider meets the qualifications for that service. HHSC is responsible for verifying the qualifications based on the documentation provided by the home and community support services agency during monitoring reviews.

**Frequency of Verification:**

HHSC verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows:

HHSC Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 15 months of the contract term and every two years thereafter.

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

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

HHSC follows the internal policy of coordinating communications and operations between all involved HHSC departments when action is taken regarding licensure violations. This policy ensures that authorized services are provided by appropriately licensed and contracted Home and Community Support Services Agencies.

# 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:**

Orientation and Mobility

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 11 Other Health and Therapeutic Services | 11130 other therapies |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Orietation and mobility teaches independent travel skills to an individual who is deafblind, so that the individual is able to negotiate in the environment safely and efficiently. The service includes evaluation of the strengths and needs of the individual, and creation of a plan to develop skills across an expanding environment using functional vision in a variety of travel situations. The service includes training other staff to create environments that enhance independent travel to meet the goals and objectives of orientation and mobility activities.

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

Orientation and Mobility services are provided through the waiver when no other financial resources for the service are available or when other available resources have been exhausted. Individuals who are under 21 years of age must first access orientation and mobility benefits through the Texas Health Steps--Comprehensive Care Program Early Periodic Screening, Diagnosis, and Treatment before orientation and mobility services may be provided through the waiver.

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

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

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Home and community support services agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Orientation and Mobility**

**Provider Category:**

Agency

**Provider Type:**

Home and community support services agency

**Provider Qualifications**

**License** *(specify):*

Licensed as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

**Certificate** *(specify):*

Providers of orientation and mobility must be certified in orientation and mobility by the Academy for the Certification of Vision Rehabilitation and Education Professionals, or by The National Orientation and Mobility Certification (NOMC) through the National Blindness Professional Certification Board (NBPCB.)

**Other Standard** *(specify):*

Providers of orientation and mobility must hold a bachelor's or master's degree in orientation and mobility.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The home and community support services agency is responsible for reviewing and documenting that the service provider meets the qualifications for that service. HHSC is responsible for verifying the qualifications based on the documentation provided by the home and community support services agency during monitoring reviews.

**Frequency of Verification:**

HHSC verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows:

HHSC Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 15 months of the contract term and every two years thereafter.

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

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

HHSC follows the internal policy of coordinating communications and operations between all involved HHSC departments when action is taken regarding licensure violations. This policy ensures that authorized services are provided by appropriately licensed and contracted Home and Community Support Services Agencies.

# 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: |
|---|---|
| 11 Other Health and Therapeutic Services | 11090 physical therapy |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Physical therapy is the evaluation, examination, and utilization of exercises, rehabilitative procedures, massage, manipulations, and physical agents. Physical agents include mechanical devices, heat, cold, air, light, water, electricity, and sound used in the aid of diagnosis or treatment.

The scope of physical therapy services offered in this waiver exceeds the state plan physical therapy benefit. State plan physical therapy services are provided only to treat for acute conditions or to treat exacerbation of chronic condition lasting less than 180 days. Services provided through the waiver cover ongoing chronic conditions even after rehabilitation has reached a plateau (e.g., range of motion). Through the waiver, physical therapy services will be provided to maintain the individual’s optimum condition.

Physical therapy services include: screening and assessment; developing therapeutic treatment plans; providing direct therapeutic intervention; recommending adaptive aids; training and assisting with adaptive aids; consulting with other providers and family members; and participating on the service planning team, when appropriate.
Physical therapy is the evaluation, examination, and utilization of exercises, rehabilitative procedures, massage, manipulations, and physical agents. Physical agents include mechanical devices, heat, cold, air, light, water, electricity, and sound used in the aid of diagnosis or treatment.

The scope of physical therapy services offered in this waiver exceeds the state plan physical therapy benefit. State plan physical therapy services are provided only to treat for acute conditions or to treat exacerbation of chronic condition lasting less than 180 days. Services provided through the waiver cover ongoing chronic conditions even after rehabilitation has reached a plateau (e.g., range of motion). Through the waiver, physical therapy services will be provided to maintain the individual’s optimum condition.

Physical therapy services include: screening and assessment; developing therapeutic treatment plans; providing direct therapeutic intervention; recommending adaptive aids; training and assisting with adaptive aids; consulting with other providers and family members; and participating on the service planning team, when appropriate.

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

Physical therapy services are provided through the waiver when no other financial resources for physical therapy services are available or when other available resources have been exhausted. Individuals who are under 21 years of age must access therapy benefits through the Texas Health Steps--Comprehensive Care Program Early Periodic Screening, Diagnosis, and Treatment benefit before physical therapy services may be provided through the waiver.

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

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

☒ **Provider managed**

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Home and community support services agency |

## 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:**

Home and community support services agency

**Provider Qualifications**

**License** *(specify):*

Licensed by HHSC as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

The physical therapist and licensed physical therapy assistant must be licensed under Title 22 of the Texas Administrative Code, Part 16, Chapter 329.

**Certificate** *(specify):*

**Other Standard** *(specify):*

The home and community support services agency must hire a person who complies with the requirements for delivery of physical therapy services in accordance with the service plan, which includes the physical therapist and physical therapist assistant duties and credentialing.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The home and community support services agency is responsible for reviewing and documenting that the service provider meets the qualifications for that service. HHSC is responsible for verifying the qualifications based on the documentation provided by the home and community support services agency during monitoring reviews.

**Frequency of Verification:**

HHSC verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows:

HHSC Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 15 months of the contract term and every two years thereafter.

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

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

HHSC follows the internal policy of coordinating communications and operations between all involved HHSC departments when action is taken regarding licensure violations. This policy ensures that authorized services are provided by appropriately licensed and contracted Home and Community Support Services Agencies.

## 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, Hearing, and Language Therapy Services

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 11 Other Health and Therapeutic Services | 11100 speech, hearing, and language therapy |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Speech, hearing and language therapy services are defined as the evaluation and treatment of impairments disorders or deficiencies related to an individual's speech and language by a licensed speech language pathologist or a licensed speech language pathologist assistant under the direction of the licensed speech language pathologist, within the scope of state licensure. Speech, hearing, and language therapy services include: screening and assessment; developing therapeutic treatment plans; providing direct therapeutic intervention; recommending augmentative communication devices; training and assisting with augmentative communication devices; consulting with other providers and family members; and participating on the service planning team, as appropriate.

The scope of speech, hearing, and language therapy services offered in this waiver exceeds the state plan speech, hearing, and language therapy benefit. Through the waiver, speech, hearing, and language therapy will be provided to maintain the individual’s optimum condition.

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

Speech, hearing, and language therapy services are provided through the waiver when no other financial resources for speech, hearing, and language therapy services are available or when other available resources have been exhausted. Individuals who are under 21 years of age must access speech, hearing and language therapy services through the Texas Health Steps--Comprehensive Care Program Early Periodic Screening, Diagnosis, and Treatment benefit before speech, hearing, and language therapy services may be provided through the waiver.

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

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

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

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

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Home and community support services agency |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Speech, Hearing, and Language Therapy Services**

**Provider Category:**

Agency

**Provider Type:**

Home and community support services agency

**Provider Qualifications**

**License** *(specify):*

Licensed by HHSC as a home and community support services agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.

The speech-language pathologist and assistant speech-language pathologist must be licensed under Texas Occupations Code, Chapter 401 and Title 16 of the Texas Administrative Code, Part 4, Chapter 111.

**Certificate** *(specify):*

**Other Standard** *(specify):*

The home and community support services agency must hire a person who complies with the requirements for delivery of speech, hearing, and language therapy services in accordance with the service plan, which includes the speech-language pathologist and assistant speech-language pathologist duties and credentialing.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The home and community support services agency is responsible for reviewing and documenting that the service provider meets the qualifications for that service. HHSC is responsible for verifying the qualifications based on the documentation provided by the home and community support services agency during monitoring reviews.

**Frequency of Verification:**

HHSC verifies provider qualifications prior to awarding a provider agreement and on an ongoing basis as follows:

HHSC Community Services Contracts staff conducts at least biennial monitoring reviews. Each new contract is monitored within the first 15 months of the contract term and every two years thereafter.

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

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

HHSC follows the internal policy of coordinating communications and operations between all involved HHSC departments when action is taken regarding licensure violations. This policy ensures that authorized services are provided by appropriately licensed and contracted Home and Community Support Services Agencies.

# Appendix C: Participant Services

## C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Transition Assistance Services

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| 16 Community Transition Services | 16010 community transition services |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Transition assistance services pay for non-recurring set-up expenses for individuals transitioning from an intermediate care facility or a nursing facility into DBMD services. Allowable expenses are those necessary to enable individuals to establish basic households and may include: security deposits for leases on apartments or homes; essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture; window coverings; food preparation items; bed and bath linens; set-up fees or deposits for utility or service access, including telephone, electricity, gas, and water; services necessary for the individual's health and welfare, such as pest eradication and one-time cleaning of the residence prior to occupancy; and activities to assess need for, facilitate, arrange for, and procure needed resources (limited to up to 180 consecutive days prior to discharge from the intermediate care facility or nursing facility).

Room and board are not allowable expenses.

Transition assistance services do not include: monthly rental or mortgage expenses; food; regular utility charges; or household appliances or items that are intended for purely diversional or recreational purposes.

Transition assistance services funding is authorized for expenses that are reasonable and necessary as determined through the service plan development process, that are clearly identified in the individual service plan, and for which individuals are unable to pay for or obtain from other sources.

To be eligible to receive transition assistance services the individual must be a resident of a Texas nursing facility or intermediate care facility who wishes to be discharged from that facility, be Medicaid eligible, and be determined eligible for DBMD services.

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

Transition assistance services are one-time initial expenses for setting up a household that cannot exceed $2,500.

Transition assistance services are not available for individuals transitioning into a DBMD assisted living, or any provider leased/owned living arrangements.

**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 Transition Assistance Services Medicaid provider agreement |

## Appendix C: Participant Services

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

**Service Type: Other Service**
**Service Name: Transition Assistance Services**

**Provider Category:**

Agency

**Provider Type:**

Agencies holding a Transition Assistance Services Medicaid provider agreement

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

Transition assistance services agencies must meet requirements outlined in Title 40 of the Texas Administrative Code, Part 1, Chapter 62.

Transition assistance services agencies must meet the requirements for delivery of transition assistance services, including requirements such as allowable purchases, costs limits, and timeframes for delivery.

Transition assistance services agency staff must demonstrate knowledge of, and history in, successfully serving individuals who require home and community based services.

An employee or contractor who delivers Transition Assistance Services under this chapter is at least 18 years old, has a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma, and is not the individual's relative or legally authorized representative.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

A Transition Assistance Services provider must ensure that the employee meets the qualifications. The home and community support services agency is responsible for reviewing and documenting that the TAS provider has a current contract with HHSC. HHSC verifies provider qualifications prior to awarding a contract.

**Frequency of Verification:**

HHSC verifies provider qualifications prior to awarding a contract and on an ongoing basis as follows:

HHSC Contracts staff is responsible for conducting monitoring reviews every two years. Contract Community Services Contracts staff responds to complaints received against a contractor for failure to maintain provider qualifications. HHSC levies appropriate provider agreement actions/sanctions for failure to follow the provider agreement requirements based on the results of the monitoring activity.

## 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:

## 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):

Providers, individual/employers, and financial management services agencies must comply with the Texas Health and Safety Code, Chapter 250, by taking the following actions regarding individuals, 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 Texas Health and Safety Code §250.006, or an offense that the provider or participant employer determines is a contraindication to the person's employment to contract to provide services to the individual.

Individuals choosing to self-direct services must choose a financial management services agency that provides guidance and assistance to the individual with employer-related tasks.

**b. Abuse Registry Screening.** Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

○ **No. The state does not conduct abuse registry screening.**

◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Providers, individual/employers, and financial management services agencies must comply with the Texas Health and Safety Code, Chapters 250 and 253, by taking the following action regarding applicants, contractors, and employees:

-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 of a facility or has misappropriated an individual's property; and

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.

Providers, individual/employers, and financial management service agencies are also required to perform Nurse Aide Registry and Employee Misconduct Registry checks on contractors.

Providers must screen all employees for exclusion prior to hiring and on an ongoing monthly basis by searching both the state and federal lists of excluded individuals and entities. If any exclusion is found, it must immediately be reported.

HHSC Regulatory Services staff that are involved in licensure, survey, and enforcement activities, as part of their reviews of providers, monitor whether Nurse Aide Registry and Employee Misconduct Registry checks are 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 performed.

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 legal entity is required to have verification of registry checks prior to hiring on behalf of the individual.

During on-site reviews of providers and financial management services agencies, HHSC monitors for completion of required registry checks.

For volunteers, the Home and Community Support Services Agencies must comply with Title 40 of the Texas Administrative Code, Part 1, Chapter 97, Subchapter C.

# Appendix C: Participant Services

## C-2: General Service Specifications (2 of 3)

**c. Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

**i. Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

| Facility Type | |
|---|---|
| **Intermediate Care Facility** | |
| **Assisted Living Facility** | |

**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.

DBMD offers assisted living services in home settings serving four to six participants, which requires the provider to obtain and maintain an Assisted Living Facility license. These small residential settings are located in community neighborhoods in family homes and are constructed with kitchen areas, living rooms, bedrooms with no more than two individuals per bedroom, and bathrooms. The individuals must have access to a telephone, a place for personal belongings and the ability to entertain guests. Assisted Living Facility services are driven by a service philosophy that emphasizes personal dignity, autonomy, independence, and privacy.

Texas further ensures a home and community based character is maintained in Assisted Living Facilities through review and enforcement of licensure requirements found in Title 40 of the Texas Administrative Code, Part 1, Chapter 92, Subchapter G which include, but are not limited to, the following:
Each resident in the Assisted Living Facility has the right to:
-Participate in activities of social, religious, or community groups unless the participation interferes with the rights of others;
-Make his/her own choices regarding personal affairs, care, benefits, and services;
-Receive and send unopened mail;
-Unrestricted communication, including personal visitation with any person of the resident's choice, including family members and representatives of advocacy groups and community service organizations, at any reasonable hour;
-Make contacts with the community and to achieve the highest level of independence, autonomy, and interaction with the community of which the resident is capable;
-Unaccompanied access to a telephone at a reasonable hour or in case of an emergency or personal crisis;
-Privacy, while attending to personal needs and a private place for receiving visitors or associating with other residents;
-Retain and use personal possessions, including clothing and furnishings, as space permits;
-Determine his or her dress, hair style, or other personal effects according to individual preference; and
-Retain and use personal property in his or her immediate living quarters and to have an individual locked area (cabinet, closet, drawer, footlocker, etc.) in which to keep personal property.

DBMD offers respite in intermediate care facilities in which up to 6 individuals may reside. When receiving respite in an intermediate care facility, an individual has the right to:
- a normal residential environment;
- to communication and visits; and
- to possess personal property.

# Appendix C: Participant Services

## C-2: Facility Specifications

**Facility Type:**

Intermediate Care Facility

**Waiver Service(s) Provided in Facility:**

| Waiver Service | Provided in Facility |
|---|---|
| **Prescribed Drugs** | ☐ |
| **Intervener** | ☐ |
| **Transition Assistance Services** | ☐ |
| **Financial Management Services** | ☐ |

| Waiver Service | Provided in Facility |
|---|---|
| **Dietary Services** | ☐ |
| **Supported Employment** | ☐ |
| **Orientation and Mobility** | ☐ |
| **Chore Service** | ☐ |
| **Assisted Living** | ☐ |
| **Respite** | ☒ |
| **Residential Habilitation** | ☐ |
| **Case Management** | ☐ |
| **Occupational Therapy Services** | ☐ |
| **Employment Assistance** | ☐ |
| **Dental Treatment** | ☐ |
| **Support Consultation** | ☐ |
| **Speech, Hearing, and Language Therapy Services** | ☐ |
| **Minor Home Modifications** | ☐ |
| **Day Habilitation** | ☐ |
| **Adaptive Aids and Medical Supplies** | ☐ |
| **Audiology Services** | ☐ |
| **Behavioral Support Services** | ☐ |
| **Physical Therapy Services** | ☐ |
| **Nursing** | ☐ |

**Facility Capacity Limit:**

Six individuals

**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 | ☒ |

| Standard | Topic Addressed |
|---|---|
| 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:**

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

Assisted Living Facility

**Waiver Service(s) Provided in Facility:**

| Waiver Service | Provided in Facility |
|---|---|
| **Prescribed Drugs** | ☒ |
| **Intervener** | ☐ |
| **Transition Assistance Services** | ☐ |
| **Financial Management Services** | ☐ |
| **Dietary Services** | ☒ |
| **Supported Employment** | ☒ |
| **Orientation and Mobility** | ☒ |
| **Chore Service** | ☐ |
| **Assisted Living** | ☒ |
| **Respite** | ☐ |
| **Residential Habilitation** | ☐ |
| **Case Management** | ☒ |
| **Occupational Therapy Services** | ☐ |
| **Employment Assistance** | ☒ |
| **Dental Treatment** | ☒ |
| **Support Consultation** | ☐ |
| **Speech, Hearing, and Language Therapy Services** | ☒ |
| **Minor Home Modifications** | ☐ |

| Waiver Service | Provided in Facility |
|---|---|
| **Day Habilitation** | ☐ |
| **Adaptive Aids and Medical Supplies** | ☐ |
| **Audiology Services** | ☐ |
| **Behavioral Support Services** | ☒ |
| **Physical Therapy Services** | ☒ |
| **Nursing** | ☐ |

**Facility Capacity Limit:**

Six individuals

**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:**

N/A

## 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.*

Reimbursement for waiver services provided to an individual by an individual's family member or guardian is subject to the following restrictions/conditions:

1. Payment will not be made for waiver services provided to an individual by the spouse of the individual. ;
2. Payment will not be made for assisted living provided to an individual by the individual's guardian or relative.;
3. Payment will not be made for respite provided to an individual by a relative or guardian who lives with the individual and who is paid to provide residential habilitation to the individual.;
4. Payment for residential habilitation and respite can be made to the parent/guardian of an individual who is over the age of 17.;
5. Reimbursement for waiver services provided by a relative or guardian not prohibited above is allowed only for reasons that benefit the individual as determined and documented by the service planning team.;
6. Payments will not be made for the routine care and supervision, which that would be expected to be provided by a family member.; and
7. Following are the services which, if not self-directed, may be provided by a guardian or family member: day habilitation, residential habilitation, respite, supported employment, employment assistance, chore services, intervener, minor home modifications, and nursing.

The service planning team identifies necessary services, using a person-centered planning process, that are in the best interest of the individual. The team consists of the individual, legally authorized representative, case manager, nurse or program director, and staff providing direct services. The individual, legally authorized representative or both may designate direct service staff to be involved in the service planning and other persons such as family members, friends or advocates as well. All of the various team members contribute to development of the service plan based on the individual's interests, needs, strengths, weaknesses, likes and dislikes.

During service planning and at 90 day service reviews, service providers are discussed as part of the status of the services and the individual's satisfaction with that service. In some situations the service planning team determines that the legal guardian is the most appropriate person and it is in best interest of the participant for that person to provide the service due to the unique skills required to work with this population, the guardian's in depth knowledge of the individual, their needs and their communication methods. Additionally, familiarity can be very important in communicating with individuals with sensory deficits like those found in the DBMD waiver program.

The Individual Program Plan (IPP) which is part of the service plan requires the DBMD provider to indicate who will provide each service and information about any additional service providers that may be utilized. The service planning team assists in determining the types and amounts of services necessary for the plan and must approve of the service plan. The service planning team must all sign the service planning documents to indicate agreement with the plan. Once complete the service plan with supporting documentation is submitted to HHSC for review and approval.

For each billed service, a service delivery log which contains the type of service, the date and time of the service, the type of contact (phone or face to face) and the name of the service provider must be completed. Additionally any services', other than non-delegated tasks performed by an unlicensed service provider, service delivery logs contain a description of the service activity performed. The service delivery log is completed and signed by a staff member other than the service provider who verifies the accuracy of the information on the form. Contracts staff conduct record reviews and verify these logs are consistent with the supporting documentation and the submitted billing. If discrepancies are found between the billing and the service delivery log documentation, the provider may be recouped.

During biennial monitoring reviews, HHSC monitors all DBMD provider agencies to ensure that the DBMD agency implements service planning requirements, including that the individual's needs are being met and that their service plan changes as their needs change. Additionally, as part of the monitoring review HHSC Contracts staff verifies that the services billed were actually rendered. HHSC Contracts staff verifies that billings submitted to and paid by HHSC are for billable time and activities by verifying that billing forms, such as the service delivery log, are completed according to HHSC instructions.

○ **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:

In order to obtain a DBMD provider agreement, a provider applicant must apply for such in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 49, Subchapter B, relating to Contracting for Community Services.

Information for obtaining a DBMD contract is provided by contacting the HHSC Community Services Contracts Unit.

Any willing and qualified provider may apply to enroll if they apply in accordance with Title 40 of the Texas Administrative Code Chapter 49

## 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, licensed providers that initially met contract requirements before providing services. N: Number of newly enrolled, licensed providers that initially met contract requirements before providing services. D: Number of newly enrolled, licensed 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **Other**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**C.a.2 Number and percent of monitored providers that continually met program and fiscal monitoring requirements, evidenced by an overall monitoring score of at least 90%. N: Number of monitored providers that met program and fiscal monitoring requirements, evidenced by an overall monitoring score of at least 90%. D: Number of monitored licensed providers that received a contract monitoring.**

**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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | | |
| | ☒ **Continuously and Ongoing** | ☒ **Other**<br>Specify:<br>Licensed providers are selected for monitoring based on the contract effective date, previous formal monitoring exit date, overall compliance score of the previous formal monitoring, and expenditures. |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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.3 Number and percent of licensed providers monitored according to the schedule required by policy, to ensure that providers are continually meeting all standards. N: Number of licensed providers monitored according to the schedule required by policy, to ensure that providers are continually meeting all standards. D: All licensed providers meeting the requirements for a scheduled monitoring.**

**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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☒ **Other**<br>Specify: |

| | | |
|---|---|---|
| | | Providers are selected for monitoring based on the contract effective date, previous formal monitoring exit date, overall compliance score of the previous formal monitoring, and expenditures. |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**C.a.4 Number and percent of newly enrolled, licensed providers that had a Medicaid provider agreement executed prior to delivering services. N: Number of newly enrolled, licensed providers that had a Medicaid provider agreement executed prior to delivering services. D: Number of newly enrolled, licensed 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **Other**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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 initially met contract requirements prior to delivering services. N: Number of newly enrolled financial management services agencies that initially met contract requirements prior to delivering services. D: Number of newly enrolled financial management services agencies.**

**Data Source** (Select one):
**Record reviews, on-site**
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.b.2 Number and percent of monitored FMSA legal entities that continually met program contract requirements, evidenced by an overall monitoring score of at least 90%. N: Number of monitored FMSA legal entities that continually met program contract 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 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**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**C.b.3 Number and percent of monitored FMSA legal entities that continually met fiscal contract requirements, evidenced by an overall monitoring score of at least 90%. N: Number of monitored FMSA legal entities that continually met fiscal**

**contract 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☒ **Other**<br>Specify:<br>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**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**C.b.4 Number and percent of individuals/employers using the CDS option that had a Medicaid provider agreement for each employee. N: Number of employers using the CDS option that had a Medicaid provider agreement for each employee. D: Total number of individuals/employers reviewed.**

**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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☒ **Other**<br>Specify:<br>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**<br>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**<br>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 monitored DBMD provider agencies that completed all required training in accordance with the approved waiver. N: Number of monitored DBMD provider agencies that completed all required training in accordance with the approved waiver. D: Number of monitored DBMD provider agencies.**

**Data Source** (Select one):
**Record reviews, on-site**
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**<br>Confidence |

| | | |
|---|---|---|
| | | Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☒ **Other**<br>Specify:<br>Providers are selected for monitoring based on the contract effective date, previous formal monitoring exit date, overall compliance score of the previous formal monitoring, and expenditures. |
| | ☐ **Other**<br>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**<br>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**<br>Specify: |

**Performance Measure:**
**C.c.2 Number and percent of monitored financial management services agencies that completed all required training in accordance with the approved waiver. N: Number of financial management services agencies that completed all required training in accordance with the approved waiver. D: Number of financial management services agencies requiring training.**

**Data Source** (Select one):
**Record reviews, on-site**
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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☒ **Other**<br>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**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**C.c.3 Number and percent of reviewed provider staff meeting state training requirements by receiving a score of at least 80% on the HHSC DBMD Computer Based Training. N: Number of reviewed provider staff receiving a score of at least**

**80% on the HHSC DBMD Computer Based Training. D: Number of reviewed provider staff required to complete training during the reporting period.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Contract Workbook**

| **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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☒ **Other**<br>Specify:<br>5% of individuals per provider contract (minimum of 4 individuals per contract if serving 1-21, minimum of 5 individuals per contract if serving 22 or more; maximum of 30 individuals per contract). |
| | ☐ **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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

HHSC Contracts staff verifies that all potential providers meet the qualifications specified in the waiver prior to HHSC awarding a provider agreement/contract.

Regulatory Services surveyors monitor the performance of licensed Home and Community Support Services Agencies and Assisted Living Facilities through surveys and inspections. Surveyors conduct follow-up surveys and inspections to ensure the provider has effectively implemented any corrective action plans required due to cited state violations. Home and Community Support Services Agencies not accredited by the Joint Commission, the Community Health Accreditation Program, or the Accreditation Commission for Health Care are surveyed after they receive their license and indicate to HHSC readiness for an initial survey, approximately 18 months after the initial survey and at least every 36 months thereafter. HHSC Regulatory Services verifies upon license renewal that an accredited home and community support services agency has maintained its accreditation prior to issuing a new license. The accrediting body performs surveys to ensure that accreditation standards are met. For the Joint Commission, the Community Health Accreditation Program, and the Accreditation Commission for Health Care, the state of Texas recognizes the accreditation standards to meet or exceed the state licensing standards. Assisted Living Facilities are inspected annually. Home and Community Support Services Agencies and Assisted Living Facilities licenses are valid for two years. The Regulatory Services survey includes observation of the care of individuals.

Complaint investigations involving allegations of non-compliance with state licensing standards are conducted by HHSC Regulatory Services staff according to the priority of the allegations. Complaint investigations are conducted by HHSC Regulatory Services for all home and community support service agencies, including those that are accredited by the Joint Commission, the Community Health Accreditation Program, or the Accreditation Commission for Health Care. If an accredited and deemed home and community support services agency is a licensed and certified home health agency, HHSC Regulatory Services receives approval from the Center for Medicare and Medicaid Services prior to initiating a complaint investigation.

HHSC Contracts staff is responsible for conducting monitoring reviews of all DBMD providers. Each new contract or financial management services agency legal entity that must be monitored according to HHSC policy, is monitored within the first 15 months of the contract term.

Ongoing DBMD provider contract monitoring reviews are conducted at least every 24 months after the provider agreement/contract has been awarded. Ongoing contract monitoring reviews for Financial Management Services Agency legal entities are conducted at least every 36 months after the provider agreement/contract has been awarded. Contracts staff also responds to complaints received against a contractor for failure to maintain provider qualifications. In preparation for on-site provider reviews, Contracts staff:

- Selects a valid random sample of individuals receiving services;
- Retrieves information pertinent to the provider's operation from a database of complaints reported to Community Services Contracts staff; and
- Reviews results of the provider's past performance during on-site reviews.

While on site, HHSC Contracts staff gathers evidence of a provider's compliance with the waiver requirements as prescribed in program rules found in Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter D, and with provider agreement/contract requirements through:

- Interviews with individuals and their legally authorized representatives or families;
- Interviews with providers; and
- Reviews of individual and provider records.

HHSC Contract Oversight and Support administers the HHSC System of Contract Operation and Reporting. The HHSC System of Contract Operation and Reporting is a custom-developed Health and Human Service Enterprise application with a consolidated database for contract information and reporting. On a monthly basis, HHSC Contracts staff enter the complaint intake, complaint investigation findings, and contract and fiscal compliance monitoring results into the HHSC System of Contract Operation and Reporting. Contract Oversight and Support also utilizes the HHSC System of Contract Operation and Reporting to enter information pertaining to contract actions and sanctions. Through the HHSC System of Contract Operation and Reporting features, information

pertaining to contract expenditures, compliance, and overall history is available for analysis, trending and reporting by the Contract Oversight and Support unit.

**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.

HHSC Regulatory Services requires a corrective action plan from Home and Community Support Services Agencies for violations and deficiencies cited during a survey or investigation. In addition, staff may also impose enforcement actions for violations, including administrative penalties, denying approval for an initial license, suspending an existing license on an emergency basis, and revoking a license. The severity of an administrative penalty is based on the severity of the violation, the history of previous violations, and the hazard of the violation to the health or welfare of individuals. Surveyors conduct follow-up surveys and investigations to ensure the agency has effectively implemented any corrective action plan required due to cited state violations and federal deficiencies.

Technical assistance is shared with providers throughout the HHSC Contracts review. If, during a contract monitoring review, a provider is discovered to have not submitted a service plan within the required timeframe or if a service plan is missing signatures, the provider agency is required to submit a corrective action plan to HHSC. In accordance with 40 Texas Administrative Code §49.522 (relating to Corrective Action Plans), the corrective action plan must contain the following elements:

- A description of the non-compliance that HHSC identified from the monitoring or investigation resulting in the corrective action plan;
- A description of the activities the provider will perform to correct or prevent the identified non-compliance;
- The title of the person responsible for the activities described above and;
- Implemented schedule for performing the activities described above.

If a corrective action plan is requested from the provider, the provider is informed that they may contact HHSC staff with any questions or requests for clarification of what constitutes an acceptable 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. Providers 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 provider, up to and including termination of the provider agreement/contract. HHSC monitors the corrective action plan for the duration of the contract.

HHSC Contracts staff submits provider agreement/contract action recommendations to the Sanction Action Review Committee when a complaint investigation against a provider substantiates a reported allegation or Contracts staff recommend the provider receive a contract action/sanction greater than a corrective action plan. Sanction Action Review Committee members review the monitoring review results and, if applicable, 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, and involuntary contract termination.

Results of each contract monitoring review are documented and recorded in the HHSC System of Contract Operation and Reporting.

**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** |

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

**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.*

To date, HHSC has submitted four iterations of the HCBS Statewide Transition Plan (STP), including: (1) an initial one in December 2014, (2) a revised plan that includes the 1115 waiver in March 2015, (3) an amendment to the STP in February 2016 in response to feedback from CMS, and (4) resubmission of an updated STP in November 2016 in response to feedback from CMS. At this time, the survey process is complete for both managed care and fee-for-service programs. Staff is currently analyzing the survey results in order to develop the required remediation plan.

All states are required to submit a transition plan outlining the steps required to come into compliance with the regulations by 2022. HHSC expects to obtain approval of its plan by March 2019.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (1 of 8)

**State Participant-Centered Service Plan Title:**

Individual Service Plan

**a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
*Specify qualifications:*

☐ **Social Worker**
*Specify qualifications:*

☐ **Other**
*Specify the individuals and their qualifications:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (2 of 8)

**b. Service Plan Development Safeguards.** *Select one:*

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

The State confirms that the current DBMD providers are the only willing and qualified entity to serve this population based on the provider expertise required in working with individuals with deaf blindness.
Safeguards are in place in the DBMD program rules to ensure that individuals receive the most appropriate and effective services. At least annually, the service planning team must review the service plan and initiate changes in the service plan in response to changes in the individual's needs and identified outcomes as documented in the service plan. The case manager initiates, coordinates, and facilitates the service planning process to assure that an individual's service plan addresses the needs as identified by the individual or legally authorized representative. The individual, legally authorized representative, or both must sign the plan to indicate understanding of, and agreement with, the plan. The case manager assures that the individual, and family or legally authorized representative, as appropriate, can contact the case manager to secure information regarding services, supports and service delivery.

At enrollment and at least annually thereafter, the case manager educates the individual, legally authorized representative or both regarding:

o eligibility criteria for participation in the Deaf Blind with Multiple Disabilities waiver program;
o the individual’s rights and responsibilities, including how to file a complaint if the individual is not satisfied with the services they are receiving;
o services and supports provided by the Deaf Blind with Multiple Disabilities waiver program and the limits on those services and supports;
o the available service delivery options, and
o the available Deaf Blind with Multiple Disabilities provider agencies and that they may transfer at any time.

If the individual is not satisfied with the provider’s complaint process, the individual may also contact the Ombudsman with complaints.

Texas Administrative Code (Title 40, Part 1, Chapter 42, Subchapter B, §42.211) requires that an individual is provided choice along with the written offer of program vacancy. Texas Administrative Code (Title 40, Part 1, Chapter 42, Subchapter B, §42.223 ) also requires the case manager to give the individual the documentation of provider choice form, which is a list of providers in their geographical region, during the service planning meeting each year.

Additionally, an individual can choose to change provider agencies at any time if they are unhappy with the services or service planning they are receiving or can opt to receive services in an institution rather than the community at any time. Individuals may request to be considered or assessed for other programs while still enrolled in the DBMD waiver, but would be required to choose before enrolling in another program if the programs are mutually exclusive. The case manager submits the service plan and supporting documentation to HHSC who authorizes the requested services, conducts utilization review and has final approval on program enrollment and levels of service.

During monitoring reviews, HHSC monitors all DBMD provider agencies to ensure that the DBMD agency implements service planning requirements, including that the individual's needs are being met and that their service plan changes as their needs change.

As approved by CMS, the Deaf Blind with Multiple Disabilities waiver program offers case management services and direct services through one Deaf Blind with Multiple Disabilities provider agency. The Deaf Blind with Multiple Disabilities waiver program does not limit the free choice of qualified comprehensive waiver providers; however, the Deaf Blind with Multiple Disabilities provider is the only willing and qualified entity to provide case management services due to the unique needs of the individuals served. HHSC has granted DBMD providers authority to offer case management and provider services through one qualified provider based on the unique needs of the individual’s served. The DBMD program was structured so a single provider agency could provide both case management and direct services. The Deaf Blind Multihandicapped Association of Texas, the Deaf Blind with Multiple Disabilities advocacy stakeholder group, supports this integrated model due to the unique needs of the population served. The DBMD waiver has, from inception, utilized the single provider agency model and this model has been approved by the state and CMS . Individuals in the Deaf Blind with Multiple Disabilities waiver program must be deafblind or function as a person with deafblindness and have one or more additional disabilities that result in impairment to independent functioning.

Due to the unique needs of the individuals served, there is a small number of providers uniquely qualified to provide

both case management services and waiver services across the state. As of March 2018, the State has a total of 24 Deaf Blind with Multiple Disability providers across the state.

Aside from the Consumer Directed Services option, which is utilized by 32.6% of individuals in the Deaf Blind with Multiple Disabilities waiver program, agencies must also have administrative policies in place to protect individuals. As stated in Texas Administrative Code (Title 40, Part 1, Chapter 42, Subchapter D, §42.401), the program provider must have and implement written human resource policies and procedures that safeguard the individual against conflicts of interest with service providers.

Please refer to Main B for additional information.

## 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 case manager assures that the individual, legally authorized representative or both, as appropriate, participate in developing a person-centered service plan that meets the individual's identified needs, desired service goals, and outcomes. The case manager supports the individual, legally authorized representative, or both, as appropriate, to set action steps and short-term goals that support the outcomes chosen by the individual. The case manager also educates the individual, legally authorized representative, or both, as appropriate, about service delivery options and the full service array available through the DBMD program. The case manager informs the individual legally authorized representative or both, as appropriate, of the following:
• eligibility criteria for participation in the DBMD program;
• the application and enrollment process;
• the individual's rights and responsibilities;
• the mandatory participation requirements;
• the services and supports provided by the DBMD program and the limits of those services and supports; and
• the reasons an individual's DBMD program services may be terminated.

The case manager assures that the individual, legally authorized representative, or both, as appropriate, and family as appropriate, can contact the case manager to secure information regarding services, supports, and service delivery options; and can request to change the service plan at any time due to changes in goals or outcomes, or if needs change significantly. Approximately every 90 days, the case manager meets with the individual, legally authorized representative or both, as appropriate, and reviews the service plan and progress toward goals, outcomes, and service needs, including any changes that might have occurred since the last review. At least annually and as needed, the case manager presents information to the individual, legally authorized representative or both, as appropriate, regarding available waiver services and supports, service delivery options, and DBMD provider agencies.

The service planning team is selected by the individual, legally authorized representative, or both, as appropriate, and must consist at a minimum of: the individual, legally authorized representative or both, as appropriate, the case manager; and one additional agency participant who is either the nurse or program director. The individual, legally authorized representative, or both, as appropriate, may designate direct service staff to be involved in the service planning process, as well as invite other persons such as professionals, family members, friends, or advocates.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (4 of 8)

**d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses

participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The case manager initiates, coordinates, and facilitates the service planning process to ensure that an individual's service plan addresses the needs as identified by the individual, legally authorized representative, or both, as appropriate. The case manager ensures that: the time and location for the person-centered service planning meeting is scheduled at the convenience of the individual or legally authorized representative, or both, as appropriate, that it reflects cultural considerations, is offered in plain language, and in a manner that is accessible to the person served. The service planning team is selected by the individual, legally authorized representative, or both, as appropriate, and must consist of the individual, legally authorized representative, the case manager, and one additional participant who is either the nurse or program director. Professionals, family, friends, advocates or others as designated by the individual or legally authorized representative may participate. The case manager must meet with the individual face-to-face within the first 30 calendar days of the date the provider is notified by HHSC that they have been selected by the individual as the individual's DBMD program provider. The case manager must document any reason for delays past 30 calendar days.

As part of the initial face-to-face visit, formal assessments regarding health, level of functioning, level of care evaluation and specialized therapeutic interventions should be completed. Level of functioning is determined using the Related Conditions Eligibility Screening Instrument and the adaptive behavior level is determined by administering one of the following assessment tools:
• Inventory for Client and Agency Planning (ICAP);
• Scales of Independent Behavior (SIB-R);
• Vineland Adaptive Behavior Scales (VABS); or
• the American Association on Mental Deficiencies Adaptive Behavior Scales (AAMD).

As applicable, the service planning team also reviews the nursing, dental, or other medical assessments, therapy evaluations, social, psychological, or behavioral assessments, and orientation and mobility evaluations. Within ten business days after receipt of the signed level of care evaluation by the physician, the service planning team convenes to develop the initial service plan. Thereafter, the team meets to amend the plan in response to changes in the individual's needs or requests by the individual, legally authorized representative, or both, as appropriate. At least annually, the person-centered service planning team must meet and review the individual’s service plan and initiate changes in the plan in response to his or her requests, when circumstances change significantly, changes in the individual's needs or identified outcomes as documented in the service plan. The individual, legally authorized representative, or both, as appropriate, must sign the plan to indicate their understanding of, and agreement with, the plan.

The service planning team must document that the DBMD services in the service plan: are necessary for the individual to live in the community; are the most appropriate type and amount of services to meet the individual's assessed needs; prevent admission to an institution; and are sufficient when combined with non-waiver resources to assure the individual's health and welfare in the community. Additionally, the service planning team must document the prevention of unnecessary or inappropriate supports and services and documentation of positive interventions and supports used prior to any modifications to the person-centered service plan. The plan must support the individual’s outcomes including what is important to and for the individual, allow him or her to be integrated and engaged in community life at the level in which he or she chooses and with equal access as others not receiving services.

At a minimum, the service planning process and resulting plan must address the following:
(A) A description of the needs and preferences identified by the individual, legally authorized representative or both, as appropriate;
(B) A description of the services and supports the individual requires to continue living in a community-based setting;
(C) A description of the individual’s current natural supports and non-DBMD services that will be or are available;
(D) A description of individual outcomes to be achieved through the DBMD services and justification for each service included in the service plan;
(E) Documentation that the type, frequency, and amount of each service component included in the service plan does not replace existing natural supports or non-DBMD sources for the service components for which the individual may be eligible; and
(F) A description of actions and methods to be used to reach identified service outcomes.

The case manager assures that the service plan process identifies and focuses on the desired outcomes and needs as identified by the individual, legally authorized representative, or both, as appropriate. The case manager supports the individual’s, legally authorized representative’s, or both, as appropriate, active participation in the process by encouraging selection of the team, setting of the agenda, discovery of the individual’s preferences, and desired outcomes. In addition, the case manager provides education about the services available through the DBMD program, as well as

through other non-waiver resources for which the individual may be qualified. Formal assessments regarding health, level of functioning, and specialized therapeutic interventions are completed as the need is identified by the service planning team.

At enrollment, and at least annually, the case manager must present to the individual, legally authorized representative, or both, as appropriate, information regarding available services and supports and the available service delivery options. The case manager must also inform the individual, legally authorized representative, or both, as appropriate, that the case manager will assist in transferring the individual's DBMD services from one program provider to another program provider upon request from the individual, legally authorized representative, or both, as appropriate,. The case manager must assure the individual, legally authorized representative, or both, as appropriate, are informed of how to contact the case manager.

The individual, legally authorized representative, or both, as appropriate, case manager, and other team members selected by the individual, jointly develop a person-centered service plan that integrates DBMD services and supports and non-waiver services that support the individual’s preferences, life choices, outcomes, and ensures services are complementary and not duplicative.

The person-centered service planning process must include a description of actions to be used to reach identified outcomes through action steps and short-term objectives which include projected completion dates and the entity or person(s) responsible for implementing the methodology. The service plan must specify the type and amount of each service to be provided to the individual, as well as services and supports to be provided by non-DBMD resources during the service plan year. Approximately every 90 days and more often if the individual needs change, the case manager must review the individual’s service plan, progress toward goals, outcomes, and any change in needs that require changes to the service plan.

The individual's case manager is responsible for monitoring the implementation of the plan. The DBMD provider agency is responsible for ensuring implementation of the DBMD services outlined in the service plan. The individual and/or legally authorized representative who elects to utilize the consumer directed services 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, the case manager ensures consideration of information from the individual, legally authorized representative, or both, as appropriate, other service planning team members, and from assessments, including the annual comprehensive nursing assessment, to determine if any risks to the individuals might exist to health and welfare as a result of individual life choices and community living. Personal life choices and personal outcomes could include risks that may need to be mitigated. Strategies including program services and supports and non-waiver services and supports, formal and informal, are to be discussed in order to mitigate these risks, and if agreed upon by the individual, legally authorized representative, or both, as appropriate, become incorporated into the plan. DBMD program services may be offered in a one-to-one service provider or staff to individual ratio in a variety of settings when the service plan identifies a need for such support. When an individual, legally authorized representative, or both, as appropriate, requests a transfer to another provider or service delivery option, the case manager assists the individual to transfer from one provider agency or service delivery option to another. All DBMD providers are required to have back-up plans for services that the service planning team determines are critical to health and safety in order to minimize risk factors and ensure health and welfare of the individual. Annually the service planning team documents all non-waiver resources the individual has to meet their needs. If there is a need identified that the DBMD provider cannot meet, then at the individual's request the individual may acknowledge and accept the responsibility for that need using an individual responsibility agreement. All person-centered service plans are reviewed by HHSC Qualified Intellectual and Developmental Disability professionals to further ensure the plan meets the individual's needs.

In the Consumer Directed Services option, the service planning team identifies services critical to the health and safety of the individual for whom a back-up plan must be developed, documented in the person-centered service plan, and approved by the service planning team. Back-up plans may include paid or unpaid service providers, third party resources, natural supports, and other community resources.

The Home and Community Support Services Agency has a responsibility under its licensure rules (Title 40 Texas Administrative Code Part 1 Chapter 97) to adopt and enforce a written policy that specifies the agency's client care practices, which among other things, includes initial and reassessment and care planning. The HCSSA administrator is responsible for ensuring that the care plan is executed as written. The care plan (for non-skilled care) must be reviewed and updated by all appropriate staff members involved in client care at least annually, or more often as necessary to meet the needs of the client. The plan of care (for skilled care) must be revised as necessary, but it must be reviewed and updated at least every six months.

DBMD providers must ensure services are delivered according to the person centered service plan. The service plan must be updated annually and upon request or a significant change in condition.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (6 of 8)

**f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

When HHSC notifies an individual, legally authorized representative, or both, as appropriate, that he or she can begin the process of eligibility determination in order to enroll in DBMD services, the individual, legally authorized representative, or both, as appropriate, is sent a complete list of DBMD providers in the geographic area in which the individual wishes to reside. HHSC staff may be contacted for support during this process if desired. Individual, legally authorized representative, or both, as appropriate, are encouraged to contact providers to determine which provider best meets the individual's needs. An individual enrolled in DBMD or the legally authorized representative, if applicable, has the option of choosing from the available qualified providers, or having a qualified provider of his or her choice become employed by the DBMD provider, either directly or by contract, if the direct service provider agrees to the rate of compensation available through the waiver as payment in full. The individual, legally authorized representative, or both, as appropriate, are informed of this option annually or at his or her request and are provided with an up to date list of qualified providers.

## 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 State Medicaid Agency, has the responsibility for the day-to-day approval of service plans. HHSC reviews and approves all criteria, processes and documentation to assure requirements related to the development and approval of individual service plans. In addition to approving the above systems and processes, HHSC verifies compliance through at least biennial reviews of each DBMD provider agency, which include a provider's compliance with the approved service planning requirements. Quarterly and annually, HHSC aggregates contract monitoring data and discusses any significant findings. If necessary HHSC develops system improvements and remediation strategies to improve provider performance.

## 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:*

The DBMD provider agency and, if appropriate, the Financial Management Services Agency.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

**a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

When HHSC notifies an individual, legally authorized representative, or both, as appropriate, that individual is released from the interest list, and can begin the process of eligibility determination in order to enroll in in DBMD services, the individual, legally authorized representative, or both, as appropriate, if applicable, are sent a complete list of DBMD providers in the geographic area in which the individual wishes to reside and is asked to choose a provider in that geographic area and return the choice sheet to HHSC. HHSC notifies the chosen provider agency who then contacts the individual, legally authorized representative, or both, as appropriate, to begin the enrollment process.

The case manager is responsible for monitoring the implementation of the person-centered service plan and the individual's health and welfare. If the DBMD provider observes a change in the individual's needs, health, or welfare, or at the request of the individual, legally authorized representative, or both, as appropriate, during the service plan year, the DBMD provider representative is responsible for contacting the case manager, who then assists in convening a person-centered service planning meeting to determine how to address the needs through both DBMD services, non-waiver resources, and natural supports. At a minimum, the case manager meets face-to-face with the individual, legally authorized representative, or both, as appropriate, approximately every 90 days in accordance with the schedule in the DBMD Provider Manual to review the person-centered service plan, the individual's progress towards goals, outcomes, and any service need changes in the services and supports needed. If there is an indication of a change in needs, a revision to the person-centered service plan is made with the individual, legally authorized representative, or both, as appropriate, and the service planning team selected by the individual. At least annually, the case manager supports the individual, legally authorized representative, or both, as appropriate, to determine a time and location to convene the annual meeting with the individual present. The person-centered service planning team reviews the current service plan and assists the individual in developing their service plan for the upcoming year.

The DBMD provider agency is responsible for implementing the service plan and back-up plans to meet the individual’s outcomes, balance what is important to and for the individual, including protecting the individual's health and welfare. The DBMD provider agency provides agency specific emergency contact numbers and information for after-hours services to the individual, legally authorized representative, or both, as appropriate. The DBMD provider agency is responsible for ensuring necessary services are available to reflect risk factors and measures in place to minimize them with individualized backup plans and strategies when needed.

At least biennially, during monitoring reviews, HHSC ensures that the person-centered service plan developed and approved by the person-centered service planning team was completed according to instructions, signed by the service planning team members, is approved by HHSC, and that services are being implemented according to the service plan. HHSC ensures the case manager is monitoring service provision in accordance with program rules. HHSC also ensures that reviews are conducted in accordance with the schedule in the DBMD Provider Manual and documented by the provider. The review must indicate that the person-centered services meet the individuals’ needs or that revisions were completed within the required timeframe to amend services to meet the individual’s needs.

Additionally, HHSC monitors DBMD provider agencies to ensure compliance with requirements that the provider safeguards the rights of the individual, legally authorized representative, or both, as appropriate, to exercise free choice of providers and to transfer to a new provider at any time. If HHSC Contracts staff determines that an individual requested to transfer to another provider, HHSC determines if the transfer occurred, and if it did not, why it did not occur.

The DBMD provider agency is responsible for ensuring that the individual's rights are protected, service plan monitoring occurs as stated in the individual's person-centered service plan, required documentation is completed, and follow-up action on contract monitoring findings is taken. As required, DBMD providers are responsible for submitting plans of correction based on any problems identified during monitoring reviews. HHSC reviews the submitted plans of correction to determine if the plans are sufficient. Corrective action plans never expire and may be reviewed for the duration of that contract. If they are found out of compliance with their corrective action plan on a subsequent review, the State may take additional remediation actions including vendor holds or referrals to the Sanction Action Review Committee. Quarterly and annually, HHSC aggregates contract monitoring data and discusses any significant findings. If necessary HHSC develops system improvements and remediation strategies to improve provider performance.

**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:*

The service planning team works with the case manager to ensure that the best interests and needs of the individual are the primary considerations in the service plan development process. The person-centered service planning team process ensures that there is no conflict of interest when a case manager who monitors and assists in development of the service plan is employed by the provider agency responsible for providing other direct services. All of the service planning team members contribute to development of the person-centered service plan based on the individual's needs, preferences, life choices, interests, strengths, likes and dislikes. The team assists the individual, legally authorized representative, or both, as appropriate, in determining the types and units of individualized services necessary for the person-centered service plan. The plan must be agreed upon and signed by the individual, legally authorized representative, or both, as appropriate, with the other service planning team members signing as participants before submission to HHSC. At least biennially, HHSC Contracts staff perform monitoring reviews of each DBMD provider agency to determine that the DBMD provider agency follows service planning requirements, including that the individual's needs are being met, person-centered service plans change when needs change significantly, or at the request of the individual, legally authorized representative, or both, as appropriate.

## 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 and personal goals. D: Number of individuals with reviewed service plans.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DBMD 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**<br>Confidence Interval =<br>95% +/- 5% |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☒ **Other**<br>Specify:<br>Approximates 100% Review over the waiver year. Due to time lags that occur during the service planning process, this number may vary from the number of enrolled individuals for the waiver year. |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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 service plan expiration date. N: Number of service plans that were reassessed and renewed annually prior to 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:
**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** |

| **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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**D.c.2 Number and percent of service plans that were revised when warranted by reported changes in the individual's needs. N: Number of service plans that were revised when warranted by reported changes in the individual's needs. D: Number of service plans reviewed indicating a change in the individual's needs.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Contract Workbook**

| **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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | | |
| | ☒ **Continuously and Ongoing** | ☒ **Other**<br>Specify:<br>5% of individuals per provider contract (minimum of 4 individuals per contract if serving 1-21, minimum of 5 individuals per contract if serving 22 or more; maximum of 30 individuals per contract). |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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: 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' records that reflected services were delivered according to their service plan, including type, scope, amount, duration, and frequency. N: Number of individuals' records that reflected 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:
**Contract Workbook**

| **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**<br>Confidence Interval = |
| ☐ **Other** | ☐ **Annually** | ☐ **Stratified** |

| | | |
|---|---|---|
| Specify: | | Describe Group: |
| | ☒ **Continuously and Ongoing** | ☒ **Other**<br>Specify:<br>5% of individuals per provider contract (minimum of 4 individuals per contract if serving 1-21, minimum of 5 individuals per contract if serving 22 or more; maximum of 30 individuals per contract). |
| | ☐ **Other**<br>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**<br>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: |

**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 who were afforded choice among waiver providers during service plan renewal. N: Number of individuals who were afforded choice among waiver providers during service plan renewal. D: Number of individuals who were renewing.**

**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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | | |
| | ☒ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

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

**Performance Measure:**
**D.e.3 Number and percent of individuals with case records that reflected individuals were afforded choice between provider-delivered services and consumer-directed services. N: Number of individuals with case records that reflected individuals were afforded choice between provider-delivered services and consumer-directed services. D: Number of individuals with case records reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:

**Contract Workbook**

| **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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☒ **Other**<br>Specify:<br>5% of individuals per provider contract (minimum of 4 individuals per contract if serving 1-21, minimum of 5 individuals per contract if serving 22 or more; maximum of 30 individuals per contract). |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**D.e.1 Number and percent of individuals who were afforded choice between waiver services and institutional care during enrollment N: Number of individuals who were afforded choice between waiver services and institutional care during enrollment. D: Number of individuals who were newly enrolled.**

**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**<br>Confidence Interval = |

| | | |
|---|---|---|
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

HHSC has implemented an online portal system that allows secure submission and return of electronic documentation, rather than submission of paper documentation. This will allow for improved secure document transmission, reduced need for follow-up calls, emails and faxes, and the ability to check submission status at any time. Providers will receive status updates on submissions, including if a submission needs additional information or documentation and when a submission reaches a final status.

One hundred percent of authorized service plans are reviewed by HHSC through desk reviews. If an incomplete or incorrectly completed service plan is submitted to HHSC, the plan is returned through the online portal to the provider for correction. When these plans are returned to providers, a description of the error and required correction is included. The provider must then resubmit the corrected plan, which is reviewed again by HHSC staff. The feedback sent to the provider with the remanded service plan is captured in the Deaf Blind with Multiple Disabilities database.

HHSC staff use the Service Authorization System Online to authorize waiver services and to collect, process, and report individual service authorization data. The Service Authorization System can generate a wide variety of reports. The Service Authorization System maintains the following information:

• Information about individuals who are enrolled and their service authorizations. The system records contain information such as contact information, enrollment data, authorized service period, allotted amounts of each service, and service plan changes and reassessments.

• Provider Information about service providers is maintained in the system. The records contain information such as types of services and number of units each provider is authorized to deliver for each individual.

• Billing and Payment Information related to specific rate information for each type of service. DBMD case managers, with the service planning teams, recommend specific services for participants. The provider may bill for services only after HHSC has authorized those services in the system.

• Medicaid Eligibility Service Authorization Verification provides information about individuals for whom they are authorized to deliver services. This information includes Medicaid eligibility, level of care, and service authorization.

One hundred percent of Deaf Blind with Multiple Disabilities providers are reviewed by HHSC Contracts staff at least every two years. This monitoring includes a review of the service plans for individuals in the sample.

In order to compute D.e.1 and D.e.2, the State identifies individuals who were newly enrolled or due for an Individual Plan of Care renewal during the reporting period. The Individual Plan of Care record includes a checkbox for the Freedom of Choice Form, which covers measure D.e.1 (choice between institution care and waiver services), and a checkbox for Provider Choice, which covers measure D.e.2 (i.e. choice among waiver providers). These checkboxes are marked whenever the respective forms are completed and signed.

For computing the performance measures, Individual Plan of Care data are extracted from the Salesforce Utilization Management and Review system. A database record with a marked Freedom of Choice or Provider Choice checkbox is utilized as documentation by the Utilization Management and Review Unit that the appropriate process to afford choice was followed by the provider for each respective measure and records are aggregated to result in the appropriate numerator counts.

In addition, the Freedom of Choice and Provider Choice forms are required to be submitted by the DBMD providers as part of the documentation/justification in the submission of an enrollment or renewal Individual Plan of Care.

**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.

Technical assistance is shared with providers throughout the HHSC Contracts staff review. If, during a contract monitoring review, a provider is discovered to not have submitted a service plan within the required timeframe or if a service plan is missing signatures, the provider agency is required to submit a corrective action plan to HHSC. In accordance with 40 Texas Administrative Code §49.522 (relating to Corrective Action Plans), the corrective action plan must contain the following elements:

- A description of the non-compliance that HHSC identified from the monitoring or investigation resulting in the corrective action plan;
- A description of the activities the provider will perform to correct or prevent the identified non-compliance;
- The title of the person responsible for the activities described above; and
- Implemented schedule for performing the activities described above.

If a corrective action plan is requested from the provider, the provider is informed that they may contact HHSC staff with any questions or requests for clarification of what constitutes an acceptable 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. Providers 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 provider, up to and including termination of the provider agreement/contract. HHSC monitors the corrective action plan until the provider is in compliance. Corrective action plans never expire and may be reviewed for the duration of that contract. If they are found out of compliance with their corrective action plan on a subsequent review HHSC may take additional remediation actions including vendor holds or referrals to the Sanction Action Review Committee.

HHSC Contracts staff submits provider agreement/contract action recommendations to the Sanction Action Review Committee when a complaint investigation against a provider substantiates a reported allegation or HHSC Contracts staff recommend the provider receive a contract action/sanction more serious than a corrective action plan. Sanction Action Review Committee members review the monitoring review results and, if applicable, 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 individuals; placing a hold on provider payments; and involuntary contract termination.

Results of each contract monitoring review are documented and recorded in the HHSC System of Contract Operation and Reporting.

**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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

**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, the individual's legally authorized representative, or both, as appropriate the opportunity to be the employer of persons providing waiver services chosen for self-direction. An individual residing in his or her own private residence or the home of a family member may choose to self-direct any of the following services: residential habilitation, intervener services, supported employment, employment assistance, and respite.

The traditional agency option (provider-managed) provides any services not available through the consumer directed services option and any services that the individual or legally authorized representative elects not to self-direct. Under the traditional agency option, individuals choose a contracted provider.

Each individual or legally authorized representative electing to use the consumer directed services option must receive support from a financial management services agency, chosen by the individual or legally authorized representative. An individual or legally authorized representative may also receive support consultation, which is available only to individuals who choose the consumer directed services option.

When choosing to self-direct services, the individual or the legally authorized representative is the common-law employer of service providers and has decision-making authority over providers of self-directed services. The individual or the legally authorized representative also has budget authority. HHSC approves funding for self-directed services based on the authorized service plan. The employer or designated representative, with the assistance of the financial management services agency, budgets approved funds for self-directed services.

The case manager informs the individual, legally authorized representative, or both of the option to self-direct the services indicated above at the time of enrollment in the waiver, at least annually thereafter, and upon request of the individual or legally authorized representative. The individual or legally authorized representative may elect at any time to choose the consumer directed services option, terminate participation in the consumer directed services option, or to change financial management services agencies.

Supports for the individual directing services or the individual's legally authorized representative include:
- The case manager, who provides information about the consumer directed services option and monitors service delivery. The case management functions are global and apply to self-directed as well as provider-managed waiver services and non-waiver services; and
- A financial management services agency, chosen by the individual or legally authorized representative, to provide financial management services. The financial management services agency must hold a Medicaid provider agreement (contract) with HHSC.

Supports may also include:
- A qualified support advisor chosen by the individual or legally authorized representative employer if the individual or legally authorized representative has chosen to receive support consultation, who assists the individual or legally authorized representative employer in learning about and performing employer responsibilities; and
- A designated representative, if appointed by the individual or legally authorized representative employer, who assists in meeting employer responsibilities to the extent directed by the employer.

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 choose a designated representative capable of performing some or all of these tasks on the individual's behalf; and
- Maintain a service back-up 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*

A DBMD individual is offered the opportunity to self-direct services when:

1. The individual lives in his or her own home or the home of a family member; and
2. The service plan includes residential habilitation, respite, supported employment, employment assistance, or intervener.

## Appendix E: Participant Direction of Services

### E-1: Overview (4 of 13)

**e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The case manager provides each individual, the individual's and legally authorized representative , or both, as appropriate, a written and oral explanation of the consumer directed services option at the time of enrollment in DBMD, at each annual review of the service plan, and at any time requested by the individual, the individual's legally authorized representative, or both, as appropriate.

Each individual, the individual's legally authorized representative, or both, as appropriate, is provided information sufficient to assure informed decision- making and understanding of the consumer directed services option and of the traditional agency-directed (provider- managed) service delivery 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, the individual's legally authorized representative, or both, as appropriate, by the case manager 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, case manager, and the financial management services agency;
- 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 individual or the legally authorized representative serving as the consumer directed services employer may appoint an adult who is not the legally authorized representative as a designated representative to assist in performance of employer responsibilities to the extent desired by the individual or legally authorized representative. The consumer directed services employer documents the employer responsibilities that the designated representative may and may not perform on the consumer directed services employer's behalf. The consumer directed services employer provides this documentation to the financial management services agency. The financial management services agency legal entity monitors performance of consumer directed services employer responsibilities performed by the employer and, when applicable, the designated representative in accordance with the consumer directed services employer's 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. If an employer appoints a designated representative who is not a relative of the individual, the financial management services agency must perform a criminal history check.

To ensure the designated representative functions in the best interests of the individual, safeguards are in place that include restrictions preventing the designated representative from:

- signing or representing himself as the employer,
- providing a program service, or
- being paid to perform employer responsibilities.

## 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 |
|---|---|---|
| **Intervener** | ☒ | ☒ |
| **Supported Employment** | ☒ | ☒ |
| **Respite** | ☒ | ☒ |
| **Residential Habilitation** | ☒ | ☒ |
| **Employment Assistance** | ☒ | ☒ |
| **Support Consultation** | ☒ | ☒ |

## 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 furnish financial management services. These legal entities, called financial management services agencies, are procured through an open enrollment process and HHSC has Medicaid provider agreements with multiple entities to provide financial management services to individuals across the State.

HHSC, executes a Texas Medicaid provider agreement with each financial management services agency. These agreements include additional state contract requirements.

**ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

Entities are compensated with a flat monthly fee per individual served.

**iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☐ **Other**

*Specify:*

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:*

Runs criminal history checks

**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 has the responsibility of executing Medicaid provider agreements and monitoring of Financial Management Services Agencies. HHSC conducts monitoring reviews of each financial management services agency to determine if it is in compliance with the Medicaid provider agreement and with program rules and requirements. These reviews are conducted via desk reviews or at the location where the financial management services agencies are providing financial management services. Texas monitors 100 percent of financial management services agencies at a minimum of every three years.

HHSC assesses a financial management services agency's performance by:
- Measuring adherence to rules in Title 40 of the Texas Administrative Code, Part 1, Chapters 41 and 49;
- Matching payroll, optional benefits and tax deposits to time sheets;
- Ensuring that the hours worked and the rate of pay are consistent with individual budgets;
- Reviewing administrative payments; and
- 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:*

Information provided orally and in writing to the individual, the individual's legally authorized representative, or both, as appropriate, by the case manager includes:
- An overview of the consumer directed services option;
- Explanation of responsibilities in the consumer directed services option for the individual, individual's legally authorized representative, or both, as appropriate, case manager, and the financial management services agency;
- 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.

☒ **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 |
|---|---|
| **Prescribed Drugs** | ☐ |
| **Intervener** | ☐ |
| **Transition Assistance Services** | ☐ |
| **Financial Management Services** | ☒ |
| **Dietary Services** | ☐ |
| **Supported Employment** | ☐ |
| **Orientation and Mobility** | ☐ |
| **Chore Service** | ☐ |
| **Assisted Living** | ☐ |
| **Respite** | ☐ |
| **Residential Habilitation** | ☐ |
| **Case Management** | ☐ |
| **Occupational Therapy Services** | ☐ |
| **Employment Assistance** | ☐ |
| **Dental Treatment** | ☐ |
| **Support Consultation** | ☒ |
| **Speech, Hearing, and Language Therapy Services** | ☐ |
| **Minor Home Modifications** | ☐ |
| **Day Habilitation** | ☐ |
| **Adaptive Aids and Medical Supplies** | ☐ |
| **Audiology Services** | ☐ |

| Participant-Directed Waiver Service | Information and Assistance Provided through this Waiver Service Coverage |
|---|---|
| **Behavioral Support Services** | ☐ |
| **Physical Therapy Services** | ☐ |
| **Nursing** | ☐ |

☐ **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 case manager assists with revising the service plan for the transition of services previously delivered through the consumer directed services option to be delivered by the program provider chosen by the individual or legally authorized representative. The service planning team assists the individual as necessary to ensure continuity of all waiver services through the traditional agency-directed (provider-managed) service delivery 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 employer. When an individual voluntarily terminates self-direction of services, the case manager assists the individual to begin services through the agency option with no gap in coverage. The individual must wait 90 days before returning to the consumer directed services option.

## Appendix E: Participant Direction of Services

### E-1: Overview (12 of 13)

**m. Involuntary Termination of Participant Direction.** Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

An individual's service planning team, financial management services agency, or HHSC may recommend termination of participation in the consumer directed services option if the individual, legally authorized representative, or designated representative does not implement and successfully complete the following steps and interventions:

- Address risks to the individual's health or welfare;
- Successfully direct the delivery of program services through consumer directed services;
- Meet employer responsibilities as listed in E-2-a(ii), Participant Employer Authority, and E-2-b(i), Participant Decision Making Authority;
- Successfully implement corrective action plans; or
- Appoint a designated representative or access other available supports to assist the employer in meeting employer responsibilities.

HHSC may require immediate termination of participant direction in circumstances that jeopardize health and safety, when the designated representative is convicted of a crime, or if another regulatory agency recommends termination (Title 40 of the Texas Administrative Code, Part 1, Chapter 41).

The individual's case manager and service planning team assist the individual to ensure continuity of all waiver services through the traditional agency (provider-managed) service delivery option and maintenance of the individual's health and welfare during the transition from the consumer directed services option. The case manager must assist with revising the service plan for the transition of services previously delivered through the consumer directed services option that will be delivered by the program provider chosen by the individual or legally authorized representative. The financial management services agency closes the employer's payroll and payable accounts and completes all deposits and filing of required reports with governmental agencies on behalf of the employer.

## 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** | | 131 |
| **Year 2** | | 131 |
| **Year 3** | | 131 |
| **Year 4** | | 131 |
| **Year 5** | | 131 |

## 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 (provider-managed) service delivery option. The service plan must be approved by HHSC. The consumer directed services budget is the estimated cost of the self-directed services in the approved service plan and the adopted consumer directed services reimbursement rates. The consumer directed services budget is developed by the individual or legally authorized representative with assistance from the financial management services agency.

The consumer directed services 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 do not change the amount of funds available for the service based on the approved service plan.

Employer-related costs are paid for using the consumer directed services budget and include costs for equipment, supplies, or activities that will provide direct benefit to the individuals who self-direct services to support specific outcomes related to being an employer 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; acquisition of other background checks of a potential service provider; and purchase of 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-related support activities.

Support consultation has a specific reimbursement rate and is a component of the individual's service budget. In conjunction with the service planning team, the individual or legally authorized representative determines the level of support consultation necessary 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 HHSC. With assistance of the financial management services agency, the individual or legally authorized representative revises the consumer directed services budget to reflect the revision in the service plan.

Information concerning budget methodology for the consumer directed services budget is available to the public in Title 40 of the Texas Administrative Code, Part 1, Chapter 41, Subchapter E.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (4 of 6)

**b. Participant - Budget Authority**

**iii. Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The individual, the legally authorized representative, or both as appropriate, participates as a member of the service planning team that develops the individual's person-centered plan, upon which the service plan is based. The individual or legally authorized representative is apprised of the budget as it is developed. The individual develops the consumer directed services budget based on the finalized service plan and authorized budget. The financial management services agency and the case manager inform the individual/employer of the amount authorized for the particular service before the budget is developed.

During the service planning process, the case manager informs the individual or legally authorized representative of procedures to request a revision to the service plan. The individual/employer may request an adjustment to the budget at any time, subject to the waiver cost ceiling. An individual whose request of an adjustment to his or her participant-directed budget is denied is entitled to a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A. The case manager sends written notification to the individual or legally authorized representative, indicating the reason for the denial, the individual's right to a fair hearing, and the process the individual must follow to request a fair hearing. The specific procedures for a fair hearing are provided in Appendix F, Individual Rights.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (5 of 6)

**b. Participant - Budget Authority**

**iv. Participant Exercise of Budget Flexibility.** *Select one*:

- (◉) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- (○) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (6 of 6)

**b. Participant - Budget Authority**

**v. Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

An individual's consumer directed services budget is calculated and monitored based on projected utilization and frequency of the services as determined by the service planning team. The financial management services agency legal entity is required to monitor payroll every pay period (two weeks) and expenditures (as processed for payment) and report over- and under-utilization to the individual/employer and the case manager. When an over- or under-utilization is not corrected by the individual/employer or legally authorized representative, the financial management services agency notifies the case manager and the individual/employer. The case manager and the individual/employer identify the cause of 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 and at least annually, the case manager provides an oral and written explanation of an individual's right to request a fair hearing to the individual, legally authorized representative, or both, as appropriate, in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 42, Subchapter B, §42.212 and §42.223. The case manager documents that the explanation of the right to request a fair hearing is provided to the individual, legally authorized representative, or both, as appropriate.

An individual is entitled to request a fair hearing if an individual's request for enrollment into the DBMD program is denied or is not acted upon with reasonable promptness, or an individual's DBMD Program services are denied, suspended, reduced, or terminated in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A and Title 42, Code of Federal Regulations Part 431 Subpart E.

HHSC DBMD program staff send a letter to the provider that describes the action HHSC will take and explains the right to request a fair hearing in accordance with Title 40 of the Texas Administrative Code, Part 15, § 357.3 and § 357.11 and 42 CFR § 431.210. HHSC DBMD program staff retains a copy of the letter in the individual's record.

The provider is responsible for providing a copy of the letter to the individual or legally authorized representative 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 by 42 CFR §431.213 and §431.214.

An individual may not receive or continue to receive services while the fair hearing process is pending if the notice is not required to be provided to the individual at least 10 days prior to the effective date of action, as described above, or if an individual has not requested a fair hearing before the effective date of action, as permitted by 42 CFR §431.230.

If an individual requests a fair hearing, HHSC DBMD program staff enter the information into the Texas Integrated Eligibility Redesign System for notification to the HHSC Fair Hearings Office that conducts fair hearings. Fair hearing requests are tracked in a data system designated by HHSC and in the Texas Integrated Eligibility Redesign System.

Individuals will be afforded the opportunity to request a fair hearing in all instances where they are not allowed to select a DBMD provider from a list of all available DBMD providers within the geographic area in which they receive waiver services.

Individuals will be afforded the opportunity to request a fair hearing in all instances where they are denied the service(s) of their choice.

Individuals will be afforded the opportunity to request a fair hearing in all instances where they are not notified that they have the choice of receiving HCBS instead of institutional services.

# Appendix F: Participant-Rights

## Appendix F-2: Additional Dispute Resolution Process

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

◉ **No. This Appendix does not apply**

○ **Yes. The state operates an additional dispute resolution process**

**b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System.** *Select one:*

○ **No. This Appendix does not apply**

◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

**b. Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

HHSC, the single State Medicaid Agency, 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).

HHSC has identified that the Office of the Ombudsman is responsible for the receipt of complaints by individuals, legally authorized representatives, family members, and the general public about services, programs and staff. The Complaint and Incident Intake unit is responsible for concerns and questions regarding the facilities/agencies regulated by HHSC. The individual's case manager informs the individual and/or legally authorized representative, verbally and in writing of the complaint process upon enrollment and annually thereafter.

HHSC Complaint and Incident Intake unit staff triage and refer complaints regarding a HHSC licensed agency or facility, including Assisted Living Facilities contracted to provide waiver services, to HHSC Regulatory Services and HHSC Contracts staff. HHSC must acknowledge the complaint within 14 days after the date HHSC receives it and must conduct an inspection within a timeframe varying from 2 days to the next onsite visit, based on the allegations in the complaint, and respond within two to 120 days after that date, based on the type of complaint.

If HHSC Regulatory Services conducts the initial investigation, HHSC Contracts staff must initiate the complaint investigation within 45 workdays of the date the staff receives either the Report of Investigation or Statement of Licensing Violations and Plan of Correction form from HHSC Regulatory Services. If HHSC Regulatory Services does not initiate the investigation, HHSC Contracts staff must initiate the complaint investigation within 45 workdays from the date HHSC Complaint and Incident Intake unit posted the intake to the designated Outlook mailbox.

The initiation of the complaint investigation begins when HHSC Contracts staff makes the first contact with the complainant or the provider. Contact may be made face-to-face, by telephone, or by fax. HHSC Contracts staff must complete the on-site or desk review investigation within 15 workdays from the date the investigation was initiated.

HHSC Contracts staff maintains a complaint log for the purpose of collecting, reviewing and reporting complaint information. On a monthly basis, HHSC Contracts staff compile the Complaint Activity Report and the Complaint Resolution Activity Report and post the reports electronically to the HHSC System of Contract Operations and Reporting. HHSC Contracts staff is responsible for reporting contract management activities, including investigations, to Contract Oversight and Support for entry into the HHSC System of Contract Operations and Reporting.

With regard to specific allegations of abuse, neglect, or exploitation, HHSC Regulatory Services investigates all allegations of this nature in licensed Assisted Living Facilities. Home and Community Support Services Agencies are required to report allegations of abuse, neglect, or exploitation of an individual receiving waiver services to the Texas Department of Family and Protective Services.. HHSC Provider Investigations investigates the allegations and makes the final determination as to whether abuse, neglect, or exploitation occurred. HHSC investigates to determine compliance with licensure and certification requirements. The DBMD provider must ensure that the individual and legally authorized representative are informed of how to report allegations of abuse, neglect, or exploitation to HHSC Provider Investigations.

The HHS Office of the Ombudsman assists the public when the program's normal complaint process cannot, or does not, satisfactorily resolve an issue. Ombudsman services include:

- Conducting independent reviews of complaints concerning agency policies or practices;
- Ensuring policies and practices are consistent with the goals of HHSC;
- Ensuring individuals are treated fairly, respectfully, and with dignity; and,
- Making referrals to other agencies as appropriate.

An individual may file a complaint with the Office of the Ombudsman by calling the toll-free-number, submitting the complaint online, or by faxing or mailing the complaint. When Ombudsman staff determines HHSC has no jurisdiction to investigate, complaints are referred to other agencies, boards, or entities, as required.

Often it is necessary for the Office of the Ombudsman to refer an issue to program staff within the HHS agencies. If so, the Office of the Ombudsman will follow-up with the complainant to confirm resolution has been achieved, or to refer the complainant to other available known resources.

The Texas Medicaid Fair Hearing rules do not require an individual to file a grievance or complaint as a condition for a fair hearing.

The opportunity to request a fair hearing and an explanation of the fair hearing process is given to an individual by the case manager if HHSC denies a request for enrollment, denies or suspends a service, or proposes to reduce a service or

terminate program services.

The DBMD provider case manager is required to present an explanation of the fair hearing process at enrollment, renewal, or any time the individual requests the information. The DBMD provider is the entity responsible for assisting the individual in exercising his or her fair hearing rights.

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

**a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

**b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Deaf Blind with Multiple Disabilities (DBMD) providers must hold a Home and Community Support Services Agency license, and if providing assisted living services to four to six individuals, an Assisted Living Facility license. HHSC licensing and contracting rules contain requirements related to reporting incidents and complaints. HHSC monitors DBMD provider compliance with these requirements.

HHSC licenses Home and Community Support Services Agencies in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 97, and Assisted Living Facility providers in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 92.

DBMD providers licensed as Home and Community Support Services Agencies are required to report any instance of abuse, neglect, or exploitation of an individual by an employee, contractor, or volunteer to the Department of Family and Protective Services and to HHSC immediately upon suspicion of such activities. The HHSC Provider Investigations investigates the allegations and makes the final determination as to whether abuse, neglect, or exploitation occurred. HHSC investigates to determine compliance with licensure and certification requirements. When allegations are made relating to abuse, neglect and exploitation, the DBMD provider or CDS employer must assist the individual in obtaining medical and psychological services and take actions to secure the safety of the individual.

DBMD providers licensed as Assisted Living Facility providers are required to report allegations of abuse, neglect, and exploitation directly to Department of Family and Protective Services immediately upon suspicion of such activities whether the perpetrator is an employee of the Assisted Living Facility or the Home and Community Support Services Agency.

DBMD providers must report critical incidents rising to the level of abuse, neglect or exploitation must be reported immediately, within 24 hours of awareness to DFPS and HHSC by phone or through the web-based portal. Within 10 days DBMD providers must submit an HHSC form with notification of the ANE allegation, results of the provider's investigation and any action taken to HHSC. The form may be submitted by mail, fax or electronically.

Critical incidents which are not related to abuse, neglect or exploitation must be reported to HHSC using a secure web based application. Providers go to the website, fill out the form and submit the information. Providers will also have the option to print the form and submit by fax or mail if they do not have consistent computer access.

Intermediate Care Facilities for Individuals with Intellectual Disabilities providing out-of-home respite are also required to immediately report allegations of abuse, neglect, and exploitation to Department of Family and Protective Services. Those reports are investigated by HHSC Provider Investigations staff.

A DBMD provider must report the death of an individual to HHSC within 24 hours.

**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 DBMD, the individual is informed of their rights and responsibilities, which include an individual's right to be free from abuse, neglect, and exploitation. At enrollment and annually thereafter, the case manager must also educate the individual and legally authorized representative about protecting the individual from abuse, neglect, and exploitation. Each individual must be provided the Department of Family and Protective Services toll free number to report to HHSC an allegation of abuse, neglect, or exploitation. Facilities must post the information in a conspicuous place. Evidence supporting compliance with these requirements is reviewed during HHSC's on-site licensure surveys and program and fiscal monitoring reviews of the program provider.

In addition to information provided to each individual enrolled in the waiver, a financial management services agency provides individuals electing the consumer directed services option with training and written information related to reporting allegations of abuse, neglect, and exploitation.

**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.

HHSC is responsible for receiving and reviewing critical event/incident reports. DBMD providers are required by policy to report all critical incidents and provide follow-up information regarding all instances of confirmed abuse, neglect, or exploitation by submitting the HHSC form within the timeframes specified in §42.401 of the Texas Administrative Code. All complaints of abuse, neglect, or exploitation filed against Home and Community Support Services Agency licensed providers are referred to the HHSC Provider Investigations. HHSC also investigates complaints of abuse, neglect, or exploitation in Assisted Living Facilities and may take a range of enforcement actions including administrative penalties and licensure revocation. Licensure rules for assisted living providers require all Assisted Living Facility staff to complete an orientation that includes training regarding the reporting of abuse and neglect. HHSC Educational Services staff provides on-line and in-person training opportunities for assisted living providers including training regarding common licensure violations. HHSC Regulatory Services staff ensures that licensed providers adopt and enforce written policies governing individuals' rights, one of which is the right to be free from abuse, neglect, and exploitation by an employee, contractor, or volunteer.

HHSC Investigations:
HHSC Complaint and Incident Intake unit receives, records, triages and tracks alleged abuse, neglect, and exploitation related to assisted living providers in the Compliance, Assessment, Regulatory Enforcement System database. Abuse, neglect, and exploitation reports are also recorded in the Home and Community Support Services Agency database and are referred to the HHSC Provider Investigations for abuse, neglect, or exploitation investigation. The Complaint and Incident Intake unit is responsible for entering all data into the Home and Community Support Services Agency database.

HHSC provides due process to the perpetrator of confirmed abuse, neglect, or exploitation allegations when the act rises to the level of reportable conduct. Contracted providers are required to protect individuals from abuse, neglect, and exploitation under consumer rights rules, and they must report potential incidents of abuse, neglect, or exploitation. The methods of investigation and the time frames for completing investigations vary by the type of event or incident, the setting, and investigating party. Other specific information regarding processes and time frames is available in the licensing requirements, the HHSC Provider Investigations procedures, or contract rules.

For Assisted Living Facilities:
A provider who has cause to believe that the physical or mental health or welfare of a resident has been, or might be, adversely affected by mistreatment, neglect, or abuse must report the incident to HHSC immediately of learning of the alleged conduct or conditions. Assisted Living Facilities are required to submit their investigation report to HHSC within 5 calendar days. This includes injuries of unknown source and exploitation/misappropriation of resident property.

After receipt and triage, Complaint and Incident Intake refers reports of abuse, neglect, or exploitation alleged to have occurred in an Assisted Living Facility to HHSC Regulatory Services surveyors for investigation. Investigations that include abuse, neglect, or exploitation allegations must be initiated consistent with the following priority categories:

On-or-before 24 hours - An immediate response by Regulatory Services is warranted because a provider allegedly created or allowed a present and ongoing situation in which the provider's noncompliance with one or more requirements of licensure has failed to protect individuals from abuse, neglect, or exploitation or has caused, or is likely to cause, serious injury, harm, impairment, or death to an individual.

On-or-before 14 calendar days- The present or ongoing threat of continued abuse, neglect, or exploitation has been removed, and individuals are no longer in imminent danger; however, the provider's alleged noncompliance with one or more requirements of licensure may have or has a high potential to cause harm that impacts an individual's mental, physical, or psychosocial status and is of such consequence that a rapid response by HHSC Regulatory Services is indicated. There is evidence or suspicion that system(s) failure contributed to or brought on the threat.

On-or-before 30 calendar days- A provider's alleged noncompliance with one or more requirements of licensure or certification has caused or may cause harm that is of limited consequence and does not significantly impair the individual's/resident's mental, physical, or psychosocial status.

On-or-before 45 calendar days- A provider's alleged noncompliance with one or more requirements of licensure or certification has a low potential for more than minimal harm or may result in physical, mental, or psychosocial harm that would not directly impact individual/resident health and safety and functional status; this priority may also be assigned

for alleged violations of regulations that do not directly impact individual/resident health and safety.

Professional Review - A provider who has cause to believe that the physical or mental health or welfare of a resident has been, or may be, adversely affected by mistreatment, neglect, or abuse must self-report the incident to HHSC immediately on learning of the alleged conduct or conditions. This includes injuries of unknown source and exploitation/misappropriation of resident property.

For Home and Community Support Services Agencies:
Home and Community Support Services Agencies are required to investigate an allegation of abuse, neglect, or exploitation and submit a Provider Investigation Report to HHSC within 10 calendar days. HHSC regulatory surveyors review the reports, assessing the provider's description of the incident, the provider's summary and analysis of the investigation procedures, the provider's conclusion as to whether the allegation is supported by the provider's professional judgment, and recommendation(s) or corrective action(s) taken by the provider as a result of the investigation findings. Based on review of the provider investigation report, if further investigation is warranted to assess whether the provider complied with regulatory requirements, the survey staff will conduct an on-site investigation.

HHSC Provider Investigations is responsible for investigating allegations of abuse, neglect, and exploitation of individuals with disabilities, including cases in which a contracted provider is alleged to have abused, neglected, or exploited an individual. HHSC Provider Investigations records and tracks reports of abuse, neglect, or exploitation.

The Department of Family and Protective Services assigns one of three priority levels of allegations at intake. HHSC Provider Investigations investigators may change the priority level as a result of the phone contact. HHSC Provider Investigations must make the initial face-to-face contact with the alleged victim based on the priority level. The investigator assesses the intake to determine if the correct priority is assigned. Changes in priority have the potential to affect investigation timelines, including face-to-face interviews with victims and when investigation is due.

Priority one cases are those which include incitement to harm self or others, death, sexual abuse, or serious physical, verbal or emotional abuse, or have serious risk for the collection of evidence if investigation is delayed. Require response within 24 hours.

Priority two cases are those which include non-serious physical injury or verbal/emotional abuse or have some risk for the collection of evidence if investigation is delayed. Require response within three calendar days.

Priority three cases, are those where exploitation is the only allegation or if the incident occurred more than 30 days prior to the day of the report. Require response within seven calendar days.

HHSC Provider Investigations provides the initial and final investigation reports to the Home and Community Support Services Agency so that appropriate action can be taken to ensure the individual’s health and safety. DBMD Provider agencies must submit a follow up report to HHSC describing their response to HHSC Provider Investigations final report and recommendations.

Under the Consumer Directed Services Option:
HHSC Provider Investigations investigates allegations of abuse, neglect, and exploitation of an adult or child receiving services in the Consumer Directed Services option. HHSC Provider Investigations provides the investigation report to the Consumer Directed Services employer and the employer's Financial Management Services Agency.
When HHSC Provider Investigations receives an allegation of abuse, neglect, or exploitation related to services delivered through the Consumer Directed Services option and a Consumer Directed Services employee or designated representative is the alleged perpetrator, HHSC Provider Investigations will provide the intake report to the Consumer Directed Services employer and the individual’s Financial Management Services Agency. A copy of the intake report is provided to the case manager by the Financial Management Services Agency. After the investigation is complete, HHSC Provider Investigations will send a final investigation report, including findings, to the Consumer Directed Services employer and to the individual’s Financial Management Services Agency. A copy of the final report is provided to the case manager by the Financial Management Services Agency. The case manager documents, in writing, any actions that have been or will be taken by the Consumer Directed Services employer as a result of the findings or concerns and recommendations.

(DADS Form 1741, Corrective Action Plan, may be used for this purpose.)

**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.

HHSC Provider Investigations is responsible for investigating all reports of abuse, neglect, and exploitation of individuals receiving services in the community, except for those occurring in an Assisted Living Facility, unless the alleged perpetrator is a non-Assisted Living Facility employee, volunteer, or contractor working for a Home and Community Support Services Agency. Upon completion of an investigation in which abuse, neglect, or exploitation is alleged against an employee of a Home and Community Support Services Agency, , the HHSC Provider Investigations investigator releases the investigation findings to the DBMD provider. If the alleged perpetrator is the Consumer Directed Services employer and is not the guardian or designated representative, the final report is sent to the Consumer Directed Services employer and the Financial Management Services Agency. If the alleged perpetrator is the designated representative or the guardian the investigation is handled by the Department of Family and Protective Services Adult Protective Services In-Home unit because the relationship extends beyond a provider relationship. Home and Community Support Services Agencies are required to investigate an allegation of abuse, neglect, or exploitation and must submit a Provider Investigation Report to HHSC within 10 calendar days. HHSC staff review the reports, assessing the provider's description of the incident, the provider's summary and analysis of the investigation procedures, the provider's conclusion as to whether the allegation is supported by the provider's professional judgment, and recommendation(s) or corrective action(s) taken by the provider as a result of the investigation findings. Based on review of the provider investigation report, if further investigation is warranted to assess whether the provider complied with regulatory requirements, the survey staff conduct an on-site investigation.

Critical incidents are also reported to HHSC by providers, as required by licensure regulations, and are investigated. Investigations of self-reported critical incidents occurring in Home and Community Support Services Agencies may be completed without an on-site investigation. If further investigation is warranted to ensure compliance with federal, state, or local laws, an on-site investigation is conducted.

In addition to the reporting completed listed above, if DBMD providers or Financial Management Agencies become aware of a critical incident they must report that incident to HHSC using the HHSC form no later than the last calendar day of the month that follows the month being reported. HHSC staff compile data related to all reported critical incidents and follow up when it is determined the agency did not take sufficient or appropriate action to prevent the occurrence of the critical incident.

HHSC records the reports and outcomes of critical incidents including abuse, neglect, and exploitation investigations in several databases. The information contained in these databases is pulled for reporting purposes and shared as needed. Oversight activities occur on an ongoing basis. Information regarding confirmed instances of abuse, neglect, and exploitation are monitored, tracked and trended for purposes of training HHSC staff and to prevent recurrence. HHSC also maintains death records.

## 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).

In the DBMD program, a program provider providing licensed home health assisted living must not use restraints for disciplinary purposes, retaliation, coercion, or retribution; for the convenience of a service provider or other persons; or as a substitute for an effective, less restrictive method. A restraint may be used if it is not for one of the reasons mentioned above and only when the use is authorized in writing by a physician with specifications for the circumstances under which the restraint may be used, the duration for which the restraint may be used, or whether the use is necessary in a behavioral emergency to protect the individual or others from injury. Any use of restraints must be documented by the provider. Except in a behavioral emergency, a service provider who uses a restraint must be trained in the use of the restraint before using the restraint, annually, and when the individual's needs change. Seclusion is prohibited.

A restraint must not be administered under any circumstance if it: obstructs the individual's airway, including a procedure that places anything in, on, or over the individual's mouth or nose; impairs the individual's breathing by putting pressure on the individual's torso; interferes with the individual’s ability to communicate; or places the individual in a prone or supine position. Any physical restraint hold must be one in which the individual's limbs are held close to the body to limit or prevent movement.

If a restraint is used in a behavioral emergency, as soon as possible but no later than one hour after the use of the restraint, the service provider notifies a registered nurse of the restraint and medical services are obtained for the individual as necessary. The program provider, with the individual's consent, must make an appointment with a physician no later than the end of the first working day after the use of restraint. As soon as possible but no later than 24 hours after the use of restraint, the program provider must notify the individual's legally authorized representative, or a person actively involved in the individual's care that the individual has been restrained, unless the release of this information would violate other laws.

A program director and all service providers complete a general orientation curriculum before assuming job duties and annually, which includes training on the rights of an individual. Service providers must complete Service Provider training within 90 calendar days after assuming job duties, which includes methods and strategies for communication, active participation in home and community life, orientation and mobility, and behavior as communication. Before providing direct services to an individual, annually, and when the individual's needs change, service providers must complete specific training as outlined in Title 40 Texas Administrative Code Part 1 Chapter 42 Subchapter D §42.403 that includes the special needs of the individual, including the individual's methods of communication and managing challenging behavior, training in prevention of aggressive behavior, and de-escalation techniques.

Additional requirements apply to program providers who are providing licensed assisted living and when services are delivered to individuals in an Intermediate Care Facility for Individuals with Intellectual Disabilities.

In addition to the universal restraint requirements in DBMD if a program provider is providing licensed assisted living to an individual in a facility they must also comply with Title 40, Part 1, Chapter 92, Subchapter C, §92.41(p) of the Texas Administrative Code (relating to Standards for Type A and Type B Assisted Living Facilities).
Licensing requirements for Assisted Living Facilities prohibit the use of restraints unless the restraint is a physical or chemical restraint authorized in writing by a physician, or if the use is necessary in an emergency to protect the individual or others from injury. The facility must develop policies and procedures based on the facility's needs and population to determine if restraints will be used in the facility. Except in a behavioral emergency, a restraint must be administered only by qualified medical personnel. A facility may adopt policies that allow less use of restraint.

Licensing requirements for Assisted Living Facilities require attendants to have training within the first 16 hours of employment following orientation that includes the topics of managing disruptive behavior and behavior management practices (e.g., prevention of aggressive behavior and de-escalation techniques, practices to decrease the frequency of the use of restraint, alternatives to restraints). Direct care staff must also complete one hour of training annually in behavior management practices, such as prevention of aggressive behavior and de-escalation techniques, fall prevention, and alternatives to restraints. Training for behavior management practices must be competency-based. Facilities that employ licensed nurses, certified nurse aides, or certified medication aides must provide annual in-service training, appropriate to their job

responsibilities.

In addition to the universal restraint requirements in DBMD, program providers must ensure that six-bed Intermediate Care Facilities for Individuals with Intellectual Disabilities providing respite to individuals comply with 40 TAC §90.42(e)(4) (relating to Standards for Facilities Serving Individuals with an Intellectual Disability or Related Conditions).

In order to decrease the frequency of the use of restraint and to minimize the risk of harm to an individual, an Intermediate Care Facility for Individuals with Intellectual Disabilities must ensure that the service planning team with the participation of a physician, or a physician assistant or an advanced practice nurse acting within the scope of his or her practice, identifies the individual's known physical or medical conditions that might constitute a risk to the individual during the use of restraint; the individual's ability to communicate; and other factors that must be taken into account if the use of restraint is considered, including the individual's cognitive functioning level, height, weight, emotional condition (including whether the individual has a history of having been physically or sexually abused), and age. Conditions that constitute a risk must be documented in the individual’s record, as well as limitations on specific restraint techniques or mechanical restraint devices in the individual's record; and this must be reviewed and updated with a physician, physician assistant, or licensed nurse, at least annually or when the individual’s needs change changes. If a restraint is used, the Intermediate Care Facility for Individuals with Intellectual Disabilities must take into account the conditions, factors, and limitations of specific restraint techniques or mechanical restraint devices.

When applying a restraint, an Intermediate Care Facility for Individuals with Intellectual Disabilities must use the minimal amount of force or pressure that is reasonable and necessary to ensure the safety of the individual and others as well as safeguard the individual's dignity, privacy, and well-being.; and not secure the individual to a stationary object while the individual is in a standing position. If an individual rolls into a prone or supine position during restraint, the Intermediate Care Facility for Individuals with Intellectual Disabilities must transition the individual to a side, sitting, or standing position as soon as possible. The Intermediate Care Facility for Individuals with Intellectual Disabilities may only use a prone or supine hold as a transitional hold, and only for the shortest period of time necessary to ensure the protection of the individual or others; as a last resort, when other less restrictive interventions have proven to be ineffective; and except in a small Intermediate Care Facility for Individuals with Intellectual Disabilities, when a trained observer (with training including risk identification related to positional, compression, or restraint asphyxiation; and with prone and supine holds) is ensuring that the individual’s breathing is not impaired. An Intermediate Care Facility for Individuals with Intellectual Disabilities must release an individual from restraint as soon as the individual no longer poses a risk of imminent physical harm to the individual or others; or if the individual in restraint experiences a medical emergency, as soon as possible as indicated by the medical emergency. If an Intermediate Care Facility for Individuals with Intellectual Disabilities restrains an individual in a behavioral emergency the Intermediate Care Facility for Individuals with Intellectual Disabilities must obtain a written order authorizing the restraint from a health care professional acting within his or her scope of practice by the end of the first business day after the use of restraint. An Intermediate Care Facility for Individuals with Intellectual Disabilities may adopt policies that allow less use of restraint.

Intermediate Care Facilities for Individuals with Intellectual Disabilities must report the use of restraints to HHSC and must evaluate use of restraints at least annually. The evaluation must, at a minimum, compare aggregate data provided by HHSC. Based on an Intermediate Care Facility for Individuals with Intellectual Disabilities’ evaluation, the program provider must develop and implement a plan to reduce the use of restraints.

All individuals in the DBMD program receive a comprehensive nursing assessment annually or when their needs change. The comprehensive assessment contains information about restraint risks for that individual. The nurse completes an addendum that summarizes any concerns identified during the assessment. The service planning team must sign the addendum, indicating that the team has reviewed the nurse’s concerns, including those related to restraints, and explain how these concerns have been addressed (e.g., with DBMD services, unpaid supports, or natural supports).

HHSC Contracts staff monitor the use of restraints through on-site surveys and complaint investigations. The State considers unauthorized use of restraints as abuse and requires providers to report any suspected abuse immediately, within 24 hours of awareness to DFPS and HHSC. The provision of services in this program occurs primarily in the individual's own home or family home. If the State becomes aware that an unauthorized restraint occurred (through any means i.e. witnessing it during a monitoring review, seeing it in a complaint report, etc.) that was not reported, the State would require that provider to follow the proper reporting requirements for reporting abuse, neglect and exploitation and would ensure appropriate follow up occurred.

**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:

Complaints concerning unnecessary or unapproved use of restraint can be made to HHSC; or if use of the restraint resulted in abuse, it must be reported to the Department of Family and Protective Services. The DBMD provider must assure that an individual, the individual's legally authorized representative, or both, as appropriate, are informed orally and in writing of the processes for filing complaints.

The State considers unauthorized use of restraints as abuse and requires providers to report any suspected abuse immediately, within 24 hours of awareness to DFPS and HHSC. The provision of services in this program occurs primarily in the individual's own home or family home. If the State becomes aware that an unauthorized restraint occurred (through any means i.e. witnessing it during a monitoring or face to face utilization review, seeing it in a complaint report, etc.) that was not reported, the State would require that provider to follow the proper reporting requirements for reporting abuse, neglect and exploitation and would ensure appropriate follow up occurred.

HHSC surveys licensed providers for compliance with licensure requirements related to restraint and seclusion. HHSC investigates reports of abuse, neglect and exploitation related to restraint or seclusion.

## 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.

In the DBMD program, the primary function for the use of restrictive interventions is for safety and positioning in specific circumstances once the use of less restrictive methods have failed and have been clearly documented. HHSC does not have an exclusive list of approved restrictive interventions. Restrictive interventions include restraints, and protective devices. Examples of the types of protective devices that are permitted include a safety vest, lap belt, bed rail, safety padding, adaptation to furniture or a safety helmet. A program provider must not use a protective device to modify or control an individual's behavior; for disciplinary purposes; for convenience; or as a substitute for an effective, less restrictive method. Prior to authorizing the use of restrictive interventions, the following must occur:

- The individual's needs must be assessed by a registered nurse.
- Less restrictive methods that, if effective, would accomplish the purpose of the protective device must be considered; and if less restrictive methods are found to be not effective, it must be documented in the individual's case record.
- The Home and Community Support Services Agency registered nurse, with input from the individual, the individual's legally authorized representative, the individual's service planning team, and other professional personnel, must develop a written service plan, signed by a physician.
- The protective device must be clearly documented on the service plan, including under what circumstances and what type of protective device is to be used, how to use the protective device and any contraindications specific to the individual, how and when to document the use of the protective device, and when and whom the program staff must notify of the use of a protective device
- The service planning team must approve the service plan.
- Verbal and written notification to the individual, the individual's legally authorized representative, or both, as appropriate, must be provided describing the right to discontinue use of the restrictive intervention at any time, and written consent of the individual, the individual's legally authorized representative, or both, as appropriate, must be documented in the case record.
- Allowance for a revised plan must be made when the restrictive intervention is not working.
- The effects of the techniques in relation to the individual's health and welfare must be considered.
- Each person who is to apply the protective device must be trained in the proper use at least annually and as the needs of the individual change. The training must be documented in the case record.

At least annually, and when the individual's needs change, the service planning team must review the need for use of the protective device to determine the effectiveness of the program and the need to continue the restrictive intervention.

A registered nurse must revise the service plan when the individual's service planning team and physician determine that a protective device is not effective or needed.
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**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 surveys licensed providers for compliance with licensure requirements related to restraint and seclusion. HHSC investigates reports of abuse, neglect and exploitation related to restraint or seclusion.

The State considers unauthorized use of restrictive interventions as abuse and requires providers to report any suspected abuse immediately, within 24 hours of awareness to DFPS and HHSC. The provision of services in this program occurs primarily in the individual's own home or family home. If the State becomes aware that an unauthorized restrictive intervention occurred (through any means i.e. witnessing it during a monitoring review or face to face utilization review, seeing it in a complaint report, etc.) that was not reported, the State would require that provider to follow the proper reporting requirements for reporting abuse, neglect and exploitation and would ensure appropriate follow up occurred.

Complaints concerning the use of restraint are made to HHSC, or if use of the restrictive intervention resulted in abuse, it must be reported to the Department of Family and Protective Services. The DBMD provider must ensure that an individual, the individual's legally authorized representative, or both, as appropriate, are informed orally and in writing of the processes for filing complaints about the provision of DBMD services.

## 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 the DBMD waiver.

Complaints concerning any use of seclusion are made to HHSC; or if use of seclusion resulted in abuse, it must be reported to Department of Family and Protective Services. The State considers seclusion as abuse and requires providers to report any suspected abuse immediately, within 24 hours of awareness to DFPS and HHSC. The provision of services in this program occurs primarily in the individual's own home or family home. If the State becomes aware that seclusion occurred (through any means i.e. witnessing it during a monitoring review or face to face utilization review, seeing it in a complaint report, etc.) that was not reported, the State would require that provider to follow the proper reporting requirements for reporting abuse, neglect and exploitation and would ensure appropriate follow up occurred.

The DBMD provider must assure that an individual, the individual's legally authorized representative, or both as appropriate, are informed orally and in writing of the processes for filing complaints about the provision of DBMD services.

HHSC surveys licensed providers for compliance with licensure requirements related to restraint and seclusion. HHSC investigates reports of abuse, neglect and exploitation related to restraint or seclusion.

○ **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.

DBMD providers holding a Home and Community Support Services Agency license, and if required, an Assisted Living Facility license, must administer medications in accordance with their licensure requirements.

Providers holding Assisted Living Facility licenses are required to monitor all aspects of an individual's medication. The provider registered nurse reviews the individual's medications annually and upon significant changes in the individual's condition.

Home and Community Support Services Agencies licensed providers who administer medications are required to ensure they have policies for maintaining a current medication list and a medication administration record.

HHSC Regulatory Services performs licensing surveys that include medication management, specifically medication administration by Home and Community Support Services Agencies and Assisted Living Facilities responsible for medication management. HHSC Regulatory Services surveys that occur during the waiver year and any contract investigations in response to complaints regarding providers are collected and reported annually. The frequency of licensing surveys varies with each type of license. HHSC requires plans of correction for every cited violation and may take enforcement action such as administrative penalties and license revocation when an agency violates medication administration rules. HHSC Contracts staff monitoring does not include a specific component for medication management, but if the issue rises to the level of abuse, neglect, or exploitation, HHSC Contracts staff will refer to HHSC Provider Investigations and HHSC Regulatory staff follow up to ensure corrective action plans are properly implemented.

**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.

HHSC Regulatory Services licenses a DBMD provider as a Home and Community Support Services Agency and, if necessary, as an Assisted Living Facility. Medication management, specifically medication administration, is part of the license requirements for these providers. HHSC Regulatory Services surveyors monitor Home and Community Support Services Agencies and Assisted Living Facilities for compliance with licensing requirements. HHSC Regulatory Services surveyors and contract monitoring staff also monitor these entities to ensure services are delivered to individuals in accordance with Title 40 of the Texas Administrative Code Chapter 97. HHSC Regulatory Services surveyors may conduct follow-up surveys and inspections to ensure the provider has effectively implemented any corrective action plan required due to cited violations. HHSC Contracts staff reviews corrective action plans during the next scheduled review.

HHSC Regulatory Services surveys Home and Community Support Services Agencies that are not accredited by the Joint Commission, Community Health Accreditation Program, or Accreditation Commission for Health Care are surveyed after they receive the license and indicate to HHSC readiness for an initial survey, approximately 18 months after the initial survey and at least every 36 months thereafter. HHSC surveys Assisted Living Facilities biennially. HHSC may survey or monitor facilities or Home and Community Support Services Agencies more frequently, if appropriate.

# Appendix G: Participant Safeguards

## Appendix G-3: Medication Management and Administration (2 of 2)

**c. Medication Administration by Waiver Providers**

**i. Provider Administration of Medications.** *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

**ii. State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DBMD providers must administer medications as required by applicable licensure. Licensure regulations only allow licensed nurses, certified medication aides (under the direct supervision of a licensed nurse), or persons who administer medication as a registered nurse-delegated task to administer medications.

A registered nurse who supervises a medication aide or delegates medication administration must provide ongoing supervision and any necessary training to the unlicensed person. Registered nurses must follow procedures for delegation in accordance with the Nurse Practice Act.

Licensure regulations require Assisted Living Facilities that are responsible for monitoring of an individual's medication to monitor all aspects of that individual's medication. For individuals residing in an Assisted Living Facility who self-administer their medication and store their medication in their room, the Assisted Living Facility is required to provide monthly medication counseling to the individual. The Assisted Living Facility also reviews an individual's medications upon significant change in the individual's condition. A significant change to an individual's condition that would require a review of the individual's medication might include a new diagnosis or medication.

Licensure regulations require Home and Community Support Services Agencies to maintain a current medication administration record and medication list for individuals who are being administered medications by the agency. Home and Community Support Services Agencies are required to review and update an individual’s plan of care, including medications, at least every six months. Home and Community Support Services Agencies and Assisted Living Facilities must report to the supervisor any unusual medication reactions. The provider must also document any time a medication is not administered and the reason it was not administered.

**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:

HHSC

(b) Specify the types of medication errors that providers are required to *record:*

Providers are required to record any type of medication error, regardless of the severity. A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, DBMD provider or individual regardless if the medication is self-administered under the supervision of the DBMD provider or administered by the provider.

(c) Specify the types of medication errors that providers must *report* to the state:

All medication errors must be reported to HHSC by providers.

○ **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.

HHSC is responsible for monitoring compliance with licensing requirements and surveying licensed providers for compliance with licensing requirements on a regular basis. Licensure surveys include a review of medication administration policies.

Home and Community Support Services Agencies review and update an individual's medications annually and upon significant change in the individual's condition. Assisted Living Facilities review an individual's plan of care, including medications, at least every six months. A significant change to an individual's condition that would require a review of the individual's medication might include a new diagnosis or medication. Home and Community Support Services Agencies and Assisted Living Facilities must report to a supervisor any unusual medication reactions. The provider must also document any time a medication is not administered and the reason it was not administered.

HHSC Regulatory Services reports the number of validated instances of licensure violations, which includes medication administration violations. The incidence of violations related to medication administration is so low that occurrences are dealt with on a case-by-case basis.

All quality issues are discussed during quarterly quality review team meetings and remediation activities are determined. HHSC trends and analyzes data as part of the quarterly review process.

## 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.1a 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:
**DBMD Consolidated Microsoft 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **Other**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**G.a.1b 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:
**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**<br>Confidence Interval = |
| ☒ **Other**<br>Specify:<br>Department of Family and Protective Services | ☐ **Annually** | ☐ **Stratified**<br>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.2a 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:
**DBMD Consolidated Microsoft Database**

| **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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>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**<br>Specify: |

**Performance Measure:**
**G.a.2b 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:
**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**<br>Confidence Interval = |
| ☒ **Other**<br>Specify:<br>Department of Family and Protective Services | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**G.a.3a 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:
**DBMD Consolidated Microsoft 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**G.a.3b 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:
**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**<br>Confidence Interval = |
| ☒ **Other**<br>Specify:<br>Department of Family and Protective Services | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**G.a.4 Number and percent of provider-reported ANE incidents for which providers took action as necessary to protect the health and safety of the individual. N: Number of provider-reported ANE incidents for which providers took action as necessary to protect the health and safety of the individual. D: Number of provider-reported ANE incidents.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Notification of Critical Incidents 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**<br>Confidence Interval = |

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| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**G.a.5 Number and percent of individuals with reviewed records who received information on how to report abuse, neglect, or exploitation. N: Number of individuals with reviewed records who received information on how to report abuse, neglect, or exploitation. D: Number of individuals with reviewed records.**

**Data Source** (Select one):

**Other**
If 'Other' is selected, specify:
**Contract Workbook**

| **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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☒ **Other**<br>Specify:<br>5% of individuals per provider contract (minimum of 4 individuals per contract if serving 1-21, minimum of 5 individuals per contract if serving 22 or more; maximum of 30 individuals per contract). |
| | ☐ **Other**<br>Specify: | |

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**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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**G.a.6a 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:
**DBMD Consolidated Microsoft 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** |

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| | | 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.6b 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:
**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**<br>Confidence Interval = |
| ☒ **Other**<br>Specify:<br>Department of Family and Protective Services | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**G.a.7 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:
**Contract Workbook**

| **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**<br>Confidence Interval = |

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| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☒ **Other**<br>Specify:<br>5% of individuals per provider contract (minimum of 4 individuals per contract if serving 1-21, minimum of 5 individuals per contract if serving 22 or more; maximum of 30 individuals per contract). |
| | ☐ **Other**<br>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**<br>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**<br>Specify: |

**Performance Measure:**
**G.a.8 Number and percent of priority one complaints resolved by Regulatory Services. N: Number of priority one complaints resolved by Regulatory Services. D: Number of priority one complaints.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DBMD Consolidated Microsoft 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

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**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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**G.a.9 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.10 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):
**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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**G.a.11 Number and percent of provider staff meeting training requirements by scoring at least 80% on the ANE Competency Exam before providing services and at least annually thereafter. N: Number of provider staff meeting training requirements by scoring at least 80% on the ANE Competency Exam before providing services and at least annually thereafter. D: Number of provider staff reviewed.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Contract Workbook**

| **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**<br>Confidence Interval = |

| | | |
|---|---|---|
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☒ **Other**<br>Specify:<br>100% of provider staff required to complete the ANE Competency Exam who provided services to individuals included in the 5% Contract Monitoring sample. |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

**b.** ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

**Performance Measures**

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

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

**Performance Measure:**
**G.b.1 Number and percent of provider-reported critical incidents for which providers took action as necessary to protect the health and safety of the individual. N: Number of provider-reported critical incidents for which providers took action as necessary to protect the health and safety of the individual. D: Number of provider-reported critical incidents**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Notification of Critical Incidents 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**<br>Confidence Interval = |
| ☐ **Other** | ☐ **Annually** | ☐ **Stratified** |

| | | |
|---|---|---|
| Specify: | | Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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:
**DBMD Consolidated Microsoft 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>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**<br>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**<br>Specify: |

**Performance Measure:**
**G.b.3 Number and percent of self-reported critical incidents addressed according to HHSC policies and procedures. N: Number of self-reported critical incidents addressed according to HHSC policies and procedures. D: Number of self-reported critical incidents.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DBMD Consolidated Microsoft 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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
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| | | |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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 individuals whose records reflect that the provider was**

**in compliance with requirements related to restraint. N: Number of individuals whose records reflect that the provider was in compliance with requirements related to restraint. D: Number of individuals with reviewed records.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Contract Workbook**

| **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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☒ **Other**<br>Specify:<br>5% of individuals per provider contract (minimum of 4 individuals per contract if serving 1-21, minimum of 5 individuals per contract if serving 22 or more; maximum of 30 individuals per contract). |

| | | |
|---|---|---|
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**G.c.2 Number and percent of individuals whose records reflect that the provider was in compliance with the prohibition of seclusion. N: Number of individuals whose records reflect that the provider was in compliance with the prohibition of seclusion. D: Number of individuals with reviewed records.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Contract Workbook**

| **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: 5% of individuals per provider contract (minimum of 4 individuals per contract if serving 1-21, minimum of 5 individuals per contract if serving 22 or more; maximum of 30 individuals per contract). |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

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

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

**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 their service plan. N: Number of individuals with reviewed records who received nursing services according to their service plan. D: Number of individuals with reviewed records.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Contract Workbook**

| **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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☒ **Continuously and Ongoing** | ☒ **Other**<br>Specify:<br>5% of individuals per provider contract (minimum of 4 individuals per contract if serving 1-21, minimum of 5 individuals per contract if serving 22 or more; maximum of 30 individuals per contract). |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**
**G.d.2 Number and percent of individuals with reviewed records who received an annual nursing assessment as required. N: Number of individuals with reviewed records who received an annual nursing assessment as required. D: Number of individuals with reviewed records.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Contract Workbook**

| **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**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | | |
| | ☒ **Continuously and Ongoing** | ☒ **Other**<br>Specify:<br>5% of individuals per provider contract (minimum of 4 individuals per contract if serving 1-21, minimum of 5 individuals per contract if serving 22 or more; maximum of 30 individuals per contract). |
| | ☐ **Other**<br>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**<br>Specify: | ☒ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

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

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

The Texas Administrative Code requires providers to protect individuals from abuse, neglect, and exploitation and to report suspected incidents of abuse, neglect, and exploitation. Providers are also required by rule to explain, during the initial face-to-face enrollment meeting and annually thereafter, the procedures for an individual, the individual's legally authorized representative, or both, as appropriate, to file a complaint regarding a DBMD program provider and to review the individual's rights, which include the right to be free from abuse and neglect.

In accordance with state law, HHSC maintains a State Employee Misconduct Registry that includes the names of unlicensed staff who HHSC or the Department of Family and Protective Services has confirmed have abused, neglected, or exploited an individual receiving services administered by HHSC which rises to the level of reportable conduct. In addition, in accordance with federal law, HHSC maintains a Nurse Aide Registry that lists all certified nurse aides. The Nurse Aide Registry indicates if a nurse aide is designated as unemployable because the aide has been confirmed to have abused, neglected, or exploited an individual residing in a facility. Providers must consult these registries prior to offering employment and annually thereafter, to a non-licensed employee and must refrain from employing that person if either registry indicated a finding of reportable conduct by an unlicensed employee of a facility, of an agency, or of an individual/employer—i.e., the individual seeking employment was confirmed to have abused, neglected, or exploited an individual receiving program services.

Home and Community Support Services Agencies and Assisted Living Facilities are required to report allegations of abuse, neglect, and exploitation directly to the Department of Family and Protective Services immediately upon suspicion of such activities.

Approximately every 90 days during the case manager review contact, the case manager is responsible for determining if any existing situations jeopardize the individual's health and welfare. Additional contacts may be scheduled to ensure the individual's health and welfare.

HHSC requires providers to maintain a complaint log and investigate/resolve complaints according to HHSC Community Services complaint procedure rules. Additionally, HHSC Contracts staff maintain a complaint log for the purpose of collecting, reviewing, and reporting complaint or incident information. On a monthly basis, HHSC Contracts staff compiles a Complaint Activity Report and a Complaint Resolution Activity Report and posts the reports internally.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the 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.

Complaints and incidents are entered into the HHSC intake tracking database and assigned a priority. After Complaint and Incident Intake completes the intake, it is forwarded electronically via the intake tracking system to HHSC Regulatory Services-Survey Operations. Complaint and incident intakes involving service provider non-compliance with contract requirements are also referred by Complaint and Incident Intake via e-mail to HHSC Contracts staff.

HHSC Contracts staff conducts complaint investigations involving the individual, provider staff, or HHSC staff. Depending upon the nature of the complaint, HHSC Contracts staff may also refer the complaint to HHSC Regulatory Services, HHSC Provider Investigations, the Texas Board of Nursing, the Office of the Inspector General or local law enforcement agencies. HHSC Contracts staff informs providers of complaint findings at the conclusion of the investigation, including whether the allegations were substantiated. If the investigation findings substantiate an immediate risk to the health or welfare of a waiver individual, the provider is required to take immediate action to resolve the situation. The provider is also required to develop and implement an immediate corrective action plan addressing the prevention of future occurrences of the situation or similar events. The purpose of the immediate corrective action plan is for the provider to communicate in writing the specific action taken to resolve the identified situation and the steps that will be taken to ensure the continued health and safety of the individuals served. The immediate corrective action plan must include the following elements:

- A description of the health and safety issue;
- Action taken to resolve the issue; and
- A plan to prevent the occurrence of the issue.

HHSC Contracts staff does not investigate abuse, neglect, or exploitation. Allegations of this nature are handled in accordance with Title 2 of the Texas Human Resource Code, Subtitle D, Chapter 48, Subchapter F. If at any time during the course of the investigation, HHSC Contracts staff becomes aware of an immediate threat to an individual's health and safety or abuse, neglect, or exploitation, staff must report the situation within one hour to:

- HHSC - Complaint and Incident Intake;
- HHSC- Provider Investigations;
- HHSC - Regulatory Services; and
- HHSC - Contracts staff manager or manager's designee.

HHSC has the responsibility to investigate reported incidents and complaints involving abuse, neglect, or exploitation of an individual receiving DBMD services by a facility or agency employee, volunteer, or contractor . In addition, facilities and agencies are required by rule to investigate allegations of abuse, neglect, and exploitation. HHSC records and tracks abuse, neglect, and exploitation reports in its information management system.

During contract monitoring reviews, HHSC Contracts staff confirms that the individual or legally authorized representative have been informed of the complaint procedures and the process for reporting abuse, neglect, and exploitation. Providers that are unable to show evidence to support this requirement are cited and required to develop a corrective action plan and may receive other sanctions. HHSC Sanction Action Review Committee reviews all substantiated allegations of contract non-compliance if contract staff recommends a referral hold, vendor hold, or contract termination. The Sanction Action Review Committee review may result in a contract action (e.g., corrective action plan or referral hold) or sanction (such as a vendor hold or contract termination).

**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**<br>Specify: | ☒ **Annually** |

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>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 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 DBMD 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 inter-agency processes impacting any and all phases of the quality program, and other actions needed to assure continued improvement of the DBMD 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**<br>Specify: | ☐ **Other**<br>Specify: |

| **Responsible Party***(check each that applies):* | **Frequency of Monitoring and Analysis***(check each that applies):* |
|---|---|
| | |

**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 are generated from the HHSC Quality Reporting Unit 1915 (c) waiver database and include data for all of the waiver's performance measures, along with . remediation activities and outcomes. Performance measures are the basis for quality improvement strategy activities. HHSC presents the reports and recommendations 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, and approves all improvement plans. Active improvement plans for all waivers are monitored at each quality review team meeting to determine whether or not improvement activities resulted in their intended outcomes.

Additionally, stakeholders have the opportunity to provide testimony on policies and rules governing the delivery of services in the DBMD program in writing, at meetings of the Medical Care Advisory Committee and the HHSC Advisory Council. Stakeholders may also provide feedback and comments anytime to the DBMD mailbox. HHSCposts announcements for all stakeholder meetings on the HHSC website prior to the meeting.

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 Committee, Texas's Olmstead implementation committee, studies and makes recommendations to the State regarding appropriate care settings for persons with disabilities. The Promoting Independence Advisory Committee is another venue stakeholders can use to provide input and feedback about the DBMD 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 sub-assurance, and 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):*

## *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 to ensure that DBMD providers and financial management services agencies are complying with program requirements. HHSC conducts fiscal monitoring of DBMD providers on-site at least every two years and typically reviews a two-month sample of the provider's records. Financial management services agencies are monitored at a minimum of every three years or more frequently if the need is indicated or if there is a complaint filed against the financial management services agency. Financial management services agencies are monitored with typically a six-month sample of financial management services agencies' records reviewed. The methods used in the monitoring process include:*

- *Review of the provider's existing billing system and internal controls;*
- *Comparison of the provider's or financial management services agency's service delivery records with its billing records to verify that the payments HHSC made to the provider or financial management services agency were appropriate;*
- *Review of service plans and records; and,*
- *Comparison of service delivery and other supporting documentation with individual plans of care.*

*In E-1-h-iv of the application, the state outlines the FMSA oversight functions.*

*HHSC may perform desk and on-site compliance reviews associated with claims the provider submits under a contract. HHSC recovers improper payments, without extrapolation, when HHSC verifies that the provider has been overpaid because of improper billing or accounting practices or for failure to comply with the contract terms.*

*Upon HHSC request, the provider must provide the information to support claims information reported by the provider. If the provider fails to provide the requested information, HHSC may take adverse action against the provider contract.*

*HHSC may withhold the provider's payments and apply them to the fiscal review exception for any payments the provider owes HHSC and may require corrective action for any improper fiscal finding.*

*Provider agencies are not required to conduct independent financial audits. The Texas State Auditor's Office is responsible for the statewide financial and compliance audit. HHSC may conduct a financial review, including an audit, of a contractor at any time.*

*The Texas State Auditor's Office contracts with private firms as required by the Single Audit Act to audit the waiver program. The Inspector General performs desk reviews of other entities that are required to have independent audits performed.*

*The State Auditor's Office is responsible for conducting the independent audits of waiver providers.*

*On average, 25 fiscal on-site monitoring reviews are conducted annually, based on the number of monitoring reviews conducted between March 2013 and February 2017. This number encompasses reviews for the following provider types: financial management services agencies, DBMD providers and Transition assistance services providers.*

*The methods used for desk and on-site compliance reviews are mostly the same. The only difference is that, for desk reviews, contract staff may need to ask the provider to submit documents that would typically be reviewed on-site. For both desk and on-site reviews, contract staff complete the following pre-monitoring activities:*

- *completing the Applicant/Contractor Screening Criteria;*
- *reviewing contractor history;*
- *providing advance notice;*
- *selecting the sample;*
- *preparing applicable program and fiscal compliance monitoring tools; and*
- *providing the sample list.*

*For both desk and on-site reviews, contract staff complete the following monitoring activities:*

- *conduct an entrance conference;*
- *complete the applicable program and fiscal compliance monitoring tools;*
- *request an immediate protection plan, if applicable; and*
- *conduct an exit conference.*

*For desk reviews, contract staff conduct the entrance and exit conference via telephone.*

*After the monitoring, contract staff complete the following activities, as applicable:*

- *provide a copy of the monitoring documents;*
- *conduct an informal review;*
- *report monitoring results for provisional contracts;*
- *report suspected provider fraud;*
- *make a referral to the Sanction Action Review Committee;*
- *confirm receipt of items requested at the exit conference;*
- *process a request to place or release a vendor hold;*
- *determine the next monitoring date;*
- *verify corrective action implementation; and*
- *maintain monitoring documents in the contract file.*

*Staff are not currently conducting desk reviews for contract and fiscal compliance monitoring of DBMD providers and Financial Management Services Agencies (FMSA) DBMD legal entities. Intermittent desk reviews may be performed in the future.*

*Desk review samples do not overlap with on-site review samples because the monitoring frequency and sampling methodology for scheduling and conducting the monitoring review does not change, regardless of how the review is conducted.*

*There are no differences in post-payment review methods, scope, and frequency between self-direction and agency-direction providers in addition to FMS reviews.*

*HHSC may take one or more of the following adverse actions against providers:*
*Request a corrective action plan;*
- *Allow a provisional contract to expire;*
- *Impose a referral hold (a temporary suspension of new referrals of individuals to the provider);*
- *Impose a vendor hold (a temporary suspension of payments that are due to the provider); and*
- *Propose to terminate a contract.*

*Fraud, Waste, and Abuse cases are referred to Office of the Inspector General electronically or through a hotline. The Office of the Inspector General handles all complaints regarding Fraud, Waste, and Abuse.*

## *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 paid claims, including those from FMSAs, that were paid for according to the reimbursement methodology specified in the approved waiver. N: Total dollar amount of paid claims that were paid for according to the reimbursement methodology specified in the approved waiver. D: Total dollar amount 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***<br>*Confidence Interval =* |
| ☒ ***Other***<br>*Specify:*<br>*Texas Medicaid Health Partnership* | ☐ ***Annually*** | ☐ ***Stratified***<br>*Describe Group:* |
| | ☒ ***Continuously and Ongoing*** | ☐ ***Other***<br>*Specify:* |
| | ☐ ***Other***<br>*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***<br>*Specify:* | ☒ ***Annually*** |
| | ☐ ***Continuously and Ongoing*** |
| | ☐ ***Other***<br>*Specify:* |

***Performance Measure:***
***I.a.2 Number and percent of monitored financial management services agencies (FMSAs) for which claims were paid in accordance with the employee's established rate of pay and the service hours actually worked. N: Number of monitored FMSAs for which claims were paid in accordance with the employee's established rate of pay and the service hours actually worked. D: Total number of monitored FMSAs.***

***Data Source*** *(Select one):*
***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***<br>*Confidence Interval =* |

| | | |
|---|---|---|
| ☐ ***Other***<br>*Specify:* | ☐ ***Annually*** | ☐ ***Stratified***<br>*Describe Group:* |
| | ☒ ***Continuously and Ongoing*** | ☒ ***Other***<br>*Specify:*<br>*Providers are selected for monitoring based on the contract effective date, previous formal monitoring exit date, overall compliance score of the previous formal monitoring, and expenditures.* |
| | ☐ ***Other***<br>*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***<br>*Specify:* | ☒ ***Annually*** |
| | ☐ ***Continuously and Ongoing*** |
| | ☐ ***Other***<br>*Specify:* |

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

***Performance Measure:***
***I.a.3 Total dollar amount and percent of total dollar amount of reviewed claims free from recoupment. N: Total dollar amount of reviewed claims free from recoupment. D: Total dollar amount of reviewed claims.***

***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***<br>*Confidence Interval =* |
| ☐ ***Other***<br>*Specify:* | ☐ ***Annually*** | ☐ ***Stratified***<br>*Describe Group:* |
| | ☒ ***Continuously and Ongoing*** | ☒ ***Other***<br>*Specify:* |

| | | |
|---|---|---|
| | | *5% of individuals per provider contract (minimum of 4 individuals per contract if serving 1-21, minimum of 5 individuals per contract if serving 22 or more; maximum of 30 individuals per contract).* |
| | ☐ ***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.4 Number and percent of paid claims that reflected only the services listed in the service plan. N: Number of paid claims that reflected 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***<br>*Confidence Interval =* |
| ☐ ***Other***<br>*Specify:* | ☐ ***Annually*** | ☐ ***Stratified***<br>*Describe Group:* |
| | ☒ ***Continuously and Ongoing*** | ☐ ***Other***<br>*Specify:* |
| | ☐ ***Other***<br>*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:* |

***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 were consistent with the rate methodology in the approved waiver. N: Number of provider payment rates that were 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*** |
| ☐ ***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 Texas Medicaid and Healthcare Partnership is the state's contracted Medicaid Management Information System and constitutes a comprehensive claims processing system that providers and financial management services agencies use to submit claims electronically for waiver services delivered through the agency and the consumer directed services options. This system has numerous securities built-in to ensure accurate billing submissions. Providers are unable to submit billing claims for any service components until HHSC has authorized the service plan and the authorized service plan has been entered into the HHSC's Service Authorization System.*

*The Texas Medicaid and Healthcare Partnership verifies that an individual was Medicaid eligible on the date of service delivery specified in a request for reimbursement and allows payment only for claims of services provided within the eligibility period. The Texas Medicaid and Healthcare Partnership will deny provider claims if they do not reflect that the waiver individual meets eligibility criteria. The Texas Medicaid and Healthcare Partnership automatically denies any claim entered for a service not authorized on an individual's service plan as authorized by HHSC. The Texas Medicaid and Healthcare Partnership will also automatically deny any claim that is entered with an unauthorized billing code.*

*The Texas Medicaid and Healthcare Partnership also edits claims for the validity of the information and compliance with business rules for the service and program and calculates the payment amount and applicable reductions for claims approved for payments. Prior to issuing payment, the automated claims management system verifies that an individual's current authorized individual service plan has sufficient units to cover amounts claimed and prevents duplicate claims for services already paid.*

***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.*

*Texas monitors 100% of DBMD providers every two years. During on-site monitoring reviews, HHSC Contracts staff determines a provider's compliance with standards pertaining to fiscal accountability and verifies that the services billed were rendered. As part of the fiscal component of biennial on-site monitoring reviews, HHSC Contracts staff verifies that billings submitted to and paid by HHSC are for billable time and activities by verifying that billing forms are completed according to HHSC instructions.*

*DBMD providers must maintain documentation supporting all claims. If the DBMD provider fails to maintain the required documentation, HHSC recoups improper payments. HHSC also recoups payments when HHSC Contracts staff verifies the DBMD provider was overpaid due to improper billing. The State has mechanisms in place for the return to the Centers for Medicare & Medicaid Services of any federal matching funds received for improper billing.*

*HHSC monitors 100 percent of financial management services agencies at a minimum of every three years. HHSC assesses a financial management services agency's fiscal performance by matching payroll, benefits and tax deposits to time sheets, ensuring the hours worked and rate of pay are consistent with individual budgets, and reviewing administrative payments.*

***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***<br>*Specify:* | ☒ ***Annually*** |

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

***c. Timelines***

*When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 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. There are no variances from any portion of the rate methodology. 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. Texas uses existing service rate methodologies from other HCBS waivers to set service rates for DBMD. Reimbursement methodology rules are developed and recommended for approval by HHSC. HHSC has oversight authority with respect to the state's reimbursement methodology and cost determination rules. The rates for the DBMD program are available on the HHSC Rate Analysis webpage.*

*HHSC models the rates for the following services from other Medicaid HCBS waiver programs that use cost reports to determine rates: day habilitation; residential habilitation; respite services in the individual's or respite provider's private residence; respite services in an intermediate care facility; respite in an assisted living home; respite in a camp; supported employment; audiology services; behavioral support; chore service; dietary services; employment assistance; intervener; nursing services; occupational therapy services; physical therapy services; and speech, hearing and language therapy services.*

*The Community Living Assistance and Support Services (CLASS) (TX.0221) Habilitation rate is used for Day Habilitation and Residential Habilitation services.*

*All respite services (including respite services in the individual's or respite provider's private residence, respite services in an intermediate care facility, respite in an assisted living home and respite in a camp), supported employment, audiology services, behavioral support, dietary services, employment assistance, nursing services, occupational therapy services, physical therapy services, and speech, hearing and language therapy are services that are available in multiple 1915(c) HCBS Waivers. The State sets a single rate for each of these services. The cost report data from all of these waiver programs is combined into a single database for rate calculation. The methodology for these services is detailed in Title 1 of the Texas Administrative Code (1 TAC), Chapter 355, §355.502.*

*The Medicaid State Plan Personal Assistance Services (Primary Home Care) non-priority rate is used for the Chore service rate.*

*The 90th percentile CLASS (TX.0221) Habilitation rate is used for the intervener rate.*

*CLASS and Primary Home Care providers are required to submit biennial cost reports to the HHSC Rate Analysis Department. Providers are responsible for eliminating all unallowable expenses from the cost report prior to submission of the cost report. The HHSC Cost Report Review Unit completes a desk review sample of cost reports, with a subgroup of cost reports audited on-site. The Cost Report Review Unit removes any unallowable costs and corrects any errors detected on the cost report in the course of the review or on-site audit. Audited cost reports are used in the determination of statewide prospective rates.*

*The allowable and unallowable costs are detailed in the Texas Administrative Code: Title 1, Part 15, Chapter 355, Subchapter A, §355.102 (relating to General Principles of Allowable and Unallowable Costs) and Title 1, Part 15, Chapter 355, Subchapter A, §355.103 (relating to Specifications for Allowable and Unallowable Costs). Both may be found here:*
*http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=1&pt=15&ch=355&sch=A&rl=Y.*

*In general, recommended unit of service rates for each service are determined as follows: 1) total allowable costs for each provider are determined from the audited cost report; 2) each provider's total allowable costs are projected from the historical cost reporting period to the prospective reimbursement period; 3) payroll taxes and benefits are allocated to each salary item; 4) total projected allowable costs are divided by the number of units of service to determine the projected cost per unit of service; 5) the allowable costs per unit of service for each contracted provider are arrayed and weighted by the number of units of service and the median cost per unit of service is calculated; and 6) the median cost per unit of service for each waiver service is multiplied by 1.044.*

*When comparable services do not currently exist, reimbursement rates will be determined using 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 to set waiver rates. HHSC models rates as specified below.*

*The rate for case management is determined by modeling the salary for a case manager staff position. This rate is periodically updated for inflation.*

*The rates for assisted living are determined by modeling using a pro forma approach.*

*The rate for orientation and mobility services is determined by modeling the salary for an orientation and mobility staff position. This rate is updated periodically for inflation.*

*Prescription drugs, minor home modifications, adaptive aids and medical supplies, and dental services are paid at cost. The DBMD providers are given additional payments for the cost of acquiring minor home modifications, adaptive aids and medical supplies, and dental services for participants; these payments are called requisition fees. The rates for the requisition fees are modeled using a pro forma approach.*

*Appendix C states the maximum allowable amount under the limits section of Prescribed Drugs, Minor Home Modification, Adaptive Aids and Medical Supplies, and Dental Treatment. Prescribed Drugs has no limit. Minor Home Modification has a maximum lifetime expenditure of $10,000. After the lifetime maximum is reached, $300 is allowed per service plan year per individual for repairs, replacements, or additional modifications. The maximum amount of funds available for adaptive aids is $10,000 per individual per service plan year. The total amount allowable for the dental treatment service is limited to a maximum expenditure of $2,500.00 per service plan year for routine preventive, therapeutic, orthodontic, or emergency treatment and $2,000.00 per individual per service plan year for sedation. The rates for Prescribed Drugs, Minor Home Modification, Adaptive Aids and Medical Supplies, and Dental Treatment are not fixed, but rather are the actual costs to the provider. The maximum allowable amount for Prescribed Drugs, Minor Home Modification, Adaptive Aids and Medical Supplies, and Dental Treatment is based on legislative and leadership direction.*

*The rates for support consultation, Intervener I, Intervener II, Intervener III and transition assistance services are determined by modeling the estimated salary for a person with similar skills and training requirements. These rates are updated periodically for inflation.*

*In setting the rates for financial management services provided under the consumer directed services option, the reimbursement rate to 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.*

*HHSC holds a public hearing before it approves rates. The purpose of the hearing is to give interested parties an opportunity to comment on the proposed rates. Notice of the hearing is provided to the public. The notice of the public hearing includes 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.*

**b. Flow of Billings.** *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

*For services delivered through the agency option and consumer directed services option, providers submit claims for reimbursement for waiver services provided to individuals to the CMS-approved State Medicaid Management Information System. Providers may submit claims electronically to the Medicaid Management Information System.*

## *Appendix I: Financial Accountability*

## *I-2: Rates, Billing and Claims (2 of 3)*

***c. Certifying Public Expenditures*** *(select one):*

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

***Select at least one:***

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

*Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

*Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)*

# *Appendix I: Financial Accountability*

## *I-2: Rates, Billing and Claims (3 of 3)*

***d. Billing Validation Process.*** *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

*The State's contracted Medicaid Management Information System is the claims processing system that verifies that an individual was Medicaid-eligible on the date of service delivery specified in a request for reimbursement and allows payment only on claims for services provided within the eligibility period.*

*Prior to processing claims, the automated claims management system edits claims for the validity of the information and compliance with business rules for the service and program, and calculates the payment amount and applicable reductions for claims approved for payment. For example, unless the system verifies that an individual's current authorized service plan has sufficient units to cover amounts claimed or that an authorized level of care is registered in the claims management system, the claim will be denied.*

*As noted in the Financial Integrity and Accountability section above, HHSC staff conducts on-site reviews to determine a provider's compliance with standards pertaining to fiscal accountability and to verify the services billed were actually rendered.*

***e. Billing and Claims Record Maintenance Requirement.*** *Records documenting the audit trail of adjudicated claims*

*(including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

***a. Method of payments -- MMIS*** *(select one):*

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  *Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:*

- ( ) ***Payments for waiver services are not made through an approved MMIS.***

  *Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:*

- ( ) ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

  *Describe how payments are made to the managed care entity or entities:*

## Appendix I: Financial Accountability

### I-3: Payment (2 of 7)

***b. Direct payment.*** *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

- ☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***
- ☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***
- ☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

  *Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:*

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

*Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.*

## *Appendix I: Financial Accountability*

### *I-3: Payment (3 of 7)*

***c. Supplemental or Enhanced Payments.*** *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

○ ***No. The state does not make supplemental or enhanced payments for waiver services.***

◉ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

*Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.*

*Providers of day habilitation, residential habilitation, Intervener, supported employment, employment assistance, and state plan Community First Choice personal assistance services/habilitation have the option of participating in the Attendant Compensation Rate Enhancement. The 76th Texas Legislature directed the Texas Department of Human Services (a legacy agency for 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 at least 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.*

*Determination of each provider's compliance with the attendant compensation spending requirement will be made on an annual basis using cost reports submitted to HHSC. Providers who enter or exit the program outside of their normal cost reporting period submit supplemental reports as required by HHSC. These reports contain attendant cost information on attendant wages, benefits, insurance, and mileage reimbursement for the services included in the rate enhancement program. All reports are subject to audit by the HHSC Cost Report Review Unit (CCRU). The HHSC CCRU removes any unallowable costs and corrects any errors detected on the cost report in the course of the review or on-site audit. Some cost reports are returned for correction and the revised cost reports are reviewed to determine if appropriate changes are made.*
*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.*

## *Appendix I: Financial Accountability*

### *I-3: Payment (4 of 7)*

***d. Payments to state or Local Government Providers.*** *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ◉ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

*Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:*

## *Appendix I: Financial Accountability*

### *I-3: Payment (5 of 7)*

***e. Amount of Payment to State or Local Government Providers.***

*Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:*

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

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

*Describe the recoupment process:*

## *Appendix I: Financial Accountability*

### *I-3: Payment (6 of 7)*

***f. Provider Retention of Payments.*** *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

*Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.*

## *Appendix I: Financial Accountability*

### *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.***

## *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 DBMD funds are appropriated by the Texas State Legislature to HHSC for the waiver program. There are no inter-governmental transfers or certified public expenditures. The non-federal share is exclusively from state general revenue appropriations.*

- *There are no local sources of funds.*
- *There are no certified public expenditures.*
- *DBMD non-federal share funds are appropriated to HHSC as a specific line item for the provision of DBMD services.*
- *If another agency was designated to operate the DBMD program, those funds would be removed from HHSC and appropriated to that agency.*

*HHSC DBMD appropriations remain in the state comptroller's account designated for the DBMD 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 for the cost of room and board is the responsibility of the participant except when room and board are provided under the waiver as part of out-of-home respite services. Room and board costs are excluded from the rates for assisted living services.*

## *Appendix I: Financial Accountability*

### *I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver*

***Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.*** *Select one:*

◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***

○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

*The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*

## *Appendix I: Financial Accountability*

### *I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)*

***a. Co-Payment Requirements.*** *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***

○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

***i. Co-Pay Arrangement.***

*Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):*

***Charges Associated with the Provision of Waiver Services*** *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

*Specify:*

## *Appendix I: Financial Accountability*

### *I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)*

***a. Co-Payment Requirements.***

***ii. Participants Subject to Co-pay Charges for Waiver Services.***

***Answers provided in Appendix I-7-a indicate that you do not need to complete this section.***

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

***a. Co-Payment Requirements.***

***iii. Amount of Co-Pay Charges for Waiver Services.***

***Answers provided in Appendix I-7-a indicate that you do not need to complete this section.***

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

***a. Co-Payment Requirements.***

***iv. Cumulative Maximum Charges.***

***Answers provided in Appendix I-7-a indicate that you do not need to complete this section.***

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

***b. Other State Requirement for Cost Sharing.*** *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

*Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:*

## Appendix J: Cost Neutrality Demonstration

### J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

***Composite Overview.*** *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

***Level(s) of Care: ICF/IID***

| Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 | Col. 6 | Col. 7 | Col. 8 |
|---|---|---|---|---|---|---|---|
| Year | Factor D | Factor D' | Total: D+D' | Factor G | Factor G' | Total: G+G' | Difference (Col 7 less Column4) |
| 1 | 18765.86 | 43010.42 | 61776.28 | 121145.95 | 2880.62 | 124026.57 | 62250.29 |
| 2 | 21434.20 | 38233.81 | 59668.01 | 123387.15 | 2977.41 | 126364.56 | 66696.55 |
| 3 | 22784.22 | 39708.90 | 62493.12 | 126200.38 | 3094.42 | 129294.80 | 66801.68 |
| 4 | 23087.40 | 40597.15 | 63684.55 | 128951.55 | 3209.22 | 132160.77 | 68476.22 |

| 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) |
| 5 | 23549.73 | 41699.38 | 65249.11 | 131736.90 | 3333.74 | 135070.64 | 69821.53 |

## 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 | 381 | 381 |
| Year 2 | 378 | 378 |
| Year 3 | 378 | 378 |
| Year 4 | 378 | 378 |
| Year 5 | 378 | 378 |

## 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.*

*Due to the funding appropriated for waiver services rate increases for the state fiscal 2020 - 2021 biennium (09/01/2019 – 08/31/2021), this amendment is to amend Appendix J for WY 2 (3/1/19-2/29/20), WY 3 (3/1/20-2/28/21), WY 4 (3/1/21-2/28/22), and WY 5 (3/1/22-2/28/23).*

*For WY 2, the estimate was based on actual enrollment data (calculated using claims payment information) through August 2019 and assumed partial replacement of attrition for the remainder of the waiver year. For WY 3 through WY 5, the estimate assumed a constant point-in-time enrollment of 342, with replacement of attrition, estimated at three individuals per month.*

*The State used the phase-in/phase-out schedule to calculate the Factor C as well as the PIT. In this instance, the term "phase-in/phase-out" is a budgetary management tool only and not the same as the terms described in the CMS Technical Guide.*

## 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:*

*The estimate of D' was based on utilization, units of service per user, and cost per unit information from claims payment data and CMS-372(S) report for WY 2018 (03/01/2017 – 02/28/2018). The service specific baseline information was then adjusted for the new payment rates (effective 09/01/2019 in services where a unit rate is established) and/or inflation (in services where no unit rate is established). Historically the state used services-specific cost growth methodology to develop cost estimates:*

*(1) For services where a unit rate is established:*
*Since no rate increases were approved for the state fiscal 2018 - 2019 biennium, no inflation was assumed for these services until the new payment rates became effective 09/01/2019. The new payment rates were applied to the twenty-four months period, which includes the last six months of WY 2, twelve months of WY 3, and the first six months of WY 4. An inflation of 2% was assumed in the last six months WY 4 and WY5. The resulting annual growth trends are: WY 2 and WY 3 – variable because the service specific rate increase percentage varies; WY 4 – 1% (a half of 2%); WY 5 – 2% (a full 2%).*

*Transition Assistance Services includes individual service costs and a provider fee. Individual services cost is up to $2500 per individual and the provider fee is rate based. Inflation was only applied to the provider fee.*

*(2) For services not involving unit rates (Adaptive Aids, Dental, and Minor Home Modifications):*
*The State assumed an inflation of 2% over the cost per unit information from the claims data for WY 2018 for WY 1 through WY 5.*

*3) For prescribed drugs, the baseline WY 2018 cost per prescription ($61.04) was calculated using expenditures from the 372 report ($2,136.38) and number of prescriptions from claims data for utilization (35). The State assumed a 5% inflation over the unit cost for WY 1 through WY 5.*

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 baseline estimate for D' was based on WY 2018 CMS-372(S). The state estimated the baseline D' cost per day using D' and ALOS information from WY 2018 CMS-372(S). The baseline D' cost per day was divided into two groups and estimated separately.*

*(1) For state plan services such as Community First Choice (CFC) where the new payment rates (effective 09/1/2019) were applicable, the estimate utilized similar methodology stated in i.1 with inflation index.*

*(2) For state plan services where the new payment rates were not applicable, inflation index was assumed.*

*The inflation index used is "Health Care" price deflators (IHS Global Insight Short Term Forecast for the U.S. Economy, December 2018) of 1.8% for WY 2019, 1.5% for WY 2020 (WY 2), 2.4% for WY 2021 (WY 3), 2.6% for WY 2022 (WY 4), and 2.7% for WY 2023 (WY 5), 2.8% for WY 2023 (WY 4), and 2.7% for SFY 2024 (WY5).*

*The sum of (1) and (2) is the D' cost per day. Factor D' was derived from the multiplication of D' cost per day and ALOS for the waiver population of the specified WY.*

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 were inflated using the following Personal Consumption Expenditures (PCE) deflators (Chained Price Deflators 2009= 100) as forecasted by IHS Global Insight in September 2017. Waiver year 2016-.3%; Waiver year 2017-1.19%; waiver year 2018-1.6%; renewal year one-1.31%; renewal year two-1.85%; renewal year three-2.28%; renewal year four–2.18%; renewal year five-2.16%.*

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, and were inflated using "Price and Wages: Health Care Insurance" (December 2005=100) estimated by IHS Global Insight in September 2017. Inflators used are as follows: waiver year 2016-2.83%; waiver year 2017-2.87%; waiver year 2018-1.27%; renewal year one-3.0%; renewal year two-3.36%; renewal year three-3.93%; renewal year four-3.71%; renewal year five-3.88%.*

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (4 of 9)

***Component management for waiver services.*** *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

| Waiver Services | |
|---|---|
| Case Management | |
| Day Habilitation | |
| Residential Habilitation | |
| Respite | |
| Supported Employment | |
| Prescribed Drugs | |
| Financial Management Services | |
| Support Consultation | |
| Adaptive Aids and Medical Supplies | |
| Assisted Living | |
| Audiology Services | |
| Behavioral Support Services | |
| Chore Service | |
| Dental Treatment | |
| Dietary Services | |
| Employment Assistance | |
| Intervener | |
| Minor Home Modifications | |
| Nursing | |
| Occupational Therapy Services | |
| Orientation and Mobility | |
| Physical Therapy Services | |
| Speech, Hearing, and Language Therapy Services | |
| Transition Assistance Services | |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (5 of 9)

***d. Estimate of Factor D.***

***i. Non-Concurrent Waiver.*** *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

***Waiver Year: Year 1***

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | **135055.80** |
| Case Management | Hourly | 359 | 10.00 | 37.62 | **135055.80** | |
| **Day Habilitation Total:** | | | | | | **476895.06** |
| Day Habilitation | Hourly | 38 | 877.00 | 14.31 | **476895.06** | |
| **Residential Habilitation Total:** | | | | | | **13500.00** |
| Consumer Directed Residential Habilitation | Hourly | 0 | 0.01 | 13.05 | **0.00** | |
| Residential Habilitation | Hourly | 9 | 100.00 | 15.00 | **13500.00** | |
| **Respite Total:** | | | | | | **384887.60** |
| Respite | Daily | 70 | 12.00 | 238.49 | **200331.60** | |
| Consumer Directed Respite | Daily | 86 | 10.00 | 214.60 | **184556.00** | |
| **Supported Employment Total:** | | | | | | **73741.20** |
| Supported Employment | Hourly | 3 | 377.00 | 33.10 | **37436.10** | |
| Consumer Directed Supported Employment | Hourly | 3 | 377.00 | 32.10 | **36305.10** | |
| **Prescribed Drugs Total:** | | | | | | **726073.20** |
| Prescribed Drugs | Per Rx | 79 | 40.00 | 229.77 | **726073.20** | |
| **Financial Management Services Total:** | | | | | | **211696.00** |
| Financial Management Services | Monthly | 131 | 8.00 | 202.00 | **211696.00** | |
| **Support Consultation Total:** | | | | | | **1752.18** |
| Support Consultation | Hourly | 3 | 38.00 | 15.37 | **1752.18** | |
| **Adaptive Aids and Medical Supplies Total:** | | | | | | **38618.37** |
| Adaptive Aids and Medical Supplies | Per Item | 27 | 3.00 | 476.77 | **38618.37** | |
| **Assisted Living Total:** | | | | | | **3095383.41** |
| 18 hour assisted living | Daily | 17 | 192.00 | 113.19 | **369452.16** | |
| 24 hour assisted living | Daily | 69 | 301.00 | 131.25 | **2725931.25** | |
| **Audiology Services Total:** | | | | | | **6011.22** |

| | |
|---|---|
| **GRAND TOTAL:** | **7149793.09** |
| **Total Estimated Unduplicated Participants:** | **381** |
| **Factor D (Divide total by number of participants):** | **18765.86** |
| **Average Length of Stay on the Waiver:** | 331 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Audiology Services | Hourly | 3 | 38.00 | 52.73 | 6011.22 | |
| **Behavioral Support Services Total:** | | | | | | 10816.08 |
| Behavioral Support Services | Hourly | 17 | 8.00 | 79.53 | 10816.08 | |
| **Chore Service Total:** | | | | | | 23027.52 |
| Chore Service | Hourly | 6 | 332.00 | 11.56 | 23027.52 | |
| **Dental Treatment Total:** | | | | | | 91400.40 |
| Dental Treatment | Per Treatment | 70 | 2.00 | 652.86 | 91400.40 | |
| **Dietary Services Total:** | | | | | | 1990.08 |
| Dietary Services | Hourly | 9 | 4.00 | 55.28 | 1990.08 | |
| **Employment Assistance Total:** | | | | | | 73741.20 |
| Employment Assistance | Hourly | 3 | 377.00 | 33.10 | 37436.10 | |
| Consumer Directed Employment Assistance | Hourly | 3 | 377.00 | 32.10 | 36305.10 | |
| **Intervener Total:** | | | | | | 1627973.03 |
| Consumer Directed Intervener | Hourly | 36 | 662.00 | 15.50 | 369396.00 | |
| Intervener I | Hourly | 7 | 340.00 | 21.53 | 51241.40 | |
| Consumer Directed Intervener II | Hourly | 3 | 1663.00 | 24.61 | 122779.29 | |
| Intervener II | Hourly | 7 | 340.00 | 25.61 | 60951.80 | |
| Intervener III | Hourly | 1 | 14.00 | 29.69 | 415.66 | |
| Consumer Directed Intervener I | Hourly | 8 | 680.00 | 20.53 | 111683.20 | |
| Intervener | Hourly | 61 | 820.00 | 17.39 | 869847.80 | |
| Consumer Directed Intervener III | Hourly | 3 | 484.00 | 28.69 | 41657.88 | |
| **Minor Home Modifications Total:** | | | | | | 929.04 |
| Minor Home Modifications | Per Item | 1 | 2.00 | 464.52 | 929.04 | |
| **Nursing Total:** | | | | | | 102973.86 |
| Nursing | | | | | 102973.86 | |

| | |
|---|---|
| **GRAND TOTAL:** | 7149793.09 |
| **Total Estimated Unduplicated Participants:** | 381 |
| **Factor D (Divide total by number of participants):** | 18765.86 |
| **Average Length of Stay on the Waiver:** | 331 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | Hourly | 262 | 11.00 | 35.73 | | |
| **Occupational Therapy Services Total:** | | | | | | **16340.80** |
| Occupational Therapy Services | Hourly | 7 | 32.00 | 72.95 | **16340.80** | |
| **Orientation and Mobility Total:** | | | | | | **3975.86** |
| Orientation and Mobility | Hourly | 1 | 98.00 | 40.57 | **3975.86** | |
| **Physical Therapy Services Total:** | | | | | | **154.86** |
| Physical Therapy Services | Hourly | 1 | 2.00 | 77.43 | **154.86** | |
| **Speech, Hearing, and Language Therapy Services Total:** | | | | | | **31126.32** |
| Speech/Hearing/Language | Hourly | 8 | 51.00 | 76.29 | **31126.32** | |
| **Transition Assistance Services Total:** | | | | | | **1730.00** |
| Transition Assistance Services | Per item | 1 | 1.00 | 1730.00 | **1730.00** | |
| | | | | **GRAND TOTAL:** | | **7149793.09** |
| | | | | **Total Estimated Unduplicated Participants:** | | **381** |
| | | | | **Factor D (Divide total by number of participants):** | | **18765.86** |
| | | | | **Average Length of Stay on the Waiver:** | | 331 |

## *Appendix J: Cost Neutrality Demonstration*

### *J-2: Derivation of Estimates (6 of 9)*

***d. Estimate of Factor D.***

***i. Non-Concurrent Waiver.*** *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

***Waiver Year: Year 2***

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | **179485.18** |
| Case Management | Hourly | 348 | 10.79 | 47.80 | **179485.18** | |
| **Day Habilitation Total:** | | | | | | **510020.98** |
| Day Habilitation | Hourly | 37 | 908.06 | 15.18 | **510020.98** | |
| | | | | **GRAND TOTAL:** | | **8102127.38** |
| | | | | **Total Estimated Unduplicated Participants:** | | **378** |
| | | | | **Factor D (Divide total by number of participants):** | | **21434.20** |
| | | | | **Average Length of Stay on the Waiver:** | | 331 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Residential Habilitation Total:** | | | | | | **68319.61** |
| Consumer Directed Residential Habilitation | Hourly | 1 | 309.95 | 14.18 | **4395.09** | |
| Residential Habilitation | Hourly | 18 | 225.77 | 15.73 | **63924.52** | |
| **Respite Total:** | | | | | | **580024.72** |
| Respite | Daily | 67 | 14.79 | 249.79 | **247524.40** | |
| Consumer Directed Respite | Daily | 98 | 15.01 | 226.04 | **332500.32** | |
| **Supported Employment Total:** | | | | | | **79447.27** |
| Supported Employment | Hourly | 3 | 404.93 | 33.10 | **40209.55** | |
| Consumer Directed Supported Employment | Hourly | 3 | 404.93 | 32.30 | **39237.72** | |
| **Prescribed Drugs Total:** | | | | | | **2652.97** |
| Prescribed Drugs | Per Rx | 18 | 2.19 | 67.30 | **2652.97** | |
| **Financial Management Services Total:** | | | | | | **304418.75** |
| Financial Management Services | Montly | 133 | 10.82 | 211.54 | **304418.75** | |
| **Support Consultation Total:** | | | | | | **1955.67** |
| Support Consultation | Monthly | 3 | 40.49 | 16.10 | **1955.67** | |
| **Adaptive Aids and Medical Supplies Total:** | | | | | | **108178.57** |
| Adaptive Aids and Medical Supplies | Per Item | 29 | 2.29 | 1628.95 | **108178.57** | |
| **Assisted Living Total:** | | | | | | **2985281.11** |
| 18 hour assisted living | Daily | 15 | 199.92 | 118.54 | **355477.75** | |
| 24 hour assisted living | Daily | 64 | 298.95 | 137.45 | **2629803.36** | |
| **Audiology Services Total:** | | | | | | **6707.57** |
| Audiology Services | Hourly | 3 | 40.49 | 55.22 | **6707.57** | |
| **Behavioral Support Services Total:** | | | | | | **6918.58** |
| Behavioral Support Services | Hourly | 3 | 27.92 | 82.60 | **6918.58** | |
| **Chore Service Total:** | | | | | | **37001.20** |

| | |
|---|---|
| **GRAND TOTAL:** | **8102127.38** |
| **Total Estimated Unduplicated Participants:** | **378** |
| **Factor D (Divide total by number of participants):** | **21434.20** |
| **Average Length of Stay on the Waiver:** | 331 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Chore Service | Hourly | 7 | 413.93 | 12.77 | 37001.20 | |
| **Dental Treatment Total:** | | | | | | 102518.15 |
| Dental Treatment | Per Treatment | 78 | 1.99 | 660.47 | 102518.15 | |
| **Dietary Services Total:** | | | | | | 1201.04 |
| Dietary Services | Hourly | 4 | 5.13 | 58.53 | 1201.04 | |
| **Employment Assistance Total:** | | | | | | 79447.27 |
| Employment Assistance | Hourly | 3 | 404.93 | 33.10 | 40209.55 | |
| Consumer Directed Employment Assistance | Hourly | 3 | 404.93 | 32.30 | 39237.72 | |
| **Intervener Total:** | | | | | | 2803777.62 |
| Consumer Directed Intervener | Hourly | 44 | 957.81 | 17.49 | 737092.26 | |
| Intervener I | Hourly | 6 | 1213.35 | 23.35 | 169990.34 | |
| Consumer Directed Intervener II | Hourly | 4 | 1692.85 | 25.96 | 175785.54 | |
| Intervener II | Hourly | 7 | 363.95 | 26.96 | 68684.64 | |
| Intervener III | Hourly | 1 | 14.95 | 30.57 | 457.02 | |
| Consumer Directed Intervener I | Hourly | 6 | 1442.37 | 22.35 | 193421.82 | |
| Intervener | Hourly | 62 | 1197.91 | 19.24 | 1428962.88 | |
| Consumer Directed Intervener III | Hourly | 2 | 496.84 | 29.57 | 29383.12 | |
| **Minor Home Modifications Total:** | | | | | | 21738.06 |
| Minor Home Modifications | Per Item | 5 | 1.57 | 2769.18 | 21738.06 | |
| **Nursing Total:** | | | | | | 159700.24 |
| Nursing | Hourly | 313 | 14.28 | 35.73 | 159700.24 | |
| **Occupational Therapy Services Total:** | | | | | | 18274.88 |
| Occupational Therapy Services | Hourly | 4 | 59.80 | 76.40 | 18274.88 | |
| **Orientation and Mobility Total:** | | | | | | 6422.76 |
| Orientation and Mobility | | | | | 6422.76 | |

| | |
|---|---|
| **GRAND TOTAL:** | 8102127.38 |
| **Total Estimated Unduplicated Participants:** | 378 |
| **Factor D (Divide total by number of participants):** | 21434.20 |
| **Average Length of Stay on the Waiver:** | 331 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | Hourly | 1 | 107.62 | 59.68 | | |
| **Physical Therapy Services Total:** | | | | | | **819.82** |
| Physical Therapy Services | Hourly | 3 | 3.37 | 81.09 | **819.82** | |
| **Speech, Hearing, and Language Therapy Services Total:** | | | | | | **35149.61** |
| Speech/Hearing/Language | Hourly | 12 | 36.66 | 79.90 | **35149.61** | |
| **Transition Assistance Services Total:** | | | | | | **2665.76** |
| Transition Assistance Services | Per item | 1 | 1.00 | 2665.76 | **2665.76** | |
| | | | | **GRAND TOTAL:** | | **8102127.38** |
| | | | | **Total Estimated Unduplicated Participants:** | | **378** |
| | | | | **Factor D (Divide total by number of participants):** | | **21434.20** |
| | | | | **Average Length of Stay on the Waiver:** | | 331 |

## *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 |
|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | **217067.51** |
| Case Management | Hourly | 348 | 10.76 | 57.97 | **217067.51** | |
| **Day Habilitation Total:** | | | | | | **532652.70** |
| Day Habilitation | Hourly | 37 | 905.41 | 15.90 | **532652.70** | |
| **Residential Habilitation Total:** | | | | | | **71383.38** |
| Consumer Directed Residential Habilitation | Hourly | 1 | 309.04 | 15.30 | **4728.31** | |
| Residential Habilitation | Hourly | 18 | 225.11 | 16.45 | **66655.07** | |
| **Respite Total:** | | | | | | **605922.65** |
| Respite | | | | | **257992.54** | |
| | | | | **GRAND TOTAL:** | | **8612435.94** |
| | | | | **Total Estimated Unduplicated Participants:** | | **378** |
| | | | | **Factor D (Divide total by number of participants):** | | **22784.22** |
| | | | | **Average Length of Stay on the Waiver:** | | 330 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | Daily | 67 | 14.75 | 261.06 | | |
| Consumer Directed Respite | Daily | 98 | 14.96 | 237.32 | 347930.11 | |
| **Supported Employment Total:** | | | | | | 79213.79 |
| Supported Employment | Hourly | 3 | 403.74 | 33.10 | 40091.38 | |
| Consumer Directed Supported Employment | Hourly | 3 | 403.74 | 32.30 | 39122.41 | |
| **Prescribed Drugs Total:** | | | | | | 2772.70 |
| Prescribed Drugs | Per Rx | 18 | 2.18 | 70.66 | 2772.70 | |
| **Financial Management Services Total:** | | | | | | 317279.63 |
| Financial Management Services | Monthly | 133 | 10.79 | 221.09 | 317279.63 | |
| **Support Consultation Total:** | | | | | | 2037.07 |
| Support Consultation | Monthly | 3 | 40.37 | 16.82 | 2037.07 | |
| **Adaptive Aids and Medical Supplies Total:** | | | | | | 109859.70 |
| Adaptive Aids and Medical Supplies | Per Item | 29 | 2.28 | 1661.52 | 109859.70 | |
| **Assisted Living Total:** | | | | | | 3110761.26 |
| 18 hour assisted living | Daily | 15 | 199.33 | 123.89 | 370424.91 | |
| 24 hour assisted living | Daily | 64 | 298.07 | 143.65 | 2740336.35 | |
| **Audiology Services Total:** | | | | | | 6989.26 |
| Audiology Services | Hourly | 3 | 40.37 | 57.71 | 6989.26 | |
| **Behavioral Support Services Total:** | | | | | | 7155.16 |
| Behavioral Support Services | Hourly | 3 | 27.84 | 85.67 | 7155.16 | |
| **Chore Service Total:** | | | | | | 41371.05 |
| Chore Service | Hourly | 7 | 412.72 | 14.32 | 41371.05 | |
| **Dental Treatment Total:** | | | | | | 104043.14 |
| Dental Treatment | Per Treatment | 78 | 1.98 | 673.68 | 104043.14 | |
| **Dietary Services Total:** | | | | | | 1265.05 |
| Dietary Services | | | | | 1265.05 | |

| | |
|---|---|
| **GRAND TOTAL:** | 8612435.94 |
| **Total Estimated Unduplicated Participants:** | 378 |
| **Factor D (Divide total by number of participants):** | 22784.22 |
| **Average Length of Stay on the Waiver:** | 330 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | Hourly | 4 | 5.12 | 61.77 | | |
| **Employment Assistance Total:** | | | | | | **78971.54** |
| Employment Assistance | Hourly | 3 | 403.74 | 33.10 | **40091.38** | |
| Consumer Directed Employment Assistance | Hourly | 3 | 403.74 | 32.10 | **38880.16** | |
| **Intervener Total:** | | | | | | **3068901.59** |
| Consumer Directed Intervener | Hourly | 44 | 955.01 | 19.48 | **818558.17** | |
| Intervener I | Hourly | 6 | 1209.80 | 25.17 | **182704.00** | |
| Consumer Directed Intervener II | Hourly | 4 | 1687.90 | 27.31 | **184386.20** | |
| Intervener II | Hourly | 7 | 362.89 | 28.31 | **71913.91** | |
| Intervener III | Hourly | 1 | 14.90 | 31.45 | **468.60** | |
| Consumer Directed Intervener I | Hourly | 6 | 1438.15 | 24.17 | **208560.51** | |
| Intervener | Hourly | 62 | 1194.40 | 21.23 | **1572140.94** | |
| Consumer Directed Intervener III | Hourly | 2 | 495.39 | 30.45 | **30169.25** | |
| **Minor Home Modifications Total:** | | | | | | **22172.80** |
| Minor Home Modifications | Per Item | 5 | 1.57 | 2824.56 | **22172.80** | |
| **Nursing Total:** | | | | | | **164958.01** |
| Nursing | Hourly | 313 | 14.24 | 37.01 | **164958.01** | |
| **Occupational Therapy Services Total:** | | | | | | **19043.44** |
| Occupational Therapy Services | Hourly | 4 | 59.63 | 79.84 | **19043.44** | |
| **Orientation and Mobility Total:** | | | | | | **8453.88** |
| Orientation and Mobility | Hourly | 1 | 107.31 | 78.78 | **8453.88** | |
| **Physical Therapy Services Total:** | | | | | | **854.28** |
| Physical Therapy Services | Hourly | 3 | 3.36 | 84.75 | **854.28** | |
| **Speech, Hearing, and Language Therapy Services Total:** | | | | | | **36633.12** |

| | |
|---|---|
| **GRAND TOTAL:** | **8612435.94** |
| **Total Estimated Unduplicated Participants:** | **378** |
| **Factor D (Divide total by number of participants):** | **22784.22** |
| **Average Length of Stay on the Waiver:** | 330 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Speech/Hearing/Language | Hourly | 12 | 36.56 | 83.50 | 36633.12 | |
| **Transition Assistance Services Total:** | | | | | | 2673.24 |
| Transition Assistance Services | Per item | 1 | 1.00 | 2673.24 | 2673.24 | |
| | | | | **GRAND TOTAL:** | | 8612435.94 |
| | | | | **Total Estimated Unduplicated Participants:** | | 378 |
| | | | | **Factor D (Divide total by number of participants):** | | 22784.22 |
| | | | | **Average Length of Stay on the Waiver:** | | 330 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (8 of 9)

**d. Estimate of Factor D.**

***i. Non-Concurrent Waiver.*** *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

***Waiver Year: Year 4***

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | 219850.57 |
| Case Management | Hourly | 348 | 10.79 | 58.55 | 219850.57 | |
| **Day Habilitation Total:** | | | | | | 539587.41 |
| Day Habilitation | Hourly | 37 | 908.06 | 16.06 | 539587.41 | |
| **Residential Habilitation Total:** | | | | | | 72289.44 |
| Consumer Directed Residential Habilitation | Hourly | 1 | 309.95 | 15.45 | 4788.73 | |
| Residential Habilitation | Hourly | 18 | 225.77 | 16.61 | 67500.71 | |
| **Respite Total:** | | | | | | 613867.62 |
| Respite | Daily | 67 | 14.79 | 263.68 | 261288.42 | |
| Consumer Directed Respite | Daily | 98 | 15.01 | 239.69 | 352579.20 | |
| **Supported Employment Total:** | | | | | | 80236.88 |
| Supported Employment | Hourly | 3 | 404.93 | 33.43 | 40610.43 | |
| | | | | **GRAND TOTAL:** | | 8727036.79 |
| | | | | **Total Estimated Unduplicated Participants:** | | 378 |
| | | | | **Factor D (Divide total by number of participants):** | | 23087.40 |
| | | | | **Average Length of Stay on the Waiver:** | | 331 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Consumer Directed Supported Employment | Hourly | 3 | 404.93 | 32.62 | 39626.45 | |
| **Prescribed Drugs Total:** | | | | | | 2924.57 |
| Prescribed Drugs | Per Rx | 18 | 2.19 | 74.19 | 2924.57 | |
| **Financial Management Services Total:** | | | | | | 321342.10 |
| Financial Management Services | Monthly | 133 | 10.82 | 223.30 | 321342.10 | |
| **Support Consultation Total:** | | | | | | 2063.78 |
| Support Consultation | Monthly | 3 | 40.49 | 16.99 | 2063.78 | |
| **Adaptive Aids and Medical Supplies Total:** | | | | | | 112548.35 |
| Adaptive Aids and Medical Supplies | Per Item | 29 | 2.29 | 1694.75 | 112548.35 | |
| **Assisted Living Total:** | | | | | | 3151217.80 |
| 18 hour assisted living | Daily | 15 | 199.92 | 125.13 | 375239.84 | |
| 24 hour assisted living | Daily | 64 | 298.95 | 145.09 | 2775977.95 | |
| **Audiology Services Total:** | | | | | | 7080.49 |
| Audiology Services | Hourly | 3 | 40.49 | 58.29 | 7080.49 | |
| **Behavioral Support Services Total:** | | | | | | 7247.75 |
| Behavioral Support Services | Hourly | 3 | 27.92 | 86.53 | 7247.75 | |
| **Chore Service Total:** | | | | | | 41897.99 |
| Chore Service | Hourly | 7 | 413.93 | 14.46 | 41897.99 | |
| **Dental Treatment Total:** | | | | | | 106659.42 |
| Dental Treatment | Per Treatment | 78 | 1.99 | 687.15 | 106659.42 | |
| **Dietary Services Total:** | | | | | | 1280.24 |
| Dietary Services | Hourly | 4 | 5.13 | 62.39 | 1280.24 | |
| **Employment Assistance Total:** | | | | | | 80236.88 |
| Employment Assistance | Hourly | 3 | 404.93 | 33.43 | 40610.43 | |
| Consumer Directed Employment Assistance | Hourly | 3 | 404.93 | 32.62 | 39626.45 | |

| | |
|---|---|
| **GRAND TOTAL:** | 8727036.79 |
| **Total Estimated Unduplicated Participants:** | 378 |
| **Factor D (Divide total by number of participants):** | 23087.40 |
| **Average Length of Stay on the Waiver:** | 331 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Intervener Total:** | | | | | | **3108518.47** |
| Consumer Directed Intervener | Hourly | 44 | 957.81 | 19.67 | **828965.40** | |
| Intervener I | Hourly | 6 | 1213.35 | 25.43 | **185132.94** | |
| Consumer Directed Intervener II | Hourly | 4 | 1692.85 | 27.59 | **186822.93** | |
| Intervener II | Hourly | 7 | 363.95 | 28.60 | **72862.79** | |
| Intervener III | Hourly | 1 | 14.95 | 31.77 | **474.96** | |
| Consumer Directed Intervener I | Hourly | 6 | 1442.37 | 24.42 | **211336.05** | |
| Intervener | Hourly | 62 | 1197.91 | 21.44 | **1592357.80** | |
| Consumer Directed Intervener III | Hourly | 2 | 496.84 | 30.76 | **30565.60** | |
| **Minor Home Modifications Total:** | | | | | | **22616.24** |
| Minor Home Modifications | Per Item | 5 | 1.57 | 2881.05 | **22616.24** | |
| **Nursing Total:** | | | | | | **167075.14** |
| Nursing | Hourly | 313 | 14.28 | 37.38 | **167075.14** | |
| **Occupational Therapy Services Total:** | | | | | | **19289.09** |
| Occupational Therapy Services | Hourly | 4 | 59.80 | 80.64 | **19289.09** | |
| **Orientation and Mobility Total:** | | | | | | **8563.32** |
| Orientation and Mobility | Hourly | 1 | 107.62 | 79.57 | **8563.32** | |
| **Physical Therapy Services Total:** | | | | | | **865.42** |
| Physical Therapy Services | Hourly | 3 | 3.37 | 85.60 | **865.42** | |
| **Speech, Hearing, and Language Therapy Services Total:** | | | | | | **37102.85** |
| Speech/Hearing/Language | Hourly | 12 | 36.66 | 84.34 | **37102.85** | |
| **Transition Assistance Services Total:** | | | | | | **2674.97** |
| Transition Assistance Services | Per item | 1 | 1.00 | 2674.97 | **2674.97** | |

| | |
|---|---|
| **GRAND TOTAL:** | **8727036.79** |
| **Total Estimated Unduplicated Participants:** | **378** |
| **Factor D (Divide total by number of participants):** | **23087.40** |
| **Average Length of Stay on the Waiver:** | 331 |

# Appendix J: Cost Neutrality Demonstration

## J-2: Derivation of Estimates (9 of 9)

**d. Estimate of Factor D.**

***i. Non-Concurrent Waiver.*** *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

***Waiver Year: Year 5***

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Case Management Total:** | | | | | | **224243.82** |
| Case Management | Hourly | 348 | 10.79 | 59.72 | **224243.82** | |
| **Day Habilitation Total:** | | | | | | **550338.84** |
| Day Habilitation | Hourly | 37 | 908.06 | 16.38 | **550338.84** | |
| **Residential Habilitation Total:** | | | | | | **73767.24** |
| Consumer Directed Residential Habilitation | Hourly | 1 | 309.95 | 15.76 | **4884.81** | |
| Residential Habilitation | Hourly | 18 | 225.77 | 16.95 | **68882.43** | |
| **Respite Total:** | | | | | | **626135.81** |
| Respite | Daily | 67 | 14.79 | 268.95 | **266510.62** | |
| Consumer Directed Respite | Daily | 98 | 15.01 | 244.48 | **359625.19** | |
| **Supported Employment Total:** | | | | | | **81852.55** |
| Supported Employment | Hourly | 3 | 404.93 | 34.10 | **41424.34** | |
| Consumer Directed Supported Employment | Hourly | 3 | 404.93 | 33.28 | **40428.21** | |
| **Prescribed Drugs Total:** | | | | | | **3070.82** |
| Prescribed Drugs | Per Rx | 18 | 2.19 | 77.90 | **3070.82** | |
| **Financial Management Services Total:** | | | | | | **327774.70** |
| Financial Management Services | Monthly | 133 | 10.82 | 227.77 | **327774.70** | |
| **Support Consultation Total:** | | | | | | **2105.08** |
| Support Consultation | Per Hour | 3 | 40.49 | 17.33 | **2105.08** | |

| | |
|---|---|
| **GRAND TOTAL:** | **8901799.04** |
| **Total Estimated Unduplicated Participants:** | **378** |
| **Factor D (Divide total by number of participants):** | **23549.73** |
| **Average Length of Stay on the Waiver:** | 331 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Adaptive Aids and Medical Supplies Total:** | | | | | | **114799.65** |
| Adaptive Aids and Medical Supplies | Per Item | 29 | 2.29 | 1728.65 | **114799.65** | |
| **Assisted Living Total:** | | | | | | **3214199.92** |
| 18 hour assisted living | Daily | 15 | 199.92 | 127.63 | **382736.84** | |
| 24 hour assisted living | Daily | 64 | 298.95 | 147.99 | **2831463.07** | |
| **Audiology Services Total:** | | | | | | **7221.39** |
| Audiology Services | Hourly | 3 | 40.49 | 59.45 | **7221.39** | |
| **Behavioral Support Services Total:** | | | | | | **7392.66** |
| Behavioral Support Services | Hourly | 3 | 27.92 | 88.26 | **7392.66** | |
| **Chore Service Total:** | | | | | | **42738.27** |
| Chore Service | Hourly | 7 | 413.93 | 14.75 | **42738.27** | |
| **Dental Treatment Total:** | | | | | | **108792.15** |
| Dental Treatment | Per Treatment | 78 | 1.99 | 700.89 | **108792.15** | |
| **Dietary Services Total:** | | | | | | **1305.89** |
| Dietary Services | Hourly | 4 | 5.13 | 63.64 | **1305.89** | |
| **Employment Assistance Total:** | | | | | | **81852.55** |
| Employment Assistance | Hourly | 3 | 404.93 | 34.10 | **41424.34** | |
| Consumer Directed Employment Assistance | Hourly | 3 | 404.93 | 33.28 | **40428.21** | |
| **Intervener Total:** | | | | | | **3170898.28** |
| Consumer Directed Intervener | Hourly | 44 | 957.81 | 20.07 | **845822.85** | |
| Intervener I | Hourly | 6 | 1213.35 | 25.93 | **188772.99** | |
| Consumer Directed Intervener II | Hourly | 4 | 1692.85 | 28.14 | **190547.20** | |
| Intervener II | Hourly | 7 | 363.95 | 29.17 | **74314.95** | |
| Intervener III | Hourly | 1 | 14.95 | 32.40 | **484.38** | |
| Consumer Directed Intervener I | | | | | **215490.08** | |

| | |
|---|---|
| **GRAND TOTAL:** | **8901799.04** |
| **Total Estimated Unduplicated Participants:** | **378** |
| **Factor D (Divide total by number of participants):** | **23549.73** |
| **Average Length of Stay on the Waiver:** | 331 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | Hourly | 6 | 1442.37 | 24.90 | | |
| Intervener | Hourly | 62 | 1197.91 | 21.87 | 1624294.09 | |
| Consumer Directed Intervener III | Hourly | 2 | 496.84 | 31.37 | 31171.74 | |
| **Minor Home Modifications Total:** | | | | | | 23068.56 |
| Minor Home Modifications | Per Item | 5 | 1.57 | 2938.67 | 23068.56 | |
| **Nursing Total:** | | | | | | 170427.37 |
| Nursing | Hourly | 313 | 14.28 | 38.13 | 170427.37 | |
| **Occupational Therapy Services Total:** | | | | | | 19674.20 |
| Occupational Therapy Services | Hourly | 4 | 59.80 | 82.25 | 19674.20 | |
| **Orientation and Mobility Total:** | | | | | | 8734.44 |
| Orientation and Mobility | Hourly | 1 | 107.62 | 81.16 | 8734.44 | |
| **Physical Therapy Services Total:** | | | | | | 882.70 |
| Physical Therapy Services | Hourly | 3 | 3.37 | 87.31 | 882.70 | |
| **Speech, Hearing, and Language Therapy Services Total:** | | | | | | 37841.92 |
| Speech/Hearing/Language | Hourly | 12 | 36.66 | 86.02 | 37841.92 | |
| **Transition Assistance Services Total:** | | | | | | 2680.24 |
| Transition Assistance Services | Per item | 1 | 1.00 | 2680.24 | 2680.24 | |

| | |
|---|---|
| **GRAND TOTAL:** | 8901799.04 |
| **Total Estimated Unduplicated Participants:** | 378 |
| **Factor D (Divide total by number of participants):** | 23549.73 |
| **Average Length of Stay on the Waiver:** | 331 |