

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:

Medically Dependent Children Program (MDCP)

C. Waiver Number:TX.0181

Original Base Waiver Number: TX.0181.90.R3

D. Amendment Number:TX.0181.R07.02

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

02/26/24

Approved Effective Date: 02/26/24

Approved Effective Date of Waiver being Amended: 09/01/22

2. Purpose(s) of Amendment

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

The request proposes to amend Appendix I to change existing language regarding Electronic Visit Verification (EVV) requirements. HHSC currently requires program providers to use EVV for certain personal care services. This amendment addresses the requirement in §1903(l) of the Social Security Act (U.S.C. Title 42, §1396b(l)) to also use EVV for home health care services. The amendment references the state rules that describe all of the services for which the use of EVV is required. These state rules do not currently include the home health services for which the use of EVV will be required but will include these services by January 2024. The personal care services for which the use of EVV is currently required are in-home respite provided by an attendant delivered by the provider or through the consumer directed services (CDS) option and flexible family support services provided by an attendant delivered by the provider or through the CDS option. The home health care services for which the use of EVV will be required effective January 1, 2024, are in-home respite, and flexible family support services delivered by the provider or through the CDS option.

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	
Appendix C Participant Services	
Appendix D Participant Centered Service Planning and Delivery	
Appendix E Participant Direction of Services	
Appendix F Participant Rights	
Appendix G Participant Safeguards	
Appendix H	
Appendix I Financial Accountability	Appendix I-1: Financial Integrity
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:

The request proposes to amend Appendix I to change existing language regarding Electronic Visit Verification (EVV) requirements. HHSC currently requires program providers to use EVV for certain personal care services. This amendment addresses the requirement in §1903(l) of the Social Security Act (U.S.C. Title 42, §1396b(l)) to also use EVV for home health care services. The amendment references the state rules that describe all of the services for which the use of EVV is required. These state rules do not currently include the home health services for which the use of EVV will be required but will include these services by January 2024. The personal care services for which the use of EVV is currently required are in-home respite provided by an attendant delivered by the provider or through the consumer directed services (CDS) option and flexible family support services provided by an attendant delivered by the provider or through the CDS option. The home health care services for which the use of EVV will be required effective January 1, 2024, are in-home respite, and flexible family support services delivered by the provider or through the CDS option.

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*):

Medically Dependent Children Program (MDCP)

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.0181

Waiver Number: TX.0181.R07.02

Draft ID: TX.008.07.02

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 09/01/22

Approved Effective Date of Waiver being Amended: 09/01/22

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 in 42 CFR §440.160

Nursing Facility

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

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

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

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

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

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

§1915(b)(2) (central broker)

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

§1915(b)(4) (selective contracting/limit number of providers)**A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.**A program authorized under §1915(j) of the Act.****A program authorized under §1115 of the Act.**

Specify the program:

STAR Kids (under the authority of 1115) managed care service delivery system model.

H. Dual Eligibility 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 MDCP waiver provides supports to families and primary caregivers of individuals who wish to move from a nursing facility to the community or who wish to remain in the community. Without MDCP waiver services, these individuals would require nursing facility or hospital care. Texas uses the MDCP waiver to provide services to Texans in the least restrictive environment possible. These environments include the member's or a family member's home or an agency foster home.

MDCP strives to support inclusion of children with disabilities in a cost-effective manner through a process that does not supplant the family role and to support permanency planning for all program members.

MDCP strives to: enable children and young adults who are medically dependent to remain safely in their homes; offer cost-effective alternatives to placement in nursing facilities and hospitals; and support families in their role as the primary caregiver for their children and young adults who are medically dependent.

The Health and Human Services Commission (HHSC) does not provide MDCP waiver services to individuals who are inpatients of a nursing facility, hospital or ICF/IID. MDCP waiver services are available in all counties within Texas. HHSC, the single State Medicaid Agency, acts as the operating agency for the MDCP waiver.

HHSC exercises administrative discretion in the administration and supervision of the waiver; adopts rules related to the waiver; directly performs financial eligibility determinations for prospective enrollees; develops the reimbursement rate methodology and sets reimbursement rates; and conducts Medicaid fair hearings in accordance with 42 Code of Federal Regulations, Part Â§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 and its contracted MCOs handle the routine functions necessary to the operation of the waiver. These functions include managing waiver enrollment against approved limits; monitoring waiver expenditures against approved levels; conducting level of care evaluation activities and authorizing level of care; reviewing individual service plans to ensure that waiver requirements are met; conducting utilization management and waiver service authorization functions; enrolling providers and executing the Medicaid provider agreements; conducting training and technical assistance concerning waiver requirements; managing individual's enrollment into the waiver; developing and administration of rules, policies, procedures and information; and performing quality management functions. HHSC/MCOs do not provide direct services.

HHSC's Medicaid eligibility office determines financial eligibility for Medicaid. As authorized by and in coordination with HHSC Program Support Unit staff, the MCO nurse completes the Screening and Assessment Instrument (SAI) assessment used to establish level of need and medical necessity (MN) for MDCP waiver services. Texas' Medicaid Management Information System (MMIS) contractor calculates the Resource Utilization Group level which establishes the individual cost limit and automates the initial MN determination. HHSC staff then make the final determination of MN and eligibility for MDCP waiver services for assessments that fail the initial determination.

The MCO service coordinator, the applicant, the applicant's legally authorized representative (LAR) or medical consentor, and other persons requested by the applicant or the applicant's LAR, develop a person-directed service plan that addresses respite services to support caregivers and help preserve an individual's placement in the community, the hours needed and the level of service needed. The process emphasizes the provision of supports and services necessary to maintain successful integration in the community.

The service plan describes the medical and other services (regardless of funding source) to be furnished, their frequency, and the provider who will furnish each service. Providers deliver all waiver services according to this written service plan. The service plan must have total costs that are within the applicable applicant's cost limit. An applicant must meet financial, level of need, and service plan requirements to be eligible for MDCP waiver services.

An applicant's MCO service coordinator informs the applicant/member or the applicant's/member's LAR or medical consentor at initial enrollment and during each annual reassessment of the consumer directed services (CDS) option and Service Responsibility Option (SRO). The MDCP recipient is referred to as a member once a health plan is selected.

A member or the member's LAR or medical consentor who chooses the traditional service delivery model (i.e., the agency model) chooses the provider for each service included in the service plan from those contracted to be part of the MCO provider network.

A member or the member's LAR who chooses the participant-directed service delivery model can self-direct one or more of the following services: respite care, flexible family support, minor home modifications, adaptive aids, supported employment, or employment assistance. The member or the member's LAR is the employer of the individual providers (called the CDS

employer).

The CDS employer must choose a financial management services agency (FMSA) that assists the CDS employer with all aspects of being an employer, including assisting the CDS employer to develop a budget for participant-directed services, training the CDS employer on employer responsibilities, handling payroll functions on behalf of the CDS employer, and billing HHSC or its designee for services provided.

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. Statewide.** Indicate whether the state requests a waiver of the statewide 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 inpatients 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 MDCP amendment Tribal Notification to the Tribal representatives on October 10, 2023. The Tribal Notification provided contact information to request copies of the amendment, provide comments, and request information from HHSC via email, mail, fax, or telephone. HHSC provides copies free of charge.

The Public Notice of Intent (PNI) for the MDCP amendment was published in the Texas Register (<http://www.sos.state.tx.us/texreg/index.shtml>) on October 13, 2023, allowing a 30-day comment period in compliance with federal/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 HHSC via email, mail, fax, or telephone. HHSC provides copies free of charge.

HHSC also posted the amendment on the HHSC website at <https://hhs.texas.gov/laws-regulations/policies-rules/waivers> and sent a request to the Access and Eligibility Services for local benefit offices to distribute notice of the amendment to 290 eligibility offices with instructions to post the notice in public areas.

The comment period ended on November 13th, 2023. HHSC 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:

Fox

First Name:

Steven

Title:

Manager, Federal Coordination, Rules and Committees

Agency:

Texas Health and Human Services Commission

Address:

701 W. 51st. Street

Address 2:

Mail Code: H-301

City:

Austin

State:

Texas

Zip:

78751

Phone:

(512) 438-4195

Ext:

TTY

Fax:

(512) 323-1905

E-mail:

steven.fox@hhs.texas.gov

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:

(512) 424-6767

Ext:

TTY

Fax:

(512) 323-1905

E-mail:

Attachments

TX_Medicaid_Waivers@hhs.texas.gov

Attachment #1: Transition Plan

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

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

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

Reducing the unduplicated count of participants (Factor C).

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

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

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

Specify the transition plan for the waiver:

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

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

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

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

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

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

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

****Due to the character limits in Appendix F, the language below is a continuation of Appendix F-1.****

In accordance with 42 CFR §438.410, the MCO must establish and maintain an expedited review process for MCO internal appeals, when the MCO determines (for a request from a Member) or the provider indicates (in making the request on the Member's behalf or supporting the Member's request) that taking the time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The MCO must follow all CO internal appeal requirements for standard Member appeals except where differences are specifically noted. The MCO must accept oral or written requests for expedited appeals. If a Member requests the expedited MCO internal appeal process, the Member must exhaust the expedited MCO internal appeal process before making a request for an HHSC fair hearing. After the MCO receives the request for an expedited MCO internal appeal, the MCO must notify the Member of the outcome of the expedited MCO internal appeal within 3 business days. However, the MCO must complete investigation and resolution of an MCO internal appeal relating to an ongoing emergency or denial of continued hospitalization: in accordance with the medical or dental immediacy of the case, and no later than one business day after receiving the Member's request for an expedited MCO internal appeal. The MCO is prohibited from discriminating or taking punitive action against a Member or his or her representative for requesting an expedited MCO internal appeal. The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a Member's request.

If the MCO denies a request for expedited resolution of an MCO Internal Appeal, it must transfer the appeal to the timeframe for standard resolution, make a reasonable effort to give the Member prompt oral notice of the denial and follow up within 2 calendar days with a written notice. The MCO must also inform Members that they have the right to access the HHSC fair hearing process at any time during the MCO Internal Appeal system provided by the MCO with the exception of the expedited MCO Internal Appeal process. In the case of an expedited HHSC fair hearing process, the MCO must inform the Member that the Member must exhaust the expedited MCO Internal Appeal process prior to filing for an expedited HHSC fair hearing. The MCO must notify Members that they may be represented by an authorized representative in the HHSC fair hearing process.

HHSC requires MCOs providing services to MDCP participants to comply with 42 C.F.R. Subchapter F and provide participants with the rights to grievances and appeals set forth therein. HHSC also provides an opportunity for participants who are dissatisfied with an MCO final medical necessity determination to request an external medical review (EMR) at the same time as the fair hearing and consistent with the requirements of 42 C.F.R. 438.402 (c)(1)(i)(B) or a fair hearing only. The review is at the enrollee's option, is independent of both HHSC and the MCO, is offered at no cost to the enrollee, and will not interfere with continuation of benefits or extend the fair hearing timeframes. If the participant is not satisfied with the EMR decision, the participant may proceed to fair hearing. The Member must withdraw their fair hearing request if they do not want to continue to a fair hearing, regardless of the EMR decision. The MCO, Member, authorized representative, legally authorized representative, or medical consentor can request attendance of the Independent Review Organization (IRO) at the fair hearing.

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 Division

(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.:

The Health and Human Services Commission (HHSC)'s contracted Medicaid Management Information System is responsible for processing medical necessity and level of care assessments. However, HHSC staff is responsible for eligibility determinations.

HHSC's contracted Managed Care Organizations (MCOs) conduct functional, medical necessity, and level of care assessments for Medically Dependent Children Program (MDCP) services; engage in person-centered service planning with MDCP Members; contract with MDCP service providers; provide billing support and technical assistance to MDCP service providers; and submit payments to providers.

Per 42 C.F.R., Part 438, Subpart E, HHSC contracts with an external quality review organization to conduct analyses and evaluations of aggregated information on quality, timeliness, and access to the health care services that an MCO or its contractors furnish to Medicaid beneficiaries. The external quality review organization conducts external quality reviews of the State of Texas Access Reform (STAR) Health (HHSC's agency foster care managed care program) and STAR Kids MCOs on behalf of HHSC. MDCP waiver participants receive their services through either the STAR Kids or the STAR Health programs.

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:

HHSC is responsible for assessing the performance of HHSC's contracted MCOs, external quality review organizations, and the Medicaid Management Information System.

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:

Performance assessment of HHSC's contracted MCOs is an ongoing process. HHSC monitors the MCOs' performance using the same oversight processes as those employed for HHSC's other Medicaid contracts.

For example, HHSC monitors MCO compliance with:

- Contracts
- The Uniform Managed Care Manual (UMCM);
- Texas Government Code Chapters 533 (relating to the Medicaid managed care program) and 531 (relating to the Health and Human Services Commission); and
- Title 1 of the Texas Administrative Code, Part 15, Chapters 353 (relating to Medicaid managed care) and 354 (relating to Medicaid health services), as applicable.

HHSC's major activities include monitoring of service delivery, provider networks, claims processing, deliverables, marketing, and other administrative requirements. Monitoring of service delivery includes evaluating and trending provider and member complaints, appeals and service coordination, MCO call center services, claims processes, and encounters. Monitoring provider networks involves analyzing MCO provider data and geographic access reports, and includes review of provider turnover rates, network panel status reports, and provider directories. HHSC also assists with the resolution of complex issues; facilitates internal and external stakeholder meetings; obtains and develops policy clarifications; resolves encounter data and premium payment issues; and clarifies contract requirements. HHSC staff review MCO marketing and training materials, member scripts, and Provider Manuals.

MCOs report specific data to HHSC each fiscal quarter. HHSC compiles this information by MCO, program, and service area. Each MCO may have multiple quarterly reports, which are used for monitoring purposes. These reports capture data on the following elements:

- Enrollment;
- Provider network status;
- Member hotline, behavioral health crisis hotline, and provider hotline performance;
- MCO complaints and appeals (member and provider);
- Complaints received by state agencies (member and provider);
- Claims; and
- Encounter reconciliation.

While the MCO is the initial point of contact to address member or provider concerns, HHSC will assist with issues that have been escalated to HHSC. Inquiries and complaints are referred to HHSC from a variety of sources, including elected officials, the Office of the Ombudsman, and other agencies and departments. Provider inquiries and complaints are received directly from providers through the HHSC STAR Kids dedicated email address, as well as the HHSC Managed Care Compliance and Operations Research and Resolution mailbox. Concerns and requests for assistance are also received via the MDCP/DBMD Escalation Helpline. HHSC also receives information on cases that have been overturned on appeal to track and address any issues in which it appears MCOs may have denied services inappropriately.

Based on findings from monthly and quarterly self-reported performance data, onsite visits, member or other complaints, financial status, and any other source, HHSC may impose or pursue one or more of the following remedies for each item of material non-compliance in accordance with the appropriate managed care contract:

- Corrective action plan;
- Assessment of liquidated damages;
- Accelerated monitoring of the MCO, which includes more frequent or extensive monitoring by HHSC;
- Requiring additional financial or programmatic reports to be submitted by the MCO;
- Requiring additional or more detailed financial or programmatic audits or other reviews of the MCO;
- Terminating or declining to renew or extend an MCO contract;
- Appointing temporary MCO management under the circumstances described in 42 CFR §438.706;
- Suspending member enrollment;
- Withholding or recouping payment to the MCO; and
- Requiring forfeiture of all or part of the MCO's performance bond.

HHSC determines the scope and severity of the remedy on a case-by-case basis.

In addition to the monitoring by HHSC, the Balanced Budget Act of 1997 requires state Medicaid agencies to provide an annual external independent review of quality outcomes, timeliness of services, and access to services provided by a Medicaid MCO (this includes STAR Health and STAR Kids MCOs). To comply with this requirement, and to provide HHSC with data analysis and information to effectively manage its Medicaid managed care programs, HHSC contracts with an external quality review organization. In collaboration with the external quality review organization, HHSC evaluates, assesses, monitors, guides, and directs the Medicaid managed care programs and organizations for HHSC. Since 2002, Texas has contracted with the University of Florida's Institute on Child Health Policy to conduct external quality review organization activities.

The Institute of Child Health Policy performs the following three CMS-required functions:

- Validation of performance improvement projects;
- Validation of performance measures; and
- A review to determine MCO compliance with federal Medicaid managed care regulations.

The Institute of Child Health Policy also conducts focused quality of care studies, performs encounter data validation and certification, assesses Member satisfaction, provides assistance with rate setting activities, and completes other reports and data analysis as requested by HHSC. The external quality review organization develops studies, surveys, or other analytical approaches to assess enrollee's quality and outcomes of care and to identify opportunities for MCO improvement. To facilitate these activities, HHSC ensures that the Institute of Child Health Policy has access to enrollment, health care claims and encounter, and pharmacy data. HHSC also ensures access to immunization registry data. The MCOs collaborate with the Institute of Child Health Policy to ensure medical records are available for focused clinical reviews. This process is completed in compliance with the Health Information Portability Accountability Act (HIPAA).

HHSC contracts with the Medicaid Management Information System vendor to process initial automated medical necessity for applicants/Members in accordance with state requirements and based on information on the assessment form completed by the MCO nurse.

HHSC has staff that is solely dedicated to the management of HHSC's Medicaid Management Information contract. Performance assessment of HHSC's contracted Medicaid Management Information is an ongoing process. HHSC monitors HHSC's contracted Medicaid Management Information performance using the same oversight processes as those employed for other State Medicaid contracts. For example, HHSC's Medicaid Management Information System contract requires the vendor to submit a quality plan to HHSC on a yearly basis that specifies how the vendor will review and implement quality assurance techniques and tools to deliver quality services and meet performance standards as required under the contract. All requirements under the contract are assigned to state staff for monitoring. There are multiple HHSC staff members that monitor every requirement. HHSC staff members are required to report monitoring in the Medicaid Contract Administration Tracking System. The frequency is determined by risk assessment of group requirements in a functional area, based on specific factors or as specified in the contract language and/or key requirement status, to provide performance-based outcomes. Generally, requirements are monitored monthly, quarterly, or based on a triggering event. A triggering event is one that does not necessarily occur on a particular schedule, like weekly or monthly. An example of this is the requirement of HHSC's contracted Medicaid Management Information System to report to HHSC if an operational problem occurs.

HHSC's contracted Medicaid Management Information System, like other HHSC contracts, contains a number of financial and quality incentives that provide a framework for analyzing HHSC's contracted Medicaid Management Information System's performance. Failure of HHSC's contracted Medicaid Management Information System to achieve specific performance goals can lead to liquidated damages or other HHSC remedies.

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	Contracted Entity
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.

Performance Measure:

A.a.1 Number and percent of STAR Kids and STAR Health contracts approved by HHSC

that are implemented by the MCOs. N: Number of STAR Kids and STAR Health contracts approved by HHSC that are implemented by the MCOs. D: Number of STAR Kids and STAR Health contracts implemented.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
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 Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

A.a.2 Number and percent of STAR Kids and STAR Health contracts that were monitored through an operational review to verify contract compliance. N: Number of STAR Kids and STAR Health contracts that were monitored through an operational review to verify contract compliance. D: The total number of STAR Kids and STAR Health contracts that required a review.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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 = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

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

Data Source (Select one):**Other**

If 'Other' is selected, specify:

HHS Community Services Interest List (CSIL)

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

If an MCO fails to meet a performance expectation, standard, schedule, or other contract requirement, the managed care contracts give HHSC the authority to use a variety of remedies, including:

- Corrective action plans;
- Assessment of liquidated damages;
- Accelerated monitoring of the MCO, which includes more frequent or extensive monitoring by HHSC;
- Requiring additional financial or programmatic reports to be submitted by the MCO;
- Requiring additional or more detailed financial or programmatic audits or other reviews of the MCO;
- Terminating or declining to renew or extend an MCO contract;
- Appointing temporary MCO management under the circumstances described in 42 CFR §438.706;
- Suspending member enrollment;
- Withholding or recouping payment to the MCO; and
- Requiring forfeiture of all or part of the MCO's performance bond.

ii. Remediation Data Aggregation

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

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		0			20		
		Technology Dependent							
Intellectual Disability or Developmental Disability, or Both									
		Autism							
		Developmental Disability							
		Intellectual Disability							
Mental Illness									
		Mental Illness							
		Serious Emotional Disturbance							

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

- 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:

Most individuals who receive MDCP services through either the STAR Kids or STAR Health managed care model will be served in the STAR+PLUS managed care model after they turn 21 and may be eligible to receive STAR+PLUS home and community-based services authorized under the 1115 Transformation Waiver (referred to as the STAR+PLUS Waiver Program). Some MDCP Members may experience an improvement in health status which would result in a loss of medical necessity. Others may not longer meet financial eligibility criteria for Medicaid. Thus, HHSC has indicated "most Members" transition to STAR+PLUS and receive STAR+PLUS home and community-based services. Transition planning begins one year before the MDCP Member's 21st birthday.

One year prior to transition, the MCO explains the STAR+PLUS program benefits, including STAR+PLUS home and community-based services and other specific information related to the transition and the enrollment process into STAR+PLUS. HHSC monitors the Transition Report for individuals enrolled in MDCP who will be transitioning out of MDCP at the end of the month of their 21st birthday. HHSC updates the Transition report on a quarterly basis. Nine months prior to the individual's 21st birthday, the HHSC Program Support Unit sends the Member the initial transition letter, along with a STAR+PLUS enrollment packet (including the STAR+PLUS MCO list and comparison chart). The letter serves as an introduction to the process and advises the Member that the Program Support Unit staff will contact them within 30 days to discuss the transition process and review the enrollment packet. Six months prior to the individual's 21st birthday, the HHSC Program Support Unit staff contacts the individual and reviews the STAR+PLUS Waiver enrollment packet discussed at the 9-month contact.

In addition, HHSC Program Support Unit staff explain the importance of selecting an MCO and a primary care physician within the next 30 days. Once the STAR+PLUS MCO is selected, the MCO has 45 days to assess the Member and submit a service plan to HHSC. To avoid gaps in services, HHSC staff works closely with the STAR+PLUS program MCO during the assessment and development phase. The STAR+PLUS MCO provides biweekly status updates to the HHSC Utilization Review Transition/High Needs Coordinator on all high needs transition cases.

Appendix B: Participant Access and Eligibility

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

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

No Cost Limit. The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Cost Limit in Excess of Institutional Costs. The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

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

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

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

HHSC refuses entrance to the waiver to an otherwise qualified individual when HHSC expects that the cost of home and community-based services furnished to the individual would exceed 50 percent of the institutional average. This waiver is intended to serve persons who can continue to live in their own or family home if the supports of their informal networks are augmented with basic services and supports through the waiver. Given the history of the population's service utilization, the cost limit of 50 percent of the institutional average allows flexibility for their service needs.

HHSC calculates nursing facility rates by Resource Utilization Groups due to differences in consumer acuity levels.

The individual cost limits are available in the STAR Kids handbook (<http://hhs.texas.gov/laws-regulations/handbooks>).

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:

The limit is 50 percent of the institutional average.

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 waiver is designed to provide services and supports that are essential to allow members to continue to reside in their own home, foster home, or in their family home. Members are anticipated to have an established natural support system. The waiver provides supports needed beyond what is provided through the state plan and the member's natural support system.

Using a person-centered planning approach, a service plan is developed during the enrollment process by: the applicant or the applicant's legally authorized representative or medical consentor, the MCO service coordinator, and any other person who participates in the applicant's care, such as a primary caregiver, a service provider, a representative of the school system, or other third-party resource. The service plan must include a description of the current natural supports and non-waiver services that will be available to the applicant if enrolled in the waiver and a description of the waiver services and supports required for the applicant to continue living in his or her own home, foster home, or family home. The applicant or the applicant's legally authorized representative or medical consentor has the opportunity to review recommended services and make choices regarding the service plan. The MCO service coordinator informs the applicant or the applicant's legally authorized representative or medical consentor of the consequences of service choices, including cost implications. The applicant or the applicant's legally authorized representative or medical consentor, the applicant's practitioner, and the MCO service coordinator must sign the completed service plan form prior to implementation and certify that the waiver services are necessary as an alternative to institutionalization and appropriate to meet the needs of the waiver Member in the community.

The applicant/Member or the applicant's/Member's legally authorized representative or medical consentor may request an HHSC fair hearing or an MCO internal appeal to dispute the denial or reduction of services, including a denial because the service plan exceeds the individual cost limit, in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A (relating to uniform fair hearing rules). The procedures for an HHSC fair hearing are provided within the waiver application in Appendix F, Participant Rights. The applicant/Member, or the applicant's/Member's legally authorized representative, also have the option to request an external medical review for an MCO service denial. If an external medical review is requested a Member makes a request at the same time as a request for the fair hearing .

The applicant/Member or the applicant's/Member's legally authorized representative or medical consentor is also informed of and given the opportunity to request administrative and judicial review of an HHSC fair hearing final administrative decision in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter R.

- 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:

A Member must have an service plan at a cost within the cost limit (50 percent of institutional average). For MDCP Members with needs that exceed the cost limit, HHSC has a process to ensure their needs are met. The process includes maximizing the use of State Plan services; examining third-party resources; possible transition to another waiver; or institutional services.

The applicant/Member or the applicant's/Member's legally authorized representative or medical consentor will be informed of and given the opportunity to request an HHSC fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A (relating to uniform fair hearing rules), if HHSC proposes to terminate the Member's waiver eligibility. The procedures for a HHSC fair hearing are provided within the waiver application in Appendix F, Participant Rights.

The applicant/Member or the applicant's/Member's legally authorized representative or medical consentor will also be informed of and given the opportunity to request administrative and judicial review of an HHSC fair hearing decision in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter R (relating to judicial and administrative review of hearings), if HHSC proposes to terminate the applicant/Member's eligibility.

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	6796
Year 2	6796
Year 3	6796
Year 4	6796
Year 5	6796

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	6281
Year 2	6281

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 3	6281
Year 4	6281
Year 5	6281

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 program began in 2001. This program helps individuals living in a nursing facility return to the community to receive their long-term services and supports without having to be placed on a community services interest list. The target population is individuals who are residents of a nursing facility and are enrolled in Medicaid.

Describe how the amount of reserved capacity was determined:

HHSC 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	3802
Year 2	3802
Year 3	3802
Year 4	3802
Year 5	3802

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, all individuals who are under 21 years of age seeking waiver services are placed on an interest list. The individual must provide contact information when requesting to be placed on the interest list and must be a Texas resident to be eligible for entry into the program, with the exception of individuals who are temporarily out of the state due to military assignments. HHSC maintains an up-to-date interest list and assigns an individual's placement on the interest list chronologically. If an individual seeking entrance into MDCP meets the criteria for the reserved capacity group, they bypass the interest list as long as there are reserved waiver capacity slots available.

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, the applicant 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.

Periodically, HHSC prospectively forecasts whether MDCP slots will become available in future months. If HHSC forecasts that MDCP slots will be available, HHSC also estimates the number of individuals that will be able to enroll into MDCP by taking into account currently vacant slots as well as future slots anticipated to become vacant through attrition. Based upon the estimated number of slots that will become vacant as well as the historical "take up" rate (the percentage of individuals released from the MDCP interest list who ultimately are successfully enrolled in the program), HHSC authorizes a certain number of individuals to be "released" from the interest list and assessed for eligibility into the waiver. HHSC then contacts these individuals, in the order in which the individual's name appears on the interest list, and offers a slot for MDCP. If the individual wants to apply for MDCP, HHSC begins the MDCP eligibility determination process at least 30 days before an MDCP slot is forecasted to be available. If an individual is no longer interested in applying for MDCP or is determined ineligible for MDCP, HHSC removes the name of the individual from the interest list. An individual can be enrolled in other home and community-based services waivers and receiving services and also be on the MDCP interest list, and conversely, a Member can receive services through the MDCP waiver and also be on other home and community-based services waiver interest lists.

If the applicant is denied waiver enrollment, the applicant or the applicant's legally authorized representative will be informed of and given the opportunity to request an HHSC fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A (relating to uniform fair hearing rules). The procedures for an HHSC fair hearing are provided within the waiver application in Appendix F, Participant Rights. The applicant, the applicant's authorized representative, or the applicant's legally authorized representative, also have the option to request an external medical review for an MCO service denial. If an external medical review is requested a Member makes a request at the same time as a request for the fair hearing.

If an applicant is denied waiver enrollment based on diagnosis, medical necessity, or other functional eligibility requirements, an HHSC representative will notify the applicant that, if he or she chooses, his or her name will be placed on one or more other waiver program's interest lists, using his or her original MDCP interest list request date. If the applicant requests his or her name be added to another 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.

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:

- Title IV-E Adoption Assistance Children: 42 CFR 435.145
- Mandatory Parents and Caretakers Relatives 42 CFR 435.110
- Pregnant Women and Children 42 CFR 435.116
- Children 42 CFR 435.118
- Deemed Newborns: 1902(e)(4); 42 CFR 435.117
- Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA Increases Since April 1977: 1939(a)(5)(E); 42 CFR 435.135; Section 503 of P.L. 94-566
- Disabled Adult Children: 1634(c)
- Children with Non-IV-E Adoption Assistance: 1902(a)(10)(A)(ii)(VIII); 42 CFR 435.227
- Independent Foster Care Adolescents Under Age 21: 1902(a)(10)(A)(ii)(XVII); 1905(w)

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

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

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

Not Applicable

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

Specify:

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

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

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

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

i. Allowance for the personal needs of the waiver participant

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

Specify dollar amount:

If this amount changes, this item will be revised

The following formula is used to determine the needs allowance:

Specify formula:

Other

Specify:

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

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

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

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

Select one:

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

The state does not establish reasonable limits.

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

Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

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).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

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:

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:

The level of care (LOC) assessments are performed by registered nurses employed or contracted by the MCO . MMIS uses automated criteria to calculate the individual cost limit and preliminary MN in accordance with state-established criteria.

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

The educational and professional qualifications of persons performing initial evaluations of LOC for waiver applicants/members are: MCO nurse licensed by Texas Board of Nursing, with experience in pediatrics, and who have completed LOC training within the last two years.

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

The STAR Kids Screening and Assessment Instrument is used to complete level of care and medical necessity assessments.

For applicants/members to qualify for nursing facility care, applicants/members must meet the level of care and medical necessity criteria for nursing facility admission as specified in Title 26 of the Texas Administrative Code, Part 1, Chapter 554, Subchapter Y (relating to general qualifications for medical necessity determinations). For example, the applicant/member must demonstrate a medical condition of sufficient seriousness that the applicant's/member's needs exceed the routine care which may be given by an untrained person and requires licensed nurses' supervision, assessment, planning, and intervention. The applicant/member must also require medical or nursing services that are ordered by a physician; are dependent upon the applicant's/member's documented medical conditions; require the skills of a registered or licensed vocational nurse; are provided either by or under the supervision of a licensed nurse in an institutional setting; and are required on a regular basis. Factors assessed include:

- diagnoses;
- medications and dosage;
- physician's evaluation;
- rehabilitative services;
- activities of daily living;
- sensory/perception status;
- behavioral status; and
- therapeutic interventions.

The Medicaid Management Information System automatically reviews specific criteria on the assessments which have been determined by HHSC to meet the qualifications above. MDCP assessments that do not meet the auto approval algorithm are reviewed by HHSC staff. HHSC staff make the final determination of level of care.

- 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.

The STAR Kids Screening and Assessment Instrument is the assessment instrument used to establish medical necessity and level of care for MDCP. This instrument differs from the instrument used to establish institutional care under the state plan, the minimum data set. The key difference between the minimum data set and the STAR Kids Screening and Assessment Instrument is that the STAR Kids Screening and Assessment questions that are used to evaluate medical necessity are specifically geared toward a pediatric population, whereas the minimum data set was designed to evaluate medical necessity for a frail elderly population. The pediatric focus of this assessment allows HHSC staff to better evaluate medical necessity and make better decisions related to program eligibility for the MDCP applicant/member. It is notable that although the STAR Kids Screening and Assessment Instrument contains questions geared toward a pediatric population that are used to determine medical necessity, it retains the minimum data set items that are used to establish a Resource Utilization Group level, that are used in the minimum data set. In summary, the STAR Kids Screening and Assessment will provide better and more tailored evaluations of medical necessity for a nursing facility level of care for a pediatric population but will calculate the Resource Utilization Group levels that are used to determine an individual cost limit in precisely the same way as the minimum data set.

The STAR Kids Screening and Assessment Instrument has undergone thorough validity testing and reliability testing prior to implementation. Testing was conducted on a sample population by an independent contractor. Because the elements of the STAR Kids Screening and Assessment Instrument used to determine level of care are identical to those used in the minimum data set for nursing facilities, HHSC asserts that the STAR Kids Screening and Assessment Instrument is fully comparable to the minimum data set and other assessments used to determine a nursing facility level of care and cost limit.

- f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating

waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The MCO registered nurse completes the applicant's/Member's needs-based assessment. The needs-based assessment is submitted to HHSC's Medicaid Management Information System (MMIS), which is developed by and monitored for accurate results by HHSC, where the Resource Utilization Group value which determines the waiver budget amount, is automatically determined by an algorithm. HHSC has also developed and implemented automated criteria for level of care/medical necessity determination. When the MMIS is unable to automatically determine Level of Care/medical necessity, a manual review process is initiated. HHSC staff manually review the needs-based assessment and obtain additional information as needed for determination. HHSC makes the eligibility determination for both automated and manual reviews and communicates this decision to the applicant.

The eligibility determination process is the same for level of care initial evaluations and reevaluations.

- 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*):

Services are authorized for a 12-month period. The service plan is prorated for the annual period in which the Member turns 21. The MCO service coordinator must complete the reevaluation in a timely manner in order to ensure continued payment. Reevaluation is a key activity of service coordination. The MCO service coordinator must provide additional follow-up contacts throughout the plan year to ensure that services are being provided and to determine if reevaluations are completed as required and in a timely manner. The MCO must ensure payment is not provided if required reevaluations are not completed.

- 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:

HHSC's contracted Medicaid Management Information System maintains and records level of care and medical necessity evaluations and reevaluations in accordance with HHSC record retention requirements.

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 & percent of applicants accepting an offer to participate in the enrollment eligibility process & received a level of care evaluation. N: Number of applicants accepting an offer to participate, had reasonable indication services may be needed, and received a LOC evaluation. D: Number of applicants accepting an offer to participate and had reasonable indication services may be needed.

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: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- 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 Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>

Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- 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.

The MCO is responsible for ensuring timely and accurate medical necessity and level of care assessments. In addition to the HHSC fair hearing process for applicants/members, both providers and applicants/members may submit complaints related to the assessment process to the MCO and to HHSC. The MCO must use appropriately trained pediatric providers for the purposes of reviewing all medically-based provider complaints, such as provider complaints about the quality of care or services, utilization review or management, or claims processing. If an MCO fails to meet a performance expectation, standard, schedule, or other contract requirement, the managed care contracts give HHSC the authority to use a variety of remedies, including:

- Corrective action plan;
- Assessment of liquidated damages;
- Accelerated monitoring of the MCO, which includes more frequent or extensive monitoring by HHSC;
- Requiring additional financial or programmatic reports to be submitted by the MCO;
- Requiring additional or more detailed financial or programmatic audits or other reviews of the MCO;
- Terminating or declining to renew or extend an MCO contract;
- Appointing temporary MCO management under the circumstances described in 42 CFR §438.706;
- Suspending member enrollment;
- Withholding or recouping payment to the MCO; and
- Requiring forfeiture of all or part of the MCO's performance bond.

Medicaid Management Information System

On an ongoing basis, HHSC monitors the performance of HHSC's contracted Medicaid Management Information System using the same oversight processes employed for HHSC's other Medicaid contracts. For example, the contract contains a number of financial and quality incentives that provide a framework for analyzing performance. Failure of HHSC's contracted Medicaid Management Information System to achieve specific performance goals may result in HHSC remedies including:

- Corrective action plan;
- Assessment of liquidated damages;
- Accelerated monitoring of the MCO, which includes more frequent or extensive monitoring by HHSC;
- Requiring additional financial or programmatic reports to be submitted by the MCO;
- Requiring additional or more detailed financial or programmatic audits or other reviews of the MCO;
- Terminating or declining to renew or extend an MCO contract;
- Appointing temporary MCO management under the circumstances described in 42 CFR §438.706;
- Suspending member enrollment;
- Withholding or recouping payment to the MCO; and
- Requiring forfeiture of all or part of the MCO's performance bond.

ii. Remediation Data Aggregation

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

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>

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.

MDCP transitioned into managed care in November 2016, and HHSC has incorporated MDCP into its managed care quality strategy. In accordance with Title 42, CFR Section 438.340, the state must implement a quality strategy for assessing and improving the quality of healthcare and services provided through managed care. The state must review and update the quality strategy no less than every three years or whenever a significant changes is made. A significant change includes:

- Adding new populations to the managed care programs;
- Expanding managed care programs to new parts of the state; and
- Carving new services into the managed care programs.

The managed care quality strategy was last updated in July 2021, and can be accessed on the HHSC website at <https://www.hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/tx-managed-care-quality-strategy-july-2021.pdf>

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).

The MCO service coordinator informs each applicant/member or the applicant's/member's legally authorized representative or medical consentor of any alternatives available, including the choice of institutional care versus home and community-based waiver services at the time of the initial assessment and reevaluation, and when there is a provider change.

The service plan form has an attestation related to freedom of choice. During development of the initial service plan and annually thereafter, the applicant/member or the applicant's/member's legally authorized representative or medical consentor must sign the service plan to indicate he or she freely chooses waiver services over institutional care. The MCO service coordinator also addresses living arrangements and choice of providers as well as available third-party resources during the assessment. All applicants/members or the applicant's/member's legally authorized representative or medical consentor have the right to appeal any decision they believe is detrimental to the applicant's/member's freedom of choice.

The MCO service coordinator and the Home and Community Support Services Agency are required to retain copies of the service plan with the freedom of choice section in the member's case record. The service plan contains acknowledgement and signature related to freedom of choice provided by the the applicant/member or the applicant's/member's legally authorized representative or medical consentor.

- 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 MCO service coordinator retains a copy of the service plan with the freedom of choice section according to HHSC's records retention requirements.

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):

To support the beneficiary's experience receiving medical assistance and long term services and supports in a managed care environment, HHSC maintains a system of consumer supports independent from the managed care plans to assist enrollees in understanding the coverage model and in the resolution of problems regarding services, coverage, access, and rights. The Independent Consumer Supports system is accessible through multiple entryways (e.g., phone, internet, office) and has the capacity to reach out to beneficiaries and/or authorized representatives through various means (mail, phone, in person), as appropriate.

The Independent Consumer Supports system is available to assist beneficiaries in navigating and accessing covered health care services and supports. Where an individual is enrolling in a new delivery system, the services of this system help individuals understand their choices and resolve problems and concerns that may arise between the individual and a provider/payer. The following list encompasses the system's scope of activity:

1. The system offers beneficiaries support in the pre-enrollment stage, such as unbiased health plan choice counseling and general program-related information.
2. The system serves as an access point for complaints and concerns about health plan enrollment, access to services, and other related matters.
3. The system is available to help enrollees understand the hearing, grievance, and appeal rights and processes within the health plan as well as the fair hearing, grievance, and appeal rights and processes available at the state level and assist them through the process if needed/requested.

The Independent Consumer Supports system include individuals who are knowledgeable about HHSC's Medicaid programs; beneficiary protections and rights under Medicaid managed care arrangements; and the health and service needs of persons with complex needs, including those with a chronic condition, disability, and cognitive or behavioral needs. In addition, the Independent Consumer Supports System ensures that its services are delivered in a culturally competent manner and are accessible to applicants/members with limited English proficiency.

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	Respite		
Statutory Service	Supported Employment		
Supports for Participant Direction	Financial Management Services		
Other Service	Adaptive Aids		
Other Service	Employment Assistance		
Other Service	Flexible Family Support Services		
Other Service	Minor Home Modifications		
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:

Respite

Alternate Service Title (if any):

Respite

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09011 respite, out-of-home

Category 2:

09 Caregiver Support

Sub-Category 2:

09012 respite, in-home

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Respite is a service that provides temporary relief to the primary caregiver of a waiver Member during times when the Member's primary caregiver would normally provide care. All respite settings must be located within the State of Texas. Respite may be provide in: a Member's home or place of residence.

Out of home respite may be provided in:

- A licensed child day care facility, hospital, special care facility or camp;
- Agency foster home (as defined in the Human Resources Code, §42.002);
- Medicaid certified hospital;
- Medicaid certified nursing facility;
- Specialty Care Facilities (an institution or establishment that provides a continuum of nursing or medical care or services primarily to persons with acquired immune deficiency syndrome or other terminal illnesses. The term includes a special residential care facility);
- Host Family's residence (must be licensed as an agency foster home by the Texas Department of Family and Protective Services or verified by a child-placing agency that is licensed by the Texas Department of Family and Protective Services);
- Accredited camps; and
- Licensed child care settings.

Federal financial participation is claimed for room and board for respite services delivered in the following settings:

- Medicaid certified hospitals;
- Medicaid certified nursing facilities;
- Specialty Care Facilities;
- Accredited camps;
- The host family's residence; and
- Licensed childcare settings.

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

Respite may not be provided in a setting in which identical services are already being provided.

Facility-based respite is limited to 29 days per service plan period. The 29-day limit applies to the total number of days a member receives respite in a hospital or nursing facility.

The Member may request to exceed the 29-day facility-based respite limit. Within five days of the request to exceed the 29-day limit, the MCO must review the Member's needs and the primary caregiver's ability to meet those needs and determine if the request falls within the respite criteria. The MCO must ensure there is no danger to the Member's health and welfare.

This service may not be provided at the same time the following services are provided:

- flexible family support services; or
- employment assistance or supported employment with the individual present.

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	Special Care Facilities (Out of Home Respite)

Provider Category	Provider Type Title
Individual	Participant Employer Direct Service Provider
Agency	Camp (Out of Home Respite)
Individual	Host Family
Agency	Hospital (Out of Home Respite)
Agency	Nursing Facility (Out of Home Respite)
Agency	Child Day Care Facilities (Out of Home Respite)

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):

Texas Administrative Code Title 26, Part 1, Chapter 558

Certificate (specify):

Other Standard (specify):

The Home and Community Support Services Agency must employ a respite attendant who must meet the following requirements:

- Be at least 18 years of age;
- Have a high school diploma, certificate of high school equivalency (GED credentials), or documentation of a proficiency evaluation of experience and competence to perform job tasks;
- Be trained in CPR and first-aid;
- Pass criminal history checks;
- Not be on the Employee Misconduct Registry or Nurse Aide Registry;
- Not be on the state and federal lists of excluded persons and entities;
- Be familiar with Member's specific tasks;
- Not be the Member's spouse; and
- Must not be the caregiver whether or not the provider is related to the Member.

Skilled care must be performed by a registered nurse or licensed vocational nurse or delegated by a registered nurse. Non-licensed individuals providing delegated skilled tasks must be supervised by a registered nurse. Any delegated skilled care must meet the requirements of the Texas Nursing Practice Act.

Verification of Provider Qualifications

Entity Responsible for Verification:

The MCO verifies provider agency qualifications for Home and Community Support Services Agencies.

Frequency of Verification:

The MCO verifies provider qualifications prior to awarding a provider agreement and every three years thereafter.

HHSC Long-Term Care Regulation licenses Home and Community Support Services Agencies and is responsible for ensuring that providers meet licensing qualifications. HHSC Long-Term Care Regulation conducts a survey after a Home and Community Support Services Agency receives an initial license and notifies HHSC of readiness for an initial survey, within 18 months after conducting an initial survey and at least every 36 months thereafter according to Title 26 of the Texas Administrative Code Part 1, Chapter 558 (relating to licensing standards for Home and Community Support Services Agencies). Home and Community Support Services Agencies are inspected to ensure compliance with licensing requirements. The inspection includes observation of the care of a sample of individuals. Licenses are valid for two years. Complaint investigations involving alleged licensing violations are conducted according to the priority of the allegations.

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

Appendix C: Participant Services

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

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

Provider Category:**Provider Type:****Provider Qualifications****License** (*specify*):

Department of State Health Services licenses special care facilities. The MCO verifies provider agencies are licensed.

Registered nurses and licensed vocational nurses providing services in a special care facility must have current licenses under Occupations Code, Chapter 301.

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

The service provider of the respite service component must be at least 18 years of age. The service provider must have a high school diploma or certificate of high school equivalency (GED credentials) and documentation of a proficiency evaluation of experience and competence to perform job tasks, including the ability to provide the required services as needed by the member.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Frequency of Verification:

Department of State Health Services is responsible for ensuring compliance with licensure. This is done one time within the first two years of the license, and thereafter it is done every other year, or more often if there is a complaint.

Appendix C: Participant Services

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

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

Provider Category:**Provider Type:**

Provider Qualifications**License** (*specify*):

Registered nurses and licensed vocational nurses must hold a current license from the Texas Board of Nursing.

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

The service provider of the respite service component must be:

1. At least 18 years of age;
2. Have a high school diploma, certificate of high school equivalency (GED credentials), or documentation of a proficiency evaluation of experience and competence to perform job tasks;
3. Be trained in CPR and first-aid;
4. Pass criminal history checks;
5. Not be on the Employee Misconduct Registry or Nurse Aide Registry;
6. Not be on the state and federal lists of excluded persons and entities;
7. Be familiar with Member's specific tasks;
8. Not be the Member's spouse; and
9. Must not be the caregiver whether or not the provider is related to the Member.

Skilled care must be performed by a registered nurse or licensed vocational nurse or delegated by a registered nurse. Non-licensed individuals providing delegated skilled tasks must be supervised by a registered nurse. Any delegated skilled care must meet the requirements of the Texas Nursing Practice Act.

Verification of Provider Qualifications**Entity Responsible for Verification:**

The participant employer or legally authorized representative and the Financial Management Services Agency verify employee qualifications.

Frequency of Verification:

The participant employer or legally authorized representative and the Financial Management Services Agency verify that each potential service provider meets the required qualifications prior to hiring.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite****Provider Category:**

Agency

Provider Type:

Camp (Out of Home Respite)

Provider Qualifications**License** (*specify*):

Department of State Health Services Title 25 of the Texas Administrative Code, Part 1, Chapter 265, Subchapter B.

Certificate (*specify*):

Other Standard (*specify*):

The provider of the respite service component must be at least 18 years of age. The provider must have a high school diploma or certificate of high school equivalency (GED credentials) and documentation of a proficiency evaluation of experience and competence to perform job tasks, including ability to provide the required services as needed by the member.

Registered nurses and licensed vocational nurses must have current licenses under Occupations Code, Chapter 301.

These camps are accredited by the American Camping Association.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of State Health Services licenses camps. The MCO verifies provider agencies are licensed by Department of State Health Services and accredited by the American Camping Association.

Frequency of Verification:

Department of State Health Services is responsible for ensuring compliance with licensure and are accredited by the American Camping Association. This is done annually or more often if there is a complaint.

The MCO verifies provider agencies are licensed and accredited upon initial contracting and every three years thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Individual

Provider Type:

Host Family

Provider Qualifications

License (*specify*):

Department of Family and Protective Services Title 40, Texas Administrative Code, Part 19, Chapter 745

Certificate (*specify*):

Other Standard (*specify*):

The service provider of the respite service component must be at least 18 years of age and have a high school diploma or certificate of high school equivalency (GED credentials). The host family must not provide services in its residence to more than four persons unrelated to the member at one time.

The host family must ensure that the member participates in age-appropriate community activities and the host family home environment is healthy and safe for the member.

The host family must provide services in a residence that the host family owns or leases. The residence must be a typical residence in the neighborhood and must meet the needs of the member.

Verification of Provider Qualifications

Entity Responsible for Verification:

The MCO verifies the host family provider qualifications.

Frequency of Verification:

During the initial contracting and credentialing process and every three years thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Hospital (Out of Home Respite)

Provider Qualifications

License (specify):

State license deemed via Medicare participation Department of State Health Services Title 25 of the Texas Administrative Code, Part 1, Chapter 133.

Certificate (specify):

Other Standard (specify):

The provider of the respite service component must be at least 18 years of age. The provider must have a high school diploma or certificate of high school equivalency (GED credentials) and documentation of a proficiency evaluation of experience and competence to perform job tasks, including ability to provide the required services as needed by the member.

Registered nurses and licensed vocational nurses must have current licenses under Occupations Code, Chapter 301.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of State Health Services licenses hospitals. MCO verifies provider agencies are licensed.

Frequency of Verification:

The MCO verifies provider agencies are licensed upon initial contracting and every three years thereafter. Department of State Health Services is responsible for ensuring compliance with licensure. The Department of State Health Services surveys one time in the first two years of the license, and thereafter, based upon complaints. For accredited hospitals due to Medicare, HHSC does a full survey within a month if the hospital gives up or loses its accreditation.

If they are accredited by the Joint Commission, the Joint Commission surveys once every 36 – 39 months.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Nursing Facility (Out of Home Respite)

Provider Qualifications

License (*specify*):

Texas Administrative Code Title 26, Part 1, Chapter 554

Certificate (*specify*):

Other Standard (*specify*):

The nursing facility respite provider must employ staff who must:

1. Be at least 18 years of age;
2. Have a high school diploma or certificate of high school equivalency (GED credentials) and documentation of a proficiency evaluation of experience and competence to perform job tasks;
3. Be trained in CPR and first-aid;
4. Pass criminal history checks;
5. Not be on the Employee Misconduct Registry or Nurse Aide Registry list;
6. Be familiar with the Member's tasks; and
7. Not be on the state and federal lists of excluded individuals and entities.

Verification of Provider Qualifications

Entity Responsible for Verification:

HHSC licenses nursing facilities. MCO verifies provider agencies are licensed.

Frequency of Verification:

HHSC Long-Term Care Regulation licenses nursing facilities and is responsible for ensuring that facilities meet licensing qualifications. Nursing facilities are surveyed according to Title 26 of the Texas Administrative Code, Part 1, Chapter 554, requiring two unannounced inspections per two-year licensing period of each institution licensed under Health and Safety Code Chapter 242. Nursing facilities are inspected to ensure compliance with licensing requirements. The inspection includes observation of the care of a sample of individuals.

The MCO verifies provider agencies are licensed upon initial contracting and every three years thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Child Day Care Facilities (Out of Home Respite)

Provider Qualifications

License (*specify*):

Department of Family and Protective Services Title 40 of the Texas Administrative Code, Part 19, Chapter 745

Certificate (*specify*):

Other Standard (*specify*):

The service provider of the respite service component must be at least 18 years of age. The service provider must have a high school diploma or certificate of high school equivalency (GED credentials) and documentation of a proficiency evaluation of experience and competence to perform job tasks, including the ability to provide the required services as needed by the Member.

Registered nurses and licensed vocational nurses must have current licenses under Title 3 of the Occupations Code, Chapter 301.

Child Day Care Facilities must be licensed under Title 40 of the Texas Administrative Code, Part 19, Chapter 745 which states that children with special health care needs must receive the care recommended by a health-care professional or qualified professional affiliated with the local school district or early childhood intervention program.

Verification of Provider Qualifications

Entity Responsible for Verification:

The MCO verifies provider agency qualifications for Day Care Facilities.

Frequency of Verification:

During the initial contracting and credentialing process and every three years thereafter.

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:

03 Supported Employment

Sub-Category 1:

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).

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 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 cannot be provided at the same time as employment assistance or flexible family support services.

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or 2. Payments that are passed through to users of supported employment services.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Participant Employer Direct Service Provider
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: Supported Employment

Provider Category:

Individual

Provider Type:

Participant Employer Direct Service Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

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

Option 1:

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

Option 2:

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

Option 3:

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

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

The Home and Community Support Service Agency ensures training of personnel as outlined in Title 26 of the Texas Administrative Code, Chapter 558, §558.245(a) and (b).

Verification of Provider Qualifications

Entity Responsible for Verification:

The participant employer and the Financial Management Service Agency.

Frequency of Verification:

The participant employer and the Financial Management Service Agency verify that each potential service provider meets the required qualifications prior to hiring.

Verification of Financial Management Service Agency qualifications is completed by the MCO as part of the initial contracting and credentialing process and annually thereafter.

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*):

Home and Community Support Services Agency Licensure per 26 Texas Administrative Code, Part I, Chapter 558

Certificate (*specify*):

Other Standard (*specify*):

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

Option 1:

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

Option 2:

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

Option 3:

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

Ensure training of personnel as outlined in Title 26 of the Texas Administrative Code, Part 1, Chapter 558, §558.245(a) and (b).

Verification of Provider Qualifications

Entity Responsible for Verification:

The MCO verifies provider agency qualifications for home and community support services agencies.

Frequency of Verification:

The MCO verifies provider agency qualifications prior to awarding a provider agreement and annually thereafter.

MCO staff responds to complaints received against a contractor for failure to maintain provider qualifications. The MCO 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 Long-Term Care Regulation licenses Home and Community Support Services Agencies and is responsible for ensuring that provider agencies meet licensing qualifications. HHSC Long-Term Care Regulation conducts a survey: after a Home and Community Support Services Agency receives an initial license and establishes readiness for an initial survey; within 18 months after conducting an initial survey and at least every 36 months thereafter according to Title 26 of the Texas Administrative Code, Part 1, Chapter 558 (relating to licensing standards for Home and Community Support Services Agencies). Home and Community Support Services Agencies are inspected to ensure compliance with licensing requirements. The inspection includes observation of the care of a sample of members. Licenses are valid for two years. Complaint investigations involving alleged licensing violations are conducted according to the priority of the allegations.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:

Alternate Service Title (if any):

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):**Category 4:**

Sub-Category 4:

Financial management services provides assistance to members with managing funds associated with the services elected for self-direction. The service includes initial orientation and ongoing training related to responsibilities of being an employer and adhering to legal requirements for employers. The financial management services provider, referred to as the Financial Management Services Agency, also serves as the participant's employer-agent, which is the Internal Revenue Service's (IRS) designation of the entity responsible for IRS related responsibilities on behalf of the participant. As the employer-agent the Financial Management Service Agency also:

- Files required forms and reports to the Texas Workforce Commission;
- Provides assistance in the development, monitoring and revision of the member's budget;
- Provides information about recruiting, hiring and firing staff including identifying the need for special skills and determining staff duties and schedule;
- Provides guidance on supervision and evaluation of staff performance;
- Provides assistance in determining staff wages and benefits subject to HHSC limits, assistance in hiring by verifying employee's citizenship status and qualifications, and conducting required criminal background and registry checks;
- Verifies and maintains documentation of employee qualifications, including citizenship status, and documentation of services delivered;
- Collects timesheets, processes timesheets of employees, processes payroll and payables and makes withholdings for, and payment of, applicable federal, state, and local employment-related taxes;
- Tracks disbursement of funds and provides quarterly written reports to the member of all expenditures and the status of the member's consumer directed services budget; and
- Maintains a separate account for each participant's budget.

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 Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Financial Management Services Agency

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 and are required to hold a Medicaid provider agreement with HHSC.

Prior to contracting with the MCO to provide financial management services, a Financial Management Service Agency must comply with the requirements for delivery of financial management services, including attending all mandatory training provided or authorized by HHSC. Topics covered in the training session include: contracting requirements and procedures; Financial Management Service Agency responsibilities; consumer/employer responsibilities; MCO service coordinators' responsibilities; enrollment, transfer, suspension, and termination of the consumer directed services option; employer (Member) 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 70-6, 1970-1 C.B. 420 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 rules for the consumer directed services option, located at Title 40 of the Texas Administrative Code, Part 1, Chapter 41 (relating to consumer directed services option), require Financial Management Services Agencies to act as vendor fiscal/employer agents along with describing responsibilities such as the revocation of IRS Form 2678 if the individual terminates the consumer directed services option or transfers to another Financial Management Service Agency.

The Financial Management Services Agency must not be the member's legal guardian, the spouse of the member's legal guardian, the member's designated representative, or the spouse of the member.

Verification of Provider Qualifications

Entity Responsible for Verification:

The MCO

Frequency of Verification:

Verification of financial management services agency qualifications is completed by the MCO as part of the initial contracting and credentialing process, and every three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adaptive Aids

HCBS Taxonomy:

Category 1:

Sub-Category 1:

14 Equipment, Technology, and Modifications

14031 equipment and technology

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

14 Equipment, Technology, and Modifications

14032 supplies

Category 3:**Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Adaptive aids are devices necessary to treat, rehabilitate, prevent or compensate for conditions resulting in disability or loss of function and enable members to:

- perform activities of daily living; or
- control the environment in which they live.

Adaptive aids are available through this waiver program only after benefits available through Medicare, Medicaid, Early Periodic Screening, Diagnostic or Treatment program, or other third-party resources have been exhausted. Items reimbursed with waiver funds are only accessible for items not covered under the state plan.

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

The annual cost limit of this service is \$4,000 per waiver plan year. HHSC does not make exceptions to the cost limit. Health and safety of the individual is ensured through the use of non-waiver services, the Medicaid State Plan, and the Comprehensive Care Program, which is administered through Early Periodic, Screening, Diagnosis and Treatment. The MCO service coordinator and HHSC regional nurse approves the lesser of either the actual cost or the cost limit for items that meet the waiver service definition. The MCO service coordinator, member, and the member's legally authorized representative review all resources available to the member to contribute to the cost for items beyond the service limit.

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.

If HHSC denies a request for adaptive aids, HHSC offers the member a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A (relating to uniform fair hearing rules). The member is also informed of and given the opportunity to request administrative and judicial review of a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter R (relating to judicial and administrative review of hearings). The member, the member's authorized representative, or the member's legally authorized representative, also have the option to request an external medical review for an MCO service denial. If an external medical review is requested a member makes a request at the same time as a request for the fair hearing.

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	Participant Employer Direct Service Provider
Agency	Durable Medical Equipment Supplier

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adaptive Aids

Provider Category:

Individual

Provider Type:

Participant Employer Direct Service Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The participant employer and the Financial Management Services Agency verify employee qualifications.

Frequency of Verification:

The consumer directed services employer and the Financial Management Services Agency verify that each potential service provider meets the required qualifications prior to hiring.

Verification of Financial Management Service Agency qualifications is completed by the MCO as part of the initial contracting and credentialing process and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adaptive Aids

Provider Category:

Agency

Provider Type:

Durable Medical Equipment Supplier

Provider Qualifications

License (specify):

Licensed by Department of State Health Services as a durable medical equipment provider

Certificate (specify):

Other Standard (specify):

Be a durable medical equipment supplier or be a manufacturer of items not supplied through durable medical equipment suppliers.

Verification of Provider Qualifications

Entity Responsible for Verification:

MCO

Frequency of Verification:

The MCO verifies provider agencies are licensed upon execution of the initial contract and every three years thereafter.

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:

03 Supported Employment

Category 2:

03 Supported Employment

Category 3:

Sub-Category 1:

03030 career planning

Sub-Category 2:

03010 job development

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Employment Assistance is assistance provided to a member to help the member locate paid employment in the community.

Employment assistance includes:

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

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

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

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	Participant Employer Direct Service Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Employment Assistance

Provider Category:

Agency

Provider Type:

Home and Community Support Services Agency

Provider Qualifications

License (specify):

Home and Community Support Services Agency Licensure per Title 26 of the Texas Administrative Code, Part 1, Chapter 558

Certificate (specify):

Other Standard (*specify*):

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

Option 1:

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

Option 2:

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

Option 3:

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

Ensure training of personnel as outlined in Texas Administrative Code, Chapter 558, subsection 558.245(a)&(b).

Verification of Provider Qualifications**Entity Responsible for Verification:**

The MCO verifies provider agency qualifications for Home and Community Support Services Agencies.

Frequency of Verification:

The MCO verifies provider agency qualifications prior to awarding a provider agreement and annually thereafter.

MCO staff responds to complaints received against a contractor for failure to maintain provider agency qualifications. The MCO 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 Long-Term Care Regulation licenses Home and Community Support Services Agencies and is responsible for ensuring that providers meet licensing qualifications. HHSC Long-Term Care Regulation conducts a survey after a Home and Community Support Services Agency receives an initial license and notifies HHSC of readiness for an initial survey, within 18 months after conducting an initial survey and at least every 36 months thereafter according to Title 26 of the Texas Administrative Code Part 1, Chapter 558 (relating to licensing standards for Home and Community Support Services Agencies). Home and Community Support Services Agencies are inspected to ensure compliance with licensing requirements. The inspection includes observation of the care of a sample of individuals. Licenses are valid for two years. Complaint investigations involving alleged licensing violations are conducted according to the priority of the allegations.

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:

Participant Employer Direct Service Provider

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

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

Option 1:

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

Option 2:

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

Option 3:

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

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

Ensure training of personnel as outlined in Title 26 of the Texas Administrative Code, Chapter 558, §558.245(a) and (b).

Verification of Provider Qualifications**Entity Responsible for Verification:**

The participant employer or legally authorized representative and Financial Management Services Agency

The MCO

Frequency of Verification:

The participant employer or legally authorized representative and the Financial Management Services Agency verify that each potential service provider meets the required qualifications prior to hiring.

Verification of Financial Management Services Agency qualifications is completed by the MCO as part of the initial contracting and credentialing process and annually thereafter.

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:

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:

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):**Category 4:**

Sub-Category 4:

Flexible family support services promote community inclusion in typical child/youth activities through the enhancement of natural supports and systems and through recognition that these supports may vary from setting to setting, from day to day, from moment to moment, hence the need for a diverse provider base. To accomplish this, flexible family support services service providers may provide personal care supports for activities of daily livings and instrumental activities of daily living, skilled care, non-skilled care and delegated skilled care supports to support inclusion. This service may be reimbursed if part of an approved service plan and if delivered in a setting where provision of such supports is not already required or included as a matter of practice.

Flexible family support services are a diverse array of approved, individualized, disability-related services that support independent living, participation in community-based child care, and participation in post-secondary education.

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

Flexible family support services may be used only when the primary caregiver is working, attending job training, or attending school. Flexible family support services may not be used in place of child care that is paid for by the primary caregiver.

This service may not be provided at the same time:

respite, employment assistance, or supported employment are provided with the individual present.

The services under the Medically Dependent Children Program are limited to additional services not otherwise covered under the state plan, including EPSDT, 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
Individual	Participant Employer 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: Flexible Family Support Services

Provider Category:

Individual

Provider Type:

Participant Employer Direct Service Provider

Provider Qualifications

License (specify):

Registered nurses and licensed vocational nurses must hold a current license through the Texas Board of Nursing.

Certificate (specify):

Other Standard (specify):

The service provider of the flexible family support service component must be:

1. At least 18 years of age;
2. Have a high school diploma, certificate of high school equivalency (GED credentials), or documentation of a proficiency evaluation of experience and competence to perform job tasks;
3. Be trained in CPR and first-aid;
4. Pass criminal history checks;
5. Not be on the Employee Misconduct Registry or Nurse Aide Registry;
6. Not be on the state and federal lists of excluded persons and entities;
7. Be familiar with the Member's specific tasks;
8. Not be the Member's spouse; and
9. Must not be the caregiver whether or not the provider is related to the Member.

Verification of Provider Qualifications

Entity Responsible for Verification:

The consumer directed services employer and Financial Management Services Agency.

Frequency of Verification:

The consumer directed services employer and the Financial Management Services Agency verify that each potential service provider meets the required qualifications prior to hiring.

Verification of Financial Management Service Agency qualifications is completed by the MCO as part of the initial contracting and credentialing process and annually thereafter.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Flexible Family Support Services

Provider Category:

Agency

Provider Type:

Home and Community Support Services Agency

Provider Qualifications

License (specify):

Home and Community Support Services Agency - Title 26 of the Texas Administrative Code, Part 1, Chapter 558

Certificate (specify):

Other Standard (specify):

The Home and Community Support Services Agency must employ an attendant who must meet the following requirements:

- Be at least 18 years of age;
- Have a high school diploma, certificate of high school equivalency (GED credentials), or documentation of a proficiency evaluation of experience and competence to perform job tasks;
- Be trained in CPR and first-aid;
- Pass criminal history checks;
- Not be on the Employee Misconduct Registry or Nurse Aide Registry;
- Not be on the state and federal lists of excluded persons and entities;
- Be familiar with the Member's specific tasks;
- Not be the Member's spouse; and
- Must not be the caregiver whether or not the provider is related to the Member.

Skilled care must be performed by a registered nurse or licensed vocational nurse or delegated by a registered nurse. Non-licensed individuals providing delegated skilled tasks must be supervised by a registered nurse. Any delegated skilled care must meet the requirements of the Texas Nursing Practice Act.

Verification of Provider Qualifications

Entity Responsible for Verification:

The MCO verifies provider agency qualifications for Home and Community Support Services Agencies.

Frequency of Verification:

The MCO verifies provider agency qualifications prior to awarding a provider agreement and annually thereafter.

HHSC licenses Home and Community Support Services Agencies and is responsible for ensuring that providers meet licensing qualifications. HHSC Long-Term Care Regulation conducts a survey after: a Home and Community Support Services Agency receives an initial license and establishes readiness for an initial survey; within 18 months after conducting an initial survey; and at least every 36 months thereafter according to Title 26 of the Texas Administrative Code, Part 1, Chapter 558 (relating to licensing standards for Home and Community Support Services Agencies). Home and Community Support Services Agencies are inspected to ensure compliance with licensing requirements. The inspection includes observation of the care of a sample of individuals. Licenses are valid for two years. Complaint investigations involving alleged licensing violations are conducted according to the priority of the allegations.

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

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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:

14 Equipment, Technology, and Modifications

Sub-Category 1:

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 necessary to ensure the health, welfare, and safety of the member, or to enable the member to function with greater independence in his or her home.

All minor home modifications must be authorized by MCO staff.

Covered modifications are limited to:

1. The purchase and installation of permanent and portable ramps not covered by other sources;
2. The widening of doorways;
3. Modifications of bathroom facilities; and
4. Modifications related to the approved installation or modification of ramps, doorways, or bathroom facilities.

All services shall be provided in accordance with applicable state and local building codes.

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

Modifications must be for existing structures and must not increase the square footage of the dwelling. The minor home modification lifetime limit is \$7,500 per member, and \$300 yearly for repairs. The limit on the specification fee is \$200. The MCO does not make exceptions to the cost limit. Health and safety of the member is ensured through the use of non-waiver services, the Medicaid State Plan, and the Comprehensive Care Program, which is administered through Early and Periodic Screening, Diagnosis and Treatment. The MCO Service Coordinator and HHSC regional nurse approve the lesser of either the actual cost or the cost limit for items that meet the waiver service definition. The MCO Service coordinator, member, and the member's legally authorized representative or medical consentor review all resources available to the member to contribute to the cost for items beyond the service limit.

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	Contractor
Individual	Participant Employer Direct Service Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Minor Home Modifications

Provider Category:

Individual

Provider Type:

Contractor

Provider Qualifications

License (specify):

Licensed where applicable.

Certificate (specify):

Certified where applicable.

Other Standard (specify):

Must comply with city building codes; and must comply with American with Disabilities Act standards

Verification of Provider Qualifications

Entity Responsible for Verification:

The MCO

Frequency of Verification:

The MCO verifies provider agencies comply with all applicable provider requirements for this provider type upon initial contract.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Minor Home Modifications

Provider Category:

Individual

Provider Type:

Participant Employer Direct Service Provider

Provider Qualifications

License (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):

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

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

Verification of Provider Qualifications**Entity Responsible for Verification:**

The participant employer and the Financial Management Services Agency verify employee qualifications.

Frequency of Verification:

The consumer directed services employer and the Financial Management Services Agency verify that each potential service provider meets the required qualifications prior to hiring.

Verification of Financial Management Service Agency qualifications is completed by the MCO as part of the initial contracting and credentialing process and annually thereafter.

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:**

16 Community Transition Services

Sub-Category 1:

16010 community transition services

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

☐
Category 3:**Sub-Category 3:**

☐
Service Definition (Scope):**Category 4:****Sub-Category 4:**

☐

Transition assistance services pays for non-recurring, set-up expenses for members transitioning from a nursing facility to the community.

Allowable expenses are those necessary to enable members 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, and bed and bath linens;
- Set-up fees or deposits for utility or service access, including telephone, electricity, gas, and water;
- Services necessary for the members' health and welfare such as pest eradication and one-time cleaning prior to occupancy; and
- Activities to assess need, arrange for, and procure needed resources (limited to up to 180 consecutive days prior to discharge from the nursing facility).

Transition assistance services funding is authorized for expenses that are:

- Reasonable and necessary as determined through the service plan development process; and
- Clearly identified in the service plan and members are unable to meet such expenses or the services cannot be obtained from other sources.

To be eligible to receive transition assistance services, the member must:

1. Be a resident of a Texas nursing facility;
2. Be Medicaid eligible; and
3. Be determined eligible for waiver services

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

Transition assistance services are one-time initial expenses that are required for setting up a household. An individual transitioning from a nursing facility to the community is eligible to receive up to \$2,500 in transition assistance services. There are no exceptions to this cost limit.

Room and board are not allowable expenses. Transition assistance services does 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.

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	Transition Assistance Services provider

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:

Transition Assistance Services provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The transition assistance service provider must comply with the requirements for delivery of transition assistance services, which include requirements such as allowable purchases, costs limits, and time frames for delivery. Transition assistance services providers must demonstrate knowledge of and history in successfully serving individuals who require home and community-based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The MCO

Frequency of Verification:

The MCO verifies provider agencies are in compliance with the requirements for service delivery upon initial contracting and every three years thereafter.

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:

MCO service coordinators conduct the case management functions.

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):

Provider agencies, Financial Management Services Agencies, and Members serving as consumer directed services employers must comply with the following HHSC requirements:

(1) MDCP provider agencies, Financial Management Services Agencies and consumer directed services employers must comply with the provisions of Texas Health and Safety Code, Chapter 250 (relating to the nurse aide registry and criminal history checks of employees and applicants for employment in certain facilities serving the elderly, persons with disabilities, or persons with terminal illness). This covers:

- obtaining criminal history information from the Department of Public Safety for applicants and employees of a facility or individual employer; volunteers with a facility; applicants/employees of a person or business that contracts with a facility; and students enrolled in an educational program or course of study who are at the facility for educational purposes.
- a mandate that a facility or individual employer may not employ an applicant and shall immediately discharge an employee if as a result of the criminal history check, the facility/individual employer determines that (i) the applicant has been convicted of a crime that bars employment or that the conviction is a contraindication to employment/direct contact with the Member using the consumer directed services option; (ii) the applicant is listed on the nurse aide registry; or (iii) the applicant is listed in the employee misconduct registry; and
- a mandate to perform an annual search of the nurse aide registry and the employee misconduct registry.

(2) Financial Management Services Agencies must also comply with Title 40 of the Texas Administrative Code, Part 1, Chapter 41, Subchapter C (relating to enrollment and responsibilities of Financial Management Services Agencies). This covers:

- Required criminal history checks of an applicant for employment and to be an employee (which must not be dated more than 30 calendar days before the date the applicant is hired and must be requested from the Department of Public Safety within two working days after the Financial Management Services Agency receives the request from the individual employer);
- Required initial and annual check of the nurse aide registry and the employee misconduct registry, and required initial and monthly check of the Health and Human Services Commission Office of Inspector General list of excluded individuals and entities and the Health and Human Services Commission Office of Inspector General excluded individuals/entities search; and
- A mandate that the Financial Management Services Agency must not approve of an applicant for employment or for a contract/vendor and must notify the individual employer that a service provider must be terminated immediately upon verification that the person is listed as revoked on the nurse aide registry or as unemployable in the employee misconduct registry, or listed on the Health and Human Service Commission Office of Inspector General list of excluded individuals and entities or the Health and Human Service Commission Office of Inspector General excluded individuals/entities search.

(3) Provider agencies, consumer directed services employers and Financial Management Services Agencies are also required to perform criminal history checks on contractors.

(4) Provider agencies and Members who participate in consumer directed services must comply with rules in Title 40 of the Texas Administrative Code, Part 1, Chapter 41 (relating to the consumer-directed services option). These rules require a criminal history check before a person can become a designated representative, an employee, or a contractor.

(5) Home and Community Support Service Agencies must comply with Title 26 of the Texas Administrative Code, Part 1, Chapter 558, Subchapter C (minimum standards for Home and Community Support Service Agencies), which includes:

- a. Employment restrictions related to Home and Community Support Service Agencies' managers with criminal convictions;
- b. A mandate to conduct criminal history checks for an unlicensed applicant for employment and an unlicensed employee;
- c. A mandate to conduct an initial search and an annual search thereafter of the nurse aide registry and the employee misconduct registry;
- d. A mandate to not employ and to immediately terminate employees when the Home and Community Support Service Agencies becomes aware that the employee is designated in the nurse aid registry or employee misconduct registry as unemployable or the criminal history check reveals a conviction of a crime that bars employment, or that

the home and community support service agencies has determined is a contraindication to employment;

e. A mandate regarding the requirement for criminal history checks and the nurse aid registry or employee misconduct registry for unlicensed volunteers; and

f. A mandate to maintain and provide documentation to HHSC upon request to demonstrate compliance with these requirements.

(6) Provider agencies are required to maintain documentation of the criminal history checks performed. Provider agencies, consumer-directed services employers, and financial management services agencies must keep a copy of the criminal history check for each designated representative, employer, and contractor.

(7) Each Member who chooses self direction must choose a Financial Management Services Agency that provides guidance and assistance to the Member with employer related tasks. As referenced above, the Financial Management Services Agency is required to have verification of the criminal history check prior to finalizing the hiring process on behalf of the consumer directed services employer.

(8) Provider agencies must screen all employees and contractors for exclusion prior to hiring or contracting, and monthly on an ongoing basis, by searching both the state and federal lists of excluded individuals and entities. If any exclusion is found, it must be immediately reported to the MCO.

Regulatory boards also conduct criminal background checks on licensed professionals as a part of the licensing process and ensure during surveys that licenses are appropriate. HHSC Long-Term Care Regulation staff that are involved in licensure, survey, and enforcement activities, monitor if criminal history checks are conducted as required.

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

No. The state does not conduct abuse registry screening.

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

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

Provider agencies, Financial Management Services Agencies and consumer directed services employers must comply with Texas Health and Safety Code, Chapters 250 and 253, by taking the following action regarding applicants, employees, and contractors:

(A) 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 having misappropriated an individual's property; and

(B) 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.

Provider agencies, consumer directed services employers, and Financial Management Services Agencies are also required to perform Nurse Aide Registry and Employee Misconduct Registry checks on contractors.

Provider agencies 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 be immediately reported.

Provider agencies, Financial Management Services Agencies and consumer directed services employers are required to maintain documentation of the Nurse Aide Registry and Employee Misconduct Registry checks performed.

Each Member who chooses self-direction must choose a Financial Management Services agency that provides guidance and assistance to the Member with employer related tasks. The Financial Management Services Agency is required to have verification of the registry checks prior to hiring on behalf of the Member. During on-site reviews of service providers and Financial Management Services Agencies, the MCO monitors for completion of required registry checks.

For volunteers, the Home and Community Support Services Agency providers must comply with Title 26 of the Texas Administrative Code, Part 1, Chapter 558, Subchapter C.

HHSC Long-Term Care Regulation staff that are involved in licensure, survey, and enforcement activities, as part of their reviews of provider agencies, monitor if Nurse Aide Registry and Employee Misconduct Registry checks are conducted as required.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of **extraordinary care** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Self-directed

Agency-operated

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

The state does not make payment to relatives/legal guardians for furnishing waiver services.

The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives/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.

HHSC allows a Member to select a relative or legal guardian, other than a spouse, to be their service provider for adaptive aids, flexible family support services, minor home modifications, employment assistance, supported employment, and respite. The relative or legal guardian must meet the requirements to provide waiver services and cannot be the parent or legal guardian of a Member who is under age 18. When participating in the consumer directed services option, the legally authorized representative or their spouse cannot provide waiver services.

The controls that are in place to ensure that payments are made only for services rendered are the same controls HHSC has for any of the waiver services. There are no additional service limits when a relative provides the services.

HHSC ensures waiver services provided by a relative are in the best interest of the member through the development of the service plan and the requirement for the MCO to approve the service plan.

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:

This waiver is operated concurrently with the Section 1115 Texas Healthcare Transformation and Quality Improvement Program (henceforth, the Transformation Waiver). Through the Transformation Waiver, HHSC has been granted authority to waive open enrollment of willing providers as provided in 42 CFR §431.51.

HHSC ensures compliance with 42 CFR §438.207. HHSC's contracts with MCOs providing MDCP waiver services require that these entities offer the full range of MDCP services in the amount, scope, and duration described in this waiver application. MCOs are required to adhere to all provider qualifications and monitoring requirements when contracting for services. Per MCO contract requirements, the MCO must have a sufficient number of contracts with MDCP service providers so that all members who receive MDCP services have access to medically necessary and functionally necessary services. The MCO must maintain and, as appropriate, submit to HHSC documentation ensuring an adequate provider network capacity to serve members receiving MDCP services.

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 MDCP licensed or certified provider agencies that were credentialed prior to the provision of services. N: Number of newly enrolled MDCP licensed or certified provider agencies that were credentialed prior to the provision of services. D: Number of newly enrolled MDCP licensed or certified service provider agencies.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Managed Care Organization reports

Responsible Party for	Frequency of data	Sampling Approach
-----------------------	-------------------	-------------------

data collection/generation (check each that applies):	collection/generation (check each that applies):	(check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div></div>
Other Specify: <div>Managed care organizations</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

C.a.2 Number and percent of continuing, credentialed MDCP providers that retain their licensure or certification. N: Number of continuing, credentialed MDCP providers that retain their licensure or certification. D: Number of continuing, credentialed MDCP providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Managed Care Organization reports

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

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 non-licensed MDCP provider agencies that met initial background and training qualifications. N: Number of newly enrolled non-licensed MDCP provider agencies that met initial background and training

qualifications. D: Number of newly enrolled non-licensed MDCP provider agencies.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Managed Care Organization reports

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 = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Managed care organizations</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

Performance Measure:

C.b.2 Number and percent of continuing, non-licensed MDCP provider agencies that continue to maintain their background and training qualifications. N: Number of continuing, non-licensed MDCP provider agencies that continue to maintain their background and training qualifications. D: Number of continuing, non-licensed MDCP provider agencies.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Managed Care Organization reports

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
Other Specify:	Annually	Stratified Describe Group:

Managed care organizations		
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

- c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

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

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

Performance Measure:

C.c.1 Number and percent of managed care organizations using state-approved provider trainings. N: Number of managed care organizations using state-approved provider trainings. D: Number of managed care organizations.

Data Source (Select one):

Presentation of policies or procedures

If 'Other' is selected, specify:

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 = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

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

At least once every three years, the MCO must review and approve the credentials of all participating licensed and unlicensed provider agencies who participate in the MCO's Provider Network. At a minimum, the scope and structure of an MCO's credentialing and re-credentialing processes must be consistent with recognized MCO industry standards and relevant state and federal regulations including 28 Texas Administrative Code §11.1902 and §11.1402(c), relating to provider credentialing and notice, and, as an additional requirement for Medicaid MCOs, 42 C.F.R. §438.12 and §438.214(b). The re-credentialing process must take into consideration provider agency performance data, including Member Complaints and Appeals, quality of care, and utilization management. For new provider agencies, the MCO must complete the credentialing process prior to the effective date of the Network Provider agreement.

Before contracting with unlicensed LTSS provider agencies or LTSS provider agencies not certified by an HHS Agency, the MCO must ensure that the provider agency:

1. Has not been convicted of a crime listed in Texas Health and Safety Code §250.006;
2. Is not listed as "unemployable" in the Employee Misconduct Registry or the Nurse Aide Registry maintained by HHSC by searching or ensuring a search of such registries is conducted, before hire and annually thereafter;
3. Is not listed on the following websites as excluded from participation in any federal or state health care program:
 - a. HHS-OIG Exclusion; and
 - b. HHSC-OIG Exclusion Search by searching or ensuring a search of such registries is conducted, before hire and at least monthly thereafter;
4. Is knowledgeable of acts that constitute abuse, neglect, or exploitation of a Member;
5. Is instructed on and understands how to report suspected abuse, neglect, or exploitation;
6. Adheres to applicable state laws if providing transportation; and
7. Is not a spouse of, legally responsible person for, or employment supervisor of the Member who receives the service, except as allowed in the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver.

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.

The MCO is responsible for ensuring that contracted MDCP provider agencies comply with program rules, regulations, and guidelines as specified in this waiver, the managed care contract, and other sub-regulatory guidance. The MCO is responsible for conducting a minimum of four face-to-face service coordination contacts annually in addition to monthly phone calls unless otherwise requested by the Member or legally authorized representative in order to monitor the health and welfare and ensure that authorized services are actually delivered. MCOs may escalate issues related to provider agencies or clients to HHSC for technical assistance and resolution. MCOs that fail to meet contract standards related to MDCP are subject to liquidated damages and other remedies including the following:

- Corrective action plan;
- Assessment of liquidated damages;
- Accelerated monitoring of the MCO, which includes more frequent or extensive monitoring by HHSC;
- Requiring additional financial or programmatic reports to be submitted by the MCO;
- Requiring additional or more detailed financial or programmatic audits or other reviews of the MCO;
- Terminating or declining to renew or extend an MCO contract;
- Appointing temporary MCO management under the circumstances described in 42 CFR §438.706;
- Suspending member enrollment;
- Withholding or recouping payment to the MCO; and
- Requiring forfeiture of all or part of the MCO's performance bond.

ii. Remediation Data Aggregation

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

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

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.

MDCP transitioned into managed care in November 2016, and has incorporated MDCP into its managed care quality strategy. In accordance with Title 42, CFR, Section §438.340, the state must implement a quality strategy for assessing and improving the quality healthcare and services provided through managed care. The state must review and update the quality strategy no less than every three years or whenever a significant change is made. A significant change includes:

- Adding new populations to the managed care programs;
- Expanding managed care programs to new parts of the state; and
- Carving new services into the managed care programs.

The managed care quality strategy was last updated in July 2021, and can be accessed on the HHSC website at <https://www.hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/tx-managed-care-quality-strategy-july-2021.pdf>

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.

Please refer to Main Section - Attachment #2 for information.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

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:

Licensed Social Worker

Other

Specify the individuals and their qualifications:

In addition to Registered Nurse or licensed social worker, the MCO service coordinator may also be a nurse practitioner; physician's assistant; or Licensed Professional Counselor if the Member's service needs are primarily behavioral.

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:*

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.

Supports and information available to the Member:

The MCO service coordinator supports the Member or the Member's legally authorized representative or medical consentor in setting goals that address the needs identified during the assessment and educates the member or the Member's legally authorized representative or medical consentor about waiver and non-waiver service options that are available. Using a person-centered planning approach, the service plan is developed by the service planning team which includes the Member; the Member's legally authorized representative or medical consentor; the MCO service coordinator; and any other person who participates in the Member's care, such as a service provider, a representative of the school system, or other third-party resource. The Member has the authority to determine who will be included in the service plan development process. The service planning team works together to develop an service plan that addresses the Member's goals and identifies providers, caregivers, and other third-party resources who will contribute to goal achievement. The MCO service coordinator works with the Member or the Member's legally authorized representative or medical consentor and other third-party resources.

The Member or the Member's legally authorized representative or medical consentor, the MCO service coordinator, and any designated representative sign the service plan.

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):

a. Who develops the plan, who participates in the process, and the timing of the plan:

The applicant/Member or the applicant's/Member's legally authorized representative or medical consentor, the MCO service coordinator, and any other person who participates in the applicant's/Member's care, such as a service provider, a representative of the school system, or other third-party resource, develop the service plan. The MCO service coordinator must make initial contact and meet with an applicant within 30 days of the applicant's release from the interest list or request to apply for enrollment into MDCP through the Promoting Independence/Money Follows the Person reserved capacity group. The MCO service coordinator must complete the service plan within 30 days of the initial meeting with the applicant. A re-evaluation is conducted annually and a service plan is developed for services for the next year. The member or the member's legally authorized representative or medical consentor, or MDCP provider on behalf of the Member, can request changes in the service plan at any time. The MCO service coordinator discusses the requested changes with the Member or the Member's legally authorized representative or medical consentor and approves or denies the changes.

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:

The STAR Kids Screening and Assessment Instrument is the assessment instrument used to establish medical necessity and level of care for MDCP. The information gathered during the medical necessity and level of care assessment is used in developing the service plan. The MCO service coordinator works with the Member or the Member's legally authorized representative or medical consentor to set goals to address caregiver relief, health care, social needs, and other support needs identified by the Member and the Member's legally authorized representative or medical consentor during the initial assessment. They develop a plan to achieve each goal, including those goals requiring non-waiver services that are otherwise important to the member's health and well-being. The service plan must be consistent with the desires of the Member or the Member's legally authorized representative or medical consentor.

c. How the Member or legally authorized representative or medical consentor is informed of the services that are available under the waiver:

The MCO service coordinator must educate the Member or the Member's legally authorized representative or medical consentor about all waiver services as part of the service plan development at enrollment, annually, and as the individual's needs change.

d. How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences:

As part of care coordination, the MCO service coordinator must give the Member or the Member's legally authorized representative or medical consentor information about both waiver and non-waiver services and service delivery options and refer the Member or the Member's legally authorized representative to non-waiver services, including community organizations or third-party resources that are important to the health and well-being of the Member. The service plan addresses Member goals, needs and preferences by including the Member or the Member's legally authorized representative or medical consentor, health care professionals, and other individuals who participate in the Member's care in the planning process. In addition, the Member or the Member's legally authorized representative or medical consentor must sign the service plan to indicate understanding of and agreement with the service plan. If the Member or the Member's legally authorized representative does not agree with the service plan, the Member or the Member's legally authorized representative may file an appeal. The procedures for requesting an MCO internal appeal and a fair hearing after the MCO internal appeal are provided in Appendix F, Individual Rights.

e. How waiver and other services are coordinated:

The MCO service coordinator is responsible for organizing both waiver and non-waiver medically and functionally necessary services to achieve the Member's goals. The MCO service coordinator must provide any referrals specified within the service plan in an expeditious manner, and coordinate with the Member's family members, designated representative, or legally authorized representative or medical consentor, as well as providers of non-waiver services and other community resources, as reflected in the service plan. If the individual chooses to have a service in the consumer directed services option, the MCO service coordinator will provide a list of financial management services agencies for the individual to choose from.

f. How the plan development process provides for the assignment of responsibilities to implement and monitor the service plan:

The service plan must include services, including units and frequency, and the roles of the Member or the Member's designated representative or legally authorized representative or medical consentor, the MCO service coordinator, providers, family, and informal caregivers in achieving the goals and meeting the Member's needs. The MCO service coordinator is responsible for monitoring and overseeing the implementation of the service plan. Monitoring and implementing the service plan requires that the MCO service coordinator maintain contact with the Member or the Member's designated representative or legally authorized representative or medical consentor to ensure appropriate service delivery, including whether or not an alternate service delivery plan or a service back-up plan has been utilized and, if so, if it has been effective.

The MCO is responsible for conducting a minimum of four face-to-face service coordination contacts annually in addition to monthly phone calls, unless otherwise requested by the Member or the Member's designated representative or legally authorized representative or medical consentor, in order to monitor the health and welfare and ensure that authorized services are being delivered.

g. How and when the plan is updated, including when the Member's needs change:

The service plan may be updated at the request of the Member or the Member's legally authorized representative or medical consentor, the designated representative or the provider when the Member's condition changes. The service plan may be updated when the Member decides to have a service in the consumer directed services delivery option, or if the Member decides to suspend or terminate the consumer directed services delivery option. The Member or the Member's designated representative or legally authorized representative or medical consentor may request a MCO internal appeal, and an external medical review and fair hearing or fair hearing only after the MCO internal appeal to dispute a service suspension, reduction, denial, or termination. The procedures for requesting an MCO internal appeal and requesting an external medical review and fair hearing, (fair hearing only after the MCO internal appeal) are provided in Appendix F, Individual Rights.

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 MCO service coordinator uses the STAR Kids Screening and Assessment Instrument and input from the member, the member's designated representative or legally authorized representative, or medical consentor to determine any risks that might exist to health and safety as a result of living in the community. The development of back-up plans is an integral part of the service planning process. Back-up planning includes determining the availability of informal supports, third party resources, and other community resources. The Home and Community Supports Service Agency completes and submits the alternate service delivery plan and the consumer directed services employer submits the service back-up plan to the MCO service coordinator and Financial Management Services Agency at the initial assessment, each yearly reassessment, and any time there is a change.

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.

The MCO service coordinator obtains a listing of qualified providers who have contracted with the MCO to provide MDCP services in the service delivery area and offers the Member, designated representative or legally authorized representative or medical consentor a choice among these service providers. If the Member or the Member's designated representative or legally authorized representative or medical consentor has no preferred provider, the MCO service coordinator assigns providers. The MCO service coordinator must document in the case record the Member's or the Member's designated representative, legally authorized representative or medical consentor's choice regarding the provider.

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 as the State Medicaid Agency delineates roles and responsibilities of HHSC and its contractors via its contracts. HHSC maintains monitoring and oversight functions. The service planning process is a function which HHSC has delegated to MCOs under the terms of a managed care contract.

Under the terms of the contract between HHSC and the MCO, the MCO reviews and approves or denies all service plans at enrollment, annually, and when there is a need to revise a service plan. The MCO is also responsible for ensuring that contracted MDCP provider agencies comply with program rules, regulations, and guidelines as specified in this waiver, the managed care contract, and other sub-regulatory guidance. The MCO is responsible for conducting a minimum of four face-to-face service coordination contacts annually in addition to monthly phone calls, unless otherwise requested by the Member, the Member's designated representative, or the legally authorized representative, or medical consentor, in order to monitor the Member's health and welfare and ensure that authorized services are being delivered as indicated in the service plan.

MCOs must make MDCP service plans and other documentation related to the delivery of MDCP services available to HHSC upon request. MCOs must comply with HHSC's requests for information related to utilization reviews. MCOs may escalate issues related to providers or members to HHSC for technical assistance and resolution. MCOs that fail to meet contract standards related to MDCP are subject to liquidated damages and other remedies.

HHSC's Managed Care Compliance Operations unit conducts on-site operational reviews of each MCO at least biennially to ensure the MCOs are following their documented policies and procedures and that those policies and procedures continue to align with HHSC's contractual requirements.

HHSC's Quality Review Team, which consists of representatives from several units within the HHS enterprise, meets quarterly to review comprehensive quality reports generated by the Quality Reporting Unit. The reports generated by the Quality Reporting Unit summarize data from units within HHSC as well as self-reported data collected from MCOs and include quarterly and annual scores per performance measure and remediation activities per performance measure. These reports include quarterly and annual scores per performance measure and remediation activities per performance measure. HHSC staff present the reports and recommendations to the Quality Review Team. Priorities for further scrutiny and follow-up with quality improvement projects are established in these meetings.

HHSC reviews and approves all service plans in the MDCP waiver based on standard criteria.

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:

MCO service coordinator

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.

(a) The entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare:

The MCO service coordinator is responsible for monitoring the implementation of the service plan and participant health and welfare. The MCO service coordinator assesses how well services are meeting a Member's needs and enabling the Member to achieve the goals described in the service plan.

(b) The monitoring and follow-up method(s) that are used:

The MCO service coordinator monitors the implementation of the service plan at regular intervals by contacting the Member or the Member's designated representative, legally authorized representative or medical consentor. In addition, the MCO service coordinator must re-evaluate the appropriateness of the service plan whenever the Member's condition changes significantly or upon request of the Member or the Member's designated representative or legally authorized representative.

MCO service coordinators are responsible for ensuring the service plan is reviewed 30 days after the effective date; at least every 6 months; and annually; and that the service plan is revised at least annually and whenever indicated by a change in service needs. MCO service coordinators must take appropriate actions to resolve issues noted during any contact. During the monitoring contact, MCO service coordinators are responsible for determining if any existing situations jeopardize the member's health and welfare. Additional contacts by the MCO service coordinator may be scheduled to protect the member's health and welfare.

The MCO service coordinator must review and document the following:

- Whether waiver and non-waiver services and supports are implemented and provided in accordance with the service plan and continue to meet the member's needs, goals, and preferences;
- Whether the Member or the Member's designated representative or legally authorized representative is satisfied with implementation of services;
- Whether the Member's health and welfare are reasonably ensured;
- Whether the Member or the Member's designated representative or legally authorized representative exercises free choice of providers and accesses non-waiver services, including health services;
- For Members or the Member's designated representative or legally authorized representative who select the traditional agency model, whether or not the agency exercised the alternate service delivery plan in the absence of the regularly scheduled agency staff; and
- For Members who self-direct service delivery, whether or not the consumer directed services employer implemented the backup plan, and, if so, whether the backup plan was effective.

Results of monitoring reviews are documented in the Member's case file via the service plan service review form. The MCO service coordinator takes appropriate actions to address identified problems including counseling with the Member or the Member's designated representative or legally authorized representative; convening a meeting with the Member or the Member's designated representative or legally authorized representative, and others contributing to the Member's care to resolve problems; and advocating on the Member's behalf with the MDCP provider agency or non-waiver service.

When the MCO service coordinator identifies changes in needs or preferences while monitoring the service plan, the MCO service coordinator may convene a meeting with the Member, the Member's designated representative or legally authorized representative or medical consentor, and others contributing to the Member's care to address problems or identified changes. The MCO service coordinator may also confer with MDCP provider agencies concerning improving implementation strategies. If a self-directing Member's backup plan was not effective, the MCO service coordinator, the Member or the Member's designated representative or legally authorized representative or medical consentor and Financial Management Services Agency determine the revisions that should be made to the backup plan. The MCO service coordinator must document in the Member's record that the service plan was effective or that revisions were required. The MCO service coordinator ensures that the backup plan is revised whenever necessary.

(c) The frequency with which monitoring is performed:

The MCO service coordinator must contact the Member or the member's designated representative, legally authorization representative or medical consentor in person or by telephone at least once every month. The MCO is responsible for conducting a minimum of four face-to-face service coordination contacts annually in addition to monthly phone calls, unless otherwise requested by the member or the member's designated representative legally authorized representative or medical consentor, in order to monitor the Member's health and welfare and ensure that authorized services are delivered. The Member or the Member's designated representative, legally authorized representative or medical consentor's access

to services and satisfaction with services are reviewed during the monitoring contacts. The back-up plan is reviewed by the MCO service coordinator during the face-to-face annual reassessment and monitoring contacts.

b. Monitoring Safeguards. *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the 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 needs (including health and safety risk factors), as indicated in the most recent assessment and including changes as identified by the service coordinator. N: Number of individuals with service plans that address their needs. D: Number of individuals with reviewed service plans.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Utilization Review STAR Kids/STAR Health MDCP

Responsible Party for	Frequency of data	Sampling Approach
-----------------------	-------------------	-------------------

data collection/generation (check each that applies):	collection/generation (check each that applies):	(check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95% +/- 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div>MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

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: <div></div>	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

D.a.2 Number and percent of individuals with service plans that address their goals, as indicated in the most recent assessment. N: Number of individuals with service plans that address their goals, as indicated in the most recent assessment. D: Number of individuals with reviewed service plans.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Utilization Review STAR Kids/STAR Health MDCP

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> Confidence Interval= 95% +/- 5% </div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> MCO </div>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

D.a.3 Number and percent of individuals reporting that service coordinators asked about their preferences. N: Number of individuals reporting that service coordinators asked about their preferences. D: Number of individuals reviewed.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Utilization Review STAR Kids/STAR Health MDCP

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid	Weekly	100% Review

Agency		
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>Confidence Interval= 95% +/- 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div>MCO</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

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: <div></div>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.**

Performance Measures

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

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

- c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.**

Performance Measures

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

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

Performance Measure:

D.c.1 Number and percent of service plans that were reassessed and renewed annually prior to the service plan expiration date. N: Number of service plans that were reassessed and renewed annually prior to the individual 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 = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- 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 MDCP members whose services were delivered in accordance with their service plans, including type, scope, amount, duration, and frequency. N: Number of MDCP members whose services were delivered in accordance with their service plans, including type, scope, amount, duration, and frequency. D: Number of MDCP members with new or renewed service plans.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Managed Care Organizations self-report

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 = <div style="border: 1px solid black; padding: 2px; display: inline-block;">95% +/- 5%</div>

Other Specify: <div>Managed Care Organizations</div>	Annually	Stratified Describe Group: <div>Stratification by MCO and Service Delivery Area (SDA): 75 members per MCO per quarter with continuous enrollment for at least 90 days in current plan, sampled across all SDAs serviced by the MCO.</div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

D.d.2 Number and percent of individuals reviewed with issues to access to care or health and safety. N: Number of individuals reviewed with issues to access to care or health and safety. D: Number of individuals reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Utilization Review STAR Kids/STAR Health MDCP

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; display: inline-block;">95% +/- 5%</div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 2px; display: inline-block;">(MCO)</div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Other Specify:	

--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

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

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

Performance Measure:

D.e.1 Number and percent of newly enrolled individuals who were afforded a choice among managed care organizations in their service area. N: Number of newly enrolled individuals who were afforded a choice among managed care organizations in their service area. D: Number of individuals who newly enrolled in a managed care organization.

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 = <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

D.e.2 Number and percent of individuals who reported, during interviews, that they were offered and made a choice of waiver services. N: Number of individuals who reported, during interviews, that they were offered and made a choice of waiver services. D: Number of individuals who completed interviews.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Utilization Review STAR Kids/STAR Health MDCP

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

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

D.e.3 Number and percent of individuals who reported, during interviews, that they were afforded a choice between and among waiver providers. N: Number of individuals who reported, during interviews, that they were afforded a choice between and among waiver providers. D: Number of individuals who completed interviews.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Utilization Review STAR Kids/STAR Health MDCP

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

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: <div></div>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- 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's Managed Care Compliance Operations unit conducts on-site operational reviews of each MCO at least biennially to ensure the MCOs are following their documented policies and procedures and that those policies and procedures continue to align with HHSC's contractual requirements.

HHSC's Quality Review Team, which consists of representatives from several units within the HHS enterprise, meets quarterly to review comprehensive quality reports generated by the Quality Reporting Unit. The reports generated by the Quality Reporting Unit summarize data from units within HHSC as well as self-reported data collected from MCOs and include quarterly and annual scores and remediation activities per performance measure. HHSC staff present the reports and recommendations to the Quality Review Team. Priorities for further scrutiny and follow-up with quality improvement projects are established during these meetings.

b. Methods for Remediation/Fixing Individual Problems

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

If an MCO fails to meet a performance expectation, standard, schedule, or other contract requirement, the managed care contracts give HHSC the authority to use a variety of remedies, including:

- Corrective action plan;
- Assessment of liquidated damages;
- Accelerated monitoring of the MCO, which includes more frequent or extensive monitoring by HHSC;
- Requiring additional financial or programmatic reports to be submitted by the MCO;
- Requiring additional or more detailed financial or programmatic audits or other reviews of the MCO;
- Terminating or declining to renew or extend an MCO contract;
- Appointing temporary MCO management under the circumstances described in 42 CFR §438.706;
- Suspending member enrollment;
- Withholding or recouping payment to the MCO; and
- Requiring forfeiture of all or part of the MCO's performance bond.

The MCO is responsible for ensuring that contracted MDCP provider agencies comply with program rules, regulations, and guidelines as specified in this waiver, the managed care contract, and other sub-regulatory guidance.

The MCO is responsible for conducting a minimum of four face-to-face service coordination contacts annually in addition to monthly phone calls, unless otherwise requested by the Member or the Member's legally authorized representative, in order to monitor the Member's health and welfare and ensure that authorized services are actually delivered as indicated in the service plan.

MCOs may escalate issues related to providers or clients to HHSC for technical assistance and resolution. MCOs that fail to meet contract standards related to MDCP are subject to liquidated damages and other remedies.

MCO service coordinators are responsible for monitoring the implementation of service plans and for coordinating all services, waiver and non-waiver, that Members receive. MCO service coordinators may need to consult with providers of state plan services, as well as community resources, to ensure that all needs are being met, that there is no duplication of services, and that the services are being provided in accordance with the service plan.

The MCO service coordinator discusses the MDCP back-up plan at the 30-day monitoring review which takes place after services begin. The MCO service coordinator reviews the back-up plan during the face-to-face annual reassessment visit and at the 6-month monitoring. The MCO service coordinator ensures the back-up plan is revised at least annually, or whenever the Member's service needs change. MCO service coordinators must take appropriate actions to resolve issues noted during every monitoring contact. During the monitoring contact, MCO service coordinators are responsible for determining if any situations exist that jeopardize the Member's health and welfare, and additional contacts by the MCO service coordinator may be scheduled to protect the Member's health and welfare. As necessary, the MCO service coordinator enters updates to the service plan into the MCO system of record, which is available for HHSC review.

Home and Community Support Services Agencies and other provider agencies, as applicable, are responsible for ensuring implementation of the individual plan of care. Home and Community Support Services Agencies are responsible for conducting annual nursing assessments to identify Member needs and request changes to the service plan accordingly.

ii. Remediation Data Aggregation

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

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Specify: <div></div>	
	Continuously and Ongoing
	Other Specify: <div></div>

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.

MDCP transitioned into managed care in November 2016, and HHSC has incorporated MDCP into its managed care quality strategy. In accordance with Title 42 CFR, Section 438.340, the state must implement a quality strategy for assessing and improving the quality of healthcare and services provided through managed care. The state must review and update the quality strategy no less than every three years or whenever a significant change is made. HHSC ensures that the STAR Health quality strategy aligns with the strategy of 1115, unless program requirements prohibit alignments of the quality strategy. Significant change includes:

- Adding new populations to the managed care programs;
- Expanding managed care programs to new parts of the state; and
- Carving new services into the managed care programs.

The managed care quality strategy was last updated in July 2021, and can be accessed on the HHSC website at <https://www.hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/tx-managed-care-quality-strategy-july-2021.pdf>

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.

Members have the option of choosing (1) the traditional agency option; (2) the consumer directed services option; or (3) the service responsibility option.

(1)The traditional agency option, which is provider-managed, directs any services not available through the consumer directed services option or the service responsibility option and any services that the member, the member's legally authorized representative, or medical consenter elect not to self-direct. Under the traditional agency option, the member, the member's legally authorized representative, or medical consenter chooses a network provider.

(2)Participation in the consumer directed services option provides the member, the member's legally authorized representative, or medical consenter the opportunity to be the employer of persons providing waiver services chosen for self-direction. Members residing in their own private residence or the home of a family member may choose to self-direct any of the following services: respite, supported employment, employment assistance, adaptive aids, minor home modifications, and flexible family support services. Each member, the member's legally authorized representative, or medical consenter electing to use the consumer directed services option must receive support from a financial management services provider, referred to as a Financial Management Services Agency chosen by the member, legally authorized, or medical consenter.

(3)The service responsibility option allows the member, the member's legally authorized representative, or medical consenter to select, train and provide daily management of a service provider, while the fiscal, personnel, and service back-up plan responsibilities remain with the home health agency selected by the member, member's legally authorized representative, or medical consenter.

At the time of enrollment in the waiver, at least annually thereafter, and upon request of the member, he member's legally authorized representative, or medical consenter the MCO service coordinator informs the member, the member's legally authorized representative, medical consenter, or both, of the option to use the consumer directed services option or service responsibility option to self-direct services. The member, the member's legally authorized representative, or medical consenter may elect at any time to choose the consumer directed services option or service responsibility option, terminate participation in the consumer directed services option or service responsibility option, or to change Financial Management Services Agencies.

When choosing to self-direct services, the member, the member's legally authorized representative, or medical consenter is the common-law employer (referenced as the "consumer directed services employer" from this point forward) of service providers and has decision-making authority over providers of self-directed services. The consumer directed services employer also has budget authority. The MCO approves funding for self- directed services based on the authorized service plan. The consumer directed services employer or designated representative, with the assistance of the Financial Management Service Agency, budgets approved funds for self-directed services.

Supports for the consumer directed services employer include:

1. The MCO service coordinator, who provides information about the consumer directed services option or service responsibility option, assists the consumer directed services employer with filling out required forms and monitors service delivery. The MCO service coordination functions are global and apply to self-directed as well as provider-delivered waiver services and non-waiver services;
2. A Financial Management Services Agency, chosen by the member, legally authorized representative, or medical consenter to provide financial management services. The Financial Management Services Agency must be enrolled and credentialed with the MCO.
3. Supports may also include a designated representative, if appointed by the consumer directed services employer, who assists in meeting consumer directed services employer responsibilities to the extent directed by the consumer directed services employer.

To participate in the consumer directed services option, a member, the member's legally authorized representative, or medical consenter must:

1. Select the consumer directed services option;
2. Select a Financial Management Services Agency;
3. Participate in orientation and ongoing training conducted by the Financial Management Services Agency and HHSC as applicable;
4. Perform all consumer directed services employer tasks that are required for self-direction or designate a designate representative capable of performing some or all of these tasks on the consumer directed services employer's behalf; and

5. Maintain a service back-up plan for provision of services determined by the service planning team to be critical to the Member'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 Member, Member's legally authorized representative, or medical consentor is offered the opportunity to self-direct services when:

1. The Member lives in his or her own home or the home of a family member; and
2. The service plan includes respite, supported employment, employment assistance, adaptive aids, minor home modifications, and flexible family supports.

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 MCO service coordinator provides each Member, the Member's legally authorized representative, or medical consentor a written and oral explanation of the consumer directed services option and service responsibility option, which is included in the member handbook, during the initial assessment, and at each annual review of the service plan or at any time requested by the Member, the Member's legally authorized representative, or medical consentor.

Each Member, the Member's legally authorized representative, or medical consentor is provided information sufficient to ensure informed decision making and understanding of the consumer directed services option, service responsibility option and traditional agency option.

Information provided orally and in writing to the Member, the Member's legally authorized representative, or medical consentor by the MCO service coordinator also includes:

3. An overview of the consumer directed services option and service responsibility option;
4. Explanation of responsibilities in the consumer directed services option and service responsibility option for the Member, the Member's legally authorized representative, or medical consentor, MCO service coordinator, and the Financial Management Services Agency or home health agency for the service responsibility option;
5. Explanation of benefits and risks of participating in the consumer directed services option and service responsibility option, as well as the choices a Member, a Member's legally authorized representative, or medical consentor can make with the election of the consumer directed services option or service responsibility option;
6. Self-assessment for participation in the consumer directed services option;
7. Explanation of required minimum qualifications of service providers through the consumer directed services option; and
8. Explanation of employee/consumer directed services 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 Member, the Member's legally authorized representative, or medical consentor serving as the consumer directed services employer may appoint a non-legal representative adult as a designated representative to assist in performance of consumer directed services employer responsibilities to the extent desired by the Member, the Member's legally authorized representative, or medical consentor. The consumer directed services employer must document the consumer directed services employer responsibilities that the designated representative may perform and may not perform on the consumer directed services employer's behalf. The consumer directed services employer must provide this documentation to the Financial Management Services Agency. The Financial Management Services Agency monitors performance of consumer directed services employer responsibilities performed by the consumer directed services employer and, when applicable, the designated representative in accordance with the consumer directed services employer 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 Member.

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
Employment Assistance		
Supported Employment		
Flexible Family Support Services		
Adaptive Aids		
Minor Home Modifications		
Respite		

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

Yes. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

Governmental entities

Private entities

No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

- i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

FMS are covered as the waiver service specified in Appendix C-1/C-3

The waiver service entitled:

Financial Management Services

FMS are provided as an administrative activity.

Provide the following information

- i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

Private entities furnish financial management services. These entities, called Financial Management Services Agencies, contract with the MCOs to provide financial management services to Members, the Member's legally authorized representative, or medical consentor across the state. MCOs must maintain an adequate network of MDCP providers, including Financial Management Services Agencies, in order to ensure that MDCP Members have access to financial management services.

- 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 Member.

- iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

Assist participant in verifying support worker citizenship status

Collect and process timesheets of support workers

Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

Other

Specify:

Supports furnished when the participant exercises budget authority:

Maintain a separate account for each participant's participant-directed budget

Track and report participant funds, disbursements and the balance of participant funds

Process and pay invoices for goods and services approved in the service plan

Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Other services and supports

Specify:

Additional functions/activities:

Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget

Other

Specify:

- iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The MCO has the responsibility for contracting, credentialing, and monitoring Financial Management Services Agencies. Verification of Financial Management Services Agency qualifications is completed by the MCO as part of the initial contracting and credentialing process and every three years thereafter.

HHSC provides training to financial management services agencies annually as well as regular trainings related to quality and quality assurances. Financial Management Services Agencies must pass a knowledge exam administered by HHSC to be eligible for a contract. Only contract-eligible Financial Management Services Agencies may participate in an MCO's network.

The MCO is responsible for conducting a minimum of four face-to-face service coordination contacts annually in addition to monthly phone calls, unless otherwise requested by the Member, the Member's legally authorized representative, or medical consenter, in order to monitor the Member's health and welfare and ensure that authorized services are delivered as indicated in the service plan.

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 Member, the Member's legally authorized representative, or medical consentor by the MCO service coordinator includes:

1. An overview of the consumer directed services option and service responsibility option;
2. Explanation of responsibilities in the consumer directed services option and service responsibility option for the Member, the Member's legally authorized representative or medical consentor, the MCO service coordinator, and the Financial Management Services Agency or home health agency for the service responsibility option;
3. Explanation of benefits and risks of participating in the consumer directed services option and service responsibility option;
4. Self-assessment for participation in the consumer directed services option;
5. Explanation of required minimum qualifications of service providers through the consumer directed services option; and
6. Explanation of employee/consumer directed services 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
Employment Assistance	
Supported Employment	
Flexible Family Support Services	
Adaptive Aids	
Minor Home Modifications	
Respite	
Financial Management Services	
Transition Assistance Services	

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:

A Member, the Member's legally authorized representative, or medical consentor may voluntarily terminate participation in the consumer directed services option or service responsibility option at any time. The MCO service coordinator assists with revising the service plan for the transition of services previously delivered through the consumer directed services option or service responsibility option to be delivered by the provider chosen by the member, the member's legally authorized representative, or medical consentor under a traditional agency option. The service planning team assists the member, the member's legally authorized representative, or medical consentor as necessary to ensure continuity of all waiver services and maintenance of the member's health and welfare during the transition from the consumer directed services option or service responsibility option to the traditional agency option. HHSC ensures that participants do not lose services in the interim between terminating the consumer directed services option and beginning the traditional agency option.

The Financial Management Services Agency closes the consumer directed services employer's payroll and payable accounts and completes all deposits and filings of required reports with governmental agencies on behalf of the Member, the Member's legally authorized representative, or medical consentor. When a Member, Member's legally authorized representative, or medical consentor voluntarily terminates self-direction of services, the MCO service coordinator will assist the Member, Member's legally authorized representative, or medical consentor to begin services through the traditional agency option with no gap in coverage.

The Member, Member's legally authorized representative, or medical consentor must wait 90 days before requesting re-enrollment in 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.

A Member’s service planning team, Financial Management Services Agency, or the MCO may recommend termination of participation in the consumer directed services option if the Member, Member's legally authorized representative, medical consentor, or designated representative does not implement and successfully complete the following steps and interventions:

1. Eliminate jeopardy to the Member’s health or welfare;

2. Successfully direct the delivery of program services through the consumer directed services option;

3. Meet the consumer directed services employer responsibilities;

4. Successfully implement corrective action plans; or

5. Appoint a designated representative or access other available supports to assist the consumer directed services employer in meeting consumer directed services employer responsibilities.

In addition, the MCO may require immediate termination of self-directed services in circumstances that jeopardize health and safety, when the designated representative is convicted of an offense under Chapter 32 of the Penal Code or an offense barring employment as listed in the Texas Health and Safety Code, § 250.006(a) and (b), or if HHSC or another government agency with applicable regulatory authority recommends termination. (Title 40, Texas Administrative Code, Part 1, Chapter 41, Subchapter D).

The MCO service coordinator and service planning team assist the Member, Member's legally authorized representative, or medical consentor to ensure continuity of all waiver services and maintenance of the individual’s health and welfare during the transition from the consumer directed services option to the traditional agency option. The Financial Management Services Agency closes the consumer directed services employer’s payroll and payable accounts and completes all deposits and filing of required reports with governmental agencies on behalf of the Member.

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	<div></div>	<div>3104</div>
Year 2	<div></div>	<div>3104</div>
Year 3	<div></div>	<div>3104</div>
Year 4	<div></div>	<div>3104</div>
Year 5	<div></div>	<div>3104</div>

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:

Home and Community Support Services Agency

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 Member'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:

HHSC'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:

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 Member who elects the consumer directed services option as it is for the Member who elects to have services delivered through the traditional agency option. The service plan must be approved by the MCO service coordinator. 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 Member or the Member's legally authorized representative or medical consenter 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 Member, the Member's legally authorized representative or medical consenter may make revisions to a specific consumer directed services budget that does not change the amount of funds available for the service based on the approved service plan.

Consumer directed services 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 Member or the Member's legally authorized representative who self-directs services to support specific outcomes related to being a consumer directed services employer including: recruiting expenses, a fax machine for sending employee time sheets to the Financial Management Services Agency, criminal conviction history checks from the Texas Department of Public Safety, acquiring other background checks of a potential service provider, purchasing employee job-specific training, cardio-pulmonary resuscitation training, first-aid training, and Hepatitis B vaccination if elected by an employee.

Information concerning budget methodology for the consumer directed services budget is available to the public in Title 40, Texas Administrative Code, Part 1, Chapter 41.

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 Member, the Member's legally authorized representative, or medical consenter participates as part of the service planning team that develops the Member's person-directed service plan. The service plan includes the service plan budget. Members, the Member's legally authorized representative, or medical consenter are apprised of the service plan budget as it is developed. The Member, the Member's legally authorized representative, or medical consenter develops the consumer directed services budget based on the finalized service plan which includes the authorized amount of funds.

The Financial Management Services Agency and the MCO service coordinator inform the consumer directed services employer of the amount authorized for a particular service before the consumer directed services budget is developed. The consumer directed services employer may request an adjustment to the consumer directed services budget at any time, subject to cost limits. When the MCO denies a consumer directed services employer's request for an adjustment to the consumer directed services budget, the consumer directed services employer is entitled to a fair hearing. The procedures for an MCO internal appeal, external Medical Review (EMR), and fair hearing (or fair hearing only after an MCO internal appeal) 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:

A Member's consumer directed services budget is calculated based on projected utilization and frequency of the services as determined by the service planning team. The Financial Management Services Agency is required to monitor payroll every pay period (two weeks) and expenditures (as processed for payment) and report over or under-utilization to the consumer directed services employer and the MCO service coordinator. When over- or under-utilization is not corrected by the consumer directed services employer, the Financial Management Services Agency notifies the MCO service coordinator and the consumer directed services employer. The MCO service coordinator and the consumer directed services employer identify the cause of the continuing deviation from projected utilization and develop a plan to correct the deviation or revise the service plan.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

HHSC maintains a fair hearing system and provides an opportunity to request a fair hearing in accordance with 42 CFR Part 431, Subpart E.

Informing applicants and Members, authorized representative, legally authorized representatives, medical consentor about the right to notice of action and a fair hearing: HHSC's fair hearings process is detailed in Title 1 of the Texas Administrative Code, Chapter 357. During the initial face-to-face visit by the MCO service coordinator with the Member, legally authorized representative, medical consentor, the MCO service coordinator explains the Member has the right to request an HHSC fair hearing and explains the fair hearing process. At the time of enrollment, at least annually, upon request, and at any time of any action affecting the Member or the Member's claim, the MCO service coordinator provides an oral and written explanation to the Member, authorized representative, legally authorized representative, medical consentor of a Member's right to request an HHSC fair hearing. The MCO service coordinator documents that the explanation of the right to request an HHSC fair hearing was provided to the Member, authorized representative, legally authorized representative, medical consentor. This explanation includes:

- A description of the Member's right to request an HHSC fair hearing for:
 - A denial of entrance into the waiver;
 - An action to reduce, suspend, terminate, or deny benefits;
 - A failure to act with reasonable promptness on a Member's claim for benefits or services;
 - A failure to be given the choice of HCBS as an alternative to institutional care; and
 - A denial of the service(s) of their choice or the provider(s) of their choice.

Content of and timeframe for providing notice: The MCO (or HHSC for program eligibility actions only) provides notice of action and the right to an HHSC fair hearing as required in 42 CFR §431.210 and 1 Texas Administrative Code 357.11. Written notice of an adverse action is mailed to the Member, authorized representative, legally authorized representative, medical consentor by the MCO at least 10 business days before the date the action is to take effect, except as provided by federal rules. A copy of the notice is maintained in the Member's record. Except as provided in federal regulations, the written notice of action and the right to an HHSC fair hearing includes:

- A statement of what action HHSC intends to take and the effective date of such action;
- A clear statement of the specified reasons supporting the intended action;
- The specific regulation that supports, or the change in federal or state law that requires, the action;
- An explanation of the circumstances under which the Member is eligible to receive or continue to receive services while the Member's appeal is under consideration and the actions that the Member must take in order for current services to continue;
- An explanation of the Member's right to appeal and the procedures for requesting a fair hearing; and
- The right to be represented by others, including legal counsel, and information about legal services available in the community.

If a Member, authorized representative, legally authorized representative, medical consentor elects to request an HHSC fair hearing verbally or in writing, the MCO retains a copy of the written request in the Member's record.

Requesting the hearing: The Member, authorized representative, legally authorized representative, medical consentor has the right to appeal within 90 days from the date on the notice of agency action, or the effective date of the agency action, whichever is later. The appeal may be made in writing or orally. The MCO must notify HHSC Appeals Division within 5 calendar days of the date that the member expresses a desire to appeal and allow the Member to appeal more than one action at the same time.

Continuation of services: If the agency sends the 10-day notice and the Member, authorized representative, legally authorized representative, medical consentor requests an HHSC fair hearing before the date of action, the MCO may not discontinue services until a decision is rendered after the HHSC fair hearing unless it is determined that the only issue is one of federal or state law or policy and the agency promptly informs the Member, authorized representative, legally authorized representative, medical consentor in writing that the services are to be terminated or reduced pending the HHSC fair hearing decision.

No less than 14 days prior to the HHSC fair hearing, the HHSC fair hearings officer sends all parties notice of the date, time, and place of the scheduled hearing. The notice includes:

- The basis for the action or intended action taken;
- The HHSC fair hearing procedures;
- Contact information to notify HHSC if the Member, authorized representative, legally authorized representative, medical consentor cannot participate in the HHSC fair hearing;
- An explanation that legal services may be available to the Member, authorized representative, legally authorized representative, medical consentor;
- An explanation of the requirement to request reasonable accommodations;
- An explanation that the HHSC fair hearing will be dismissed for failure to appear without good cause;
- An explanation that documents used in the HHSC fair hearing will be provided to the Member, authorized representative,

- legally authorized representative, medical consentor before, during, and after the HHSC fair hearing; and
- An explanation that the case file is available for review upon request.

Within 5 calendar days of notification that the HHSC fair hearing is set, the MCO will prepare an evidence packet as required for submission to the HHSC fair hearings staff and send a copy of the packet to the Member. The MCO sends a letter to the Member informing the Member that if an appeal is filed in a timely manner, the Member's benefits/services will continue. The Member may also contact a Member advocate or service coordinator for assistance or clarification. All documentation related to the adverse action and/or requests are maintained by the MCO in the Member's case file. No later than 90 days from the date the HHSC fair hearings appeal is received by HHSC, a decision shall be issued. This timeframe may be extended by postponements or recesses. The HHSC fair hearings officer has the right to reissue a decision within 20 days of the date of the original decision if the HHSC fair hearings officer becomes aware of an error of law or fact that would have affected the outcome of the decision. The Member may request that an HHSC fair hearing be reopened within 12 months of the decision date under certain circumstances. The MCO will implement the decision of the HHSC fair hearings officer within 10 calendar days of the date of the decision and sends confirmation to the HHSC fair hearings office documenting that the decision has been implemented.

MCO internal appeal system/Procedure to request an MCO internal appeal: The MCO must develop, implement, and maintain an MCO internal appeal process that complies with state and federal laws and regulations. The MCO's internal appeal process must be provided to Members in writing and through oral interpretive services. When a Member, authorized representative, legally authorized representative, medical consentor expresses orally or in writing any dissatisfaction or disagreement with a reduction, denial, suspension, or termination of services, the MCO is contractually required to regard the expression of dissatisfaction as an MCO internal appeal and an HHSC fair hearing request. Members must exhaust the expedited MCO internal appeal process before making a request for an expedited HHSC fair hearing. A Member may make an MCO internal appeal, orally or in writing, with the MCO within 30 days of receipt of the notice of reduction, denial, suspension, or termination of services.

The MCO must send a letter to the Member within 5 business days acknowledging receipt of the MCO internal appeal. Except for the resolution of an expedited MCO internal appeal, the MCO must complete the entire standard appeal process within 30 calendar days after receipt of the initial written or oral MCO internal appeal. The timeframe for a standard appeal may be extended up to 14 calendar days if the Member or his or her representative requests an extension, or the MCO shows that there is a need for additional information and how the delay is in the Member's interest. If the timeframe is extended and the Member did not request the delay, the MCO must give the Member written notice of the reason for delay. The MCO must designate an officer who has primary responsibility for ensuring that MCO internal appeals are resolved within these timeframes and in accordance with the MCO's written policies.

In accordance with 42 CFR §438.420, the MCO must continue the Member's benefits currently being received by the Member, including the benefit that is the subject of the MCO internal appeal, if all of the following criteria are met:

- The Member or his or her representative files the MCO internal appeal in a timely manner;
- The MCO internal appeal involves the termination, suspension, or reduction of a previously authorized services;
- The services were ordered by an authorized provider;
- The period covered by the original authorization has not expired; and
- The Member requests an extension of the benefits.

If, at the Member's request, the MCO continues or reinstates the Member's benefits while the MCO internal appeal is pending, the benefits must be continued until one of the following occurs:

- The Member withdraws the MCO internal appeal or requests for an HHSC fair hearing;
- 10 days pass after the MCO mails the notice resolving the MCO internal appeal against the Member, unless the Member, within the 10-daytime frame, has requested an HHSC fair hearing with continuation of benefits until an HHSC fair hearing decision can be reached; or
- An HHSC fair hearings officer issues a hearing decision unfavorable to the Member.

If the MCO or HHSC fair hearings officer reverses a decision to deny, limit, or delay services that were not furnished while an appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires. If the MCO or HHSC fair hearings officer reverses a decision to deny authorization of services and the Member received the disputed services while an appeal was pending, the MCO is responsible for the payment of services. The MCO is prohibited from discriminating or taking punitive action against a Member or his or her representative for making an appeal.

Due to the character limits in Appendix F-1, the continuation of this language can be found in the Main/option section.

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 and the MCO operate the grievance/complaint systems. HHSC operates and maintains an electronic complaint/grievance system that provides information to HHSC staff on any complaints/grievances related to Members of the MCOs. The MCO is also required by contract to develop, implement and maintain a Member complaint and appeal system specific to their Members.

The Member is also informed that they can contact a Member advocate or their MCO service coordinator if they need assistance for issues related to making complaints or filing a grievance.

- 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).

The MCO must develop, implement, and maintain a member complaint and appeal system that complies with the requirements in applicable federal and state laws and regulations.

The complaint and appeal system must include a complaint process, an internal appeal process, and access to HHSC's fair hearing system. The procedures must be the same for all Members and must be reviewed and approved in writing by HHSC or its designee. Modifications and amendments to the member complaint and appeal system must be submitted for HHSC's approval at least 30 days prior to implementation.

The MCO must have written policies and procedures for receiving, tracking, responding to, reviewing, reporting and resolving complaints by Members or their authorized representatives. The MCO must resolve complaints within 30 days from the date the complaint is received. The complaint procedure must be the same for all Members under the contract. The Member or Member's authorized representative may file a complaint either orally or in writing. The MCO must also inform Members how to file a complaint directly with HHSC, once the Member has exhausted the MCO's complaint process.

The MCO's complaint procedures must be provided to Members in writing and through oral interpretive services. The MCO must include a written description of the complaint process in the Member handbook. The MCO must maintain and publish in the Member handbook at least one local and one toll-free telephone number with teletypewriter/telecommunications device for the deaf (TTY/TDD) and interpreter capabilities for making complaints.

The MCO's process must require that every complaint received in person, by telephone, or in writing must be acknowledged and recorded in a written record and logged with the following details:

1. Date;
2. Identification of the individual filing the complaint;
3. Identification of the individual recording the complaint;
4. Nature of the complaint;
5. Disposition of the complaint (i.e., how the managed care organization resolved the complaint);
6. Corrective action required; and
7. Date resolved.

The MCO is prohibited from discriminating or taking punitive action against a Member or his or her representative for making a complaint.

If the Member makes a request for disenrollment, the MCO must give the Member information on the disenrollment process and direct the Member to the HHSC administrative services contractor. If the request for disenrollment includes a complaint by the Member, the complaint will be processed separately from the disenrollment request, through the complaint process.

The MCO will cooperate with HHSC's administrative services contractor and HHSC or its designee to resolve all Member complaints. Such cooperation may include, but is not limited to, providing information or assistance to internal complaint committees. The MCO must provide a designated member advocate to assist the Member in understanding and using the MCO's complaint system until the issue is resolved.

The HHSC Office of the Ombudsman assists the public when the normal complaint process cannot, or does not, satisfactorily resolve an issue. The Office of the Ombudsman may be a complainant or investigator for a complaint. The Office of the Ombudsman includes the following services:

- * Conducting independent reviews of complaints concerning agency policies or practices;
- * Ensuring that policies and practices are consistent with the goals of HHSC;
- * Ensuring that individuals are treated fairly, respectfully, and with dignity; and
- * Making referrals to other agencies as appropriate.

The process to assist with complaints and issues is as follows:

- * A member of the public, an individual, a legally authorized representative, or medical consentor or a provider makes first contact with the MCO or HHSC to request assistance with an issue or complaint;
- * If not able to resolve the issue or complaint, the Office of the Ombudsman may be contacted;
- * The Office of the Ombudsman will provide an impartial review of actions taken by the MCO; and

* The Office of the Ombudsman will seek a resolution.

Often it is necessary for the Office of the Ombudsman to refer an issue to the appropriate department. If so, the Office of the Ombudsman will follow up with the complainant to determine if a resolution has been achieved, or to refer the complainant to other available known resources.

HHSC has established an escalation help line in accordance with Texas Government Code Section 533.00253, STAR Kids Managed Care Program. Section 533.00253(f) requires HHSC to operate a Medicaid escalation help line that is dedicated to assisting families of Medicaid recipients receiving benefits under the medically dependent children (MDCP) waiver program or the deaf-blind with multiple disabilities (DBMD) waiver program in navigating and resolving issues related to the STAR Kids managed care program. HHSC has expanded the escalation help line to assist STAR Health members receiving benefits under the MDCP or DBMD waiver program.

Section 533.00253(i) states that a Medicaid managed care organization must, to the extent feasible, provide information, including information related to service coordination and prior authorization denials, that will enable HHSC staff operating the escalation help line to assist recipients.

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).

Obligation to Report

Under state law, a person is required to report suspected abuse, neglect, or exploitation of an individual receiving waiver services to the appropriate state agency. More specifically:

Reports to the Department of Family and Protective Services Statewide Intake:

- A person having cause to believe that an individual who has a disability or is receiving services from a provider (as defined by Texas Human Resources Code §48.251(a) (9)) is in a state of abuse, neglect, or exploitation is required to report the information immediately to the Department of Family and Protective Services Statewide Intake. This includes providers of home and community-based services under Section 1915(c) of the Social Security Act (also known as 42 U.S.C. Section 1396n) (see: Texas Human Resources Code, Title 2, Subtitle D, Chapter 48, §48.051 (relating to Reports of Abuse, Neglect, or Exploitation: Immunities)).
- A person having cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect by a person must report the information immediately to Department of Family and Protective Services Statewide Intake (see: Texas Family Code, Title 5, Subtitle E, Chapter 261, Subchapter B, §261.101 (relating to Persons Required to Report; Time to Report)).
- A professional who has cause to believe that a child has been abused or neglected or may be abused or neglected must make a report to Department of Family and Protective Services Statewide Intake within 48 hours after the professional first suspects abuse or neglect (see: Texas Family Code, Title 5, Subtitle E, Chapter 261, Subchapter B, §261.101(b)).

There are two options for reporting abuse, neglect, and exploitation to the Texas Department of Family and Protective Services Statewide Intake:

- Phone - Abuse Hotline, 800-252-5400, 24 hours a day and 7 days a week; or
- Electronically - a secure internet website, <https://www.txabusehotline.org>.

All urgent situations require use of the phone method. Urgent situations are described on the Department of Family and Protective Service website as those, which include, but are not limited to:

- Serious injuries;
- Any injury to a child 5 years or younger;
- Immediate need for medical treatment (including suicidal thoughts);
- Sexual abuse where the abuser has or will have access to the victim within the next 24 hours;
- Children age five and under who are alone or are likely to be left alone within the next 24 hours; or
- Anytime you believe your situation requires action in less than 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 a STAR Kids or STAR Health Member is approved for long-term services and supports, the MCO must ensure that the Member is informed orally and in the Member Handbook of the processes for reporting allegations of abuse, neglect, or exploitation. The toll-free numbers for the Health and Human Service Commission (HHSC) and Department of Family and Protective Services Statewide Intake must be provided.

In accordance and consistent with 42 CFR §438.100 (relating to Enrollee Rights), HHSC established a statement of managed care participant rights that may be found in the Texas Administrative Code (TAC) (1 TAC §353.202 relating to Member Bill of Rights). The managed care contracts and the Uniform Managed Care Manual require that MCOs maintain written policies and procedures for informing Members of their rights and responsibilities, and must notify Members of their right to request a copy of these rights and responsibilities (Member Rights and Responsibilities). Members are informed through MCO Member handbooks and are provided with additional support, as needed, to understand their rights as well as their responsibilities.

Informal Caregivers: The informal caregivers are unpaid natural supports and are outside the scope of waiver services. The Member or the Member's legally authorized representative or medical consentor is responsible for training people who provide non-waiver natural support activities, such as informal caregivers.

At the time of assessment but no later than when the Medicaid Member is approved for MDCP, the MCO must ensure that the Member is informed orally and in writing through the Member Handbook of processes for reporting allegations of abuse, neglect, or exploitation. The toll-free numbers for the Department of Family and Protective Services Statewide Intake must be provided. In addition, during annual face-to-face visits with the Member, the service coordinator must educate the Member and legally authorized representative about their rights regarding acts that constitute abuse or neglect (DFPS Child Protective Investigations) and abuse, neglect, or exploitation (DFPS Adult Protective Services and HHSC Provider Investigations).

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Department of Family and Protective Services Statewide Intake receives reports of alleged abuse, neglect, or exploitation of individuals who have a disability, or who are receiving services from a provider as defined by Texas Human Resources Code §48.251(a)(9). HHSC Provider Investigations investigates the allegations. This includes investigations of:

- An adult or child who has a disability and is receiving services from a Home and Community Support Services Agency;
- An adult with a disability or a child residing in or receiving services from a local intellectual and developmental disability authority, local mental health authority, or community center; or
- An adult with a disability receiving services through the consumer directed services option.
- An adult or child receiving services from a:
 - o Managed care organization;
 - o Provider agency contracted with an HHS agency or MCO to provide home and community-based services in accordance with 42 U.S.C. Section 1315, 42 U.S.C. Section 1315a, 42 U.S.C. Section 1396a, or 42 U.S.C. Section 1396n, and as otherwise provided by department rule.
 - o Provider agency contracted with a MCO to provide behavioral health services;
 - o An officer, employee, agent, contractor, or subcontractor of an entity listed above; or .
 - o An employee, fiscal agent, case manager, or service coordinator of an individual employer participating in the consumer directed service option, as defined by §531.051, Government Code.

The Department of Family and Protective Services investigations are governed by Title 2 of the Texas Human Resources Code, Subtitle D, Chapter 48 (relating to Investigations and Protective Services for Elderly and Disabled Persons) and Title 4 of the Texas Health and Safety Code, Subtitle B, Chapter 260A (relating to Reports of Abuse, Neglect, and Exploitation of Residents of Certain Facilities).

When the Department of Family and Protective Services Statewide Intake receives abuse, neglect, or exploitation reports concerning an individual in a facility licensed by another state agency and explicitly responsible for investigating abuse, neglect, or exploitation in that facility, the Department of Family and Protective Services forwards the report to the other state agency for investigation.

The Department of Family and Protective Services Statewide Intake receives reports of abuse, neglect, or exploitation of individuals who have a disability that occur in a facility or are perpetrated by a provider, either of which are operated, licensed, or certified by HHSC. HHSC licenses Home and Community Support Services Agencies and Nursing Facilities providing out-of-home respite.

Law Enforcement

State law requires the Department of Family and Protective Services and HHSC to notify the appropriate law enforcement agency of reports of abuse, neglect, or exploitation during certain investigations. Specifically:

- The Department of Family and Protective Services and HHSC are required to immediately notify the appropriate law enforcement agency when a caseworker or supervisor has cause to believe that an individual who has a disability has been abused, neglected, or exploited by another person in a manner that constitutes a criminal offense under any law. This requirement does not apply when the law enforcement agency is the entity that reports the alleged abuse, neglect, or exploitation to HHSC or the Department of Family and Protective Services (see: Texas Human Resources Code, Title 2, Subtitle D, Chapter 48, §48.1522 (relating to Reports of Criminal Conduct to Law Enforcement)).
- Within 24 hours after receipt of a report of abuse, neglect, or exploitation of a resident of an HHSC facility, HHSC Regulatory must report the incident to the appropriate law enforcement agency when the complaint alleges:
 - o A resident's health or safety is in imminent danger;
 - o A resident has recently died because of conduct alleged in the report of abuse, neglect, exploitation, or other complaint;
 - o A resident has been hospitalized or been treated in an emergency room because of conduct alleged in the report of abuse, neglect, exploitation, or other complaint;
 - o A resident has been a victim of any act or attempted act described by Section 21.02, 21.11, 22.011, or 22.021 of the Texas Penal Code; or
 - o A resident has suffered bodily injury, as that term is defined by Section 1.07 of the Texas Penal Code, because of conduct alleged in the report of abuse, neglect, exploitation, or other complaint (see: Texas Health & Safety Code, Title 4, Subtitle B, Chapter 260A, §260A.007 (relating to Investigation and Report by Department)).
- The Department of Family and Protective Services and HHSC must immediately notify the appropriate law enforcement agency of any report that concerns the suspected abuse, neglect, or exploitation of a child or the death of a

child from abuse or neglect. If the Department of Family and Protective Services or HHSC finds evidence indicating that a child may have been abused, neglected, or exploited, the Department of Family and Protective Services or HHSC must report the evidence to the appropriate law enforcement agency (see: Texas Family Code, Title 5, Subtitle E, Chapter 261, §261.402 (relating to Investigative Reports)).

These requirements do not apply when the law enforcement agency is the entity that reports the alleged abuse, neglect, or exploitation to HHSC or the Department of Family and Protective Services.

Section 22.04 of the Texas Penal Code makes it a criminal offense to intentionally, knowingly, recklessly, or with criminal negligence, by act or intentionally, knowingly, or recklessly by omission, cause to a child, or an individual with a disability serious bodily injury; serious mental deficiency, impairment, or injury; or bodily injury. Section 32.53 of the Texas Penal Code makes it a criminal offense to intentionally, knowingly, or recklessly cause the exploitation of a child, or an individual with a disability.

All reports that allege abuse or neglect by a person responsible for a child's care, custody, or welfare received by a local or state law enforcement agency are referred immediately to the Department of Family and Protective Services or the designated agency (see: Texas Family Code, Title 5, Subtitle E, Chapter 261, §261.105(a)). Furthermore, reports of abuse, neglect or exploitation of an individual residing in a facility regulated by HHSC received by a law enforcement agency are referred to HHSC (see: Texas Health & Safety Code, Title 4, Subtitle B, Chapter 260A, §260A.005 (relating to Telephone Hotline; Processing of Reports)).

If a child has been the victim of conduct that constitutes a criminal offense posing an immediate risk of physical or sexual abuse of a child that could result in death or serious harm to the child, the Department of Family and Protective Services, if the alleged perpetrator is a family member, or HHSC Provider Investigations, if the alleged perpetrator is a provider, conducts a joint investigation with the appropriate law enforcement agency (see: Texas Family Code, Title 5, Subtitle E, Chapter 261, §261.301(f)). If an individual believes there is a risk of immediate harm to a child, the individual may contact the Department of Family and Protective Services. Additionally, if HHSC Provider Investigations investigates and determines the alleged perpetrator is not a provider that meets Provider Investigations' jurisdiction, Provider Investigations refers the information to the appropriate investigative entity. If the Department of Family and Protective Services initiates an investigation and determines that the abuse or neglect does not involve a person responsible for the child's care, custody, or welfare, the Department of Family and Protective Services refers the report to the appropriate law enforcement agency for further investigation (see: Texas Family Code, Title 5, Subtitle E, Chapter 261, §261.105(d)).

Upon receipt of a report of alleged abuse, neglect, or exploitation of a person residing in a facility licensed, operated, certified or registered by HHSC, law enforcement must acknowledge the report and begin a joint investigation with HHSC within 24 hours after receipt of the report (see: Texas Health & Safety Code, Title 4, Subtitle B, Chapter 260A, §260A.017).

- 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.

In accordance with 42 CFR §431.10(e), HHSC is the single state Medicaid agency and retains oversight and full administrative authority over the waiver program. HHSC has a system to prevent, identify, report, investigate, and remediate critical incidents that occur within the delivery of managed long-term services and supports programs as well as to track and trend results in order to make system improvements. The obligation to report abuse, neglect, and exploitation is mandated by statute and HHSC clarifies roles, expectations, and responsibilities for providers and MCOs in the managed care contracts. Under the managed care contracts, MCOs are required to submit a quarterly report to HHSC that includes the number of critical incidents and abuse, neglect, or exploitation reports received for members receiving long-term services and supports.

The critical incident systems consists of numerous levels of participant protection:

- Prevention, identification, and reporting of abuse, neglect, or exploitation;
- Investigations of abuse, neglect, or exploitation;
- Monitoring findings;
- Remediation of issues; and
- Consumer support for Members.

1. Licensure Requirements

The state, through HHSC, licenses the following provider agencies:

- Adult day care facilities (TAC Title 40, Chapter 98);
- Adult agency foster care, serving four or more individuals (licensing: TAC Title 40, Chapter 92);
- Assisted living facilities (TAC Title 40, Chapter 92);
- Home and Community Support Services Agencies (TAC Title 26, Chapter 558); and
- Nursing facilities (TAC Title 26, Chapter 554).

Additional providers licensed through other entities:

- Licensed durable medical equipment providers (TAC Title 25, Part 1, Chapter 229, Subchapter X);
- Providers of cognitive rehabilitation therapy services;
- Occupational therapists (TAC Title 40, Part 12);
- Physical therapists (TAC Title 22, Part 16); and
- Speech therapists (TAC Title 22, Part 32).

Prior to issuing licensure to the above healthcare providers, the state screens those facilities or persons for prior disciplinary or criminal history in Texas and in other states. In accordance with Section 1919(e)(2) of the Social Security Act, HHSC maintains a registry of all nurse aides who are certified to provide services in nursing facilities and skilled nursing facilities licensed by HHSC (see: 42 U.S.C. 1396r(e)(2)). The Nurse Aide Registry lists nurse aides who are unemployable because of confirmed instances of abuse, neglect, or exploitation, misappropriation, or misconduct against a nursing facility resident or Members served by a Home and Community Support Services Agencies. For unlicensed employees, in accordance with state law, HHSC maintains an Employee Misconduct Registry that includes the names of unlicensed persons who are unemployable because of confirmed instances of abuse, neglect, or exploitation, misappropriation, or misconduct in the facilities listed above (Texas Health and Safety Code, Title 4, Subtitle B, Chapter 253 (relating to Employee Misconduct Registry)).

All HHSC-regulated facilities and agencies are required to check both the Nurse Aide Registry and Employee Misconduct Registry before hiring an individual and annually thereafter. In addition, all MCOs are required to check both the Nurse Aide Registry and Employee Misconduct Registry prior to contracting with an unlicensed or uncertified provider agency, and annually thereafter, as indicated in the Uniform Managed Care Contract.

2. Credentialing Unlicensed or Uncertified Provider Agencies by MCOs

Through their credentialing process, the MCOs ensure that the agencies they contract with have met all licensure requirements. According to the managed care contracts, before contracting with an unlicensed provider agency or provider agency not certified by a health and human services agency, such as minor home modification or home-delivered meals provider agencies, the MCOs must take steps to verify that the provider agency:

- Has not been convicted of a crime listed in Texas Health and Safety Code, §250.006;
- Is not listed as "unemployable" in the Employee Misconduct Registry or the Nurse Aide Registry maintained by HHSC by searching or ensuring a search of such registries is conducted before hire and annually thereafter;
- Is knowledgeable of acts that constitute abuse, neglect, or exploitation of a Member;
- Is instructed on and understands how to report suspected abuse, neglect, or exploitation;

- Adheres to applicable state laws if providing transportation; and
- Is not a spouse of, legally responsible person for, or employment supervisor of the Member who receives the service.

Monitoring

HHSC monitors abuse, neglect, and exploitation investigation findings as well as MCO compliance efforts. The state of Texas maintains overall responsibility for the operation of the critical incident system and engages in continuous process improvements. Protections against abuse, neglect, and exploitation are not limited to HHSC's jurisdiction, as other state and local entities have related responsibilities throughout this section.

HHSC developed a process that includes requiring MCOs on a quarterly basis to submit to HHSC aggregate data on investigations of abuse, neglect, and exploitation, as well as data on critical incidents that do not necessarily rise to the level of abuse, neglect, or exploitation. For both abuse, neglect, or exploitation and other critical incidents, HHSC's goal is to be able to identify and respond to trends and spikes in data received from the MCOs.

HHSC's Medicaid/CHIP Division provides guidance to the MCOs on Medicaid policy and managed care program requirements, reviews MCO materials, monitors the MCOs' contractual obligations, answers managed care inquiries, and resolves managed care complaints. HHSC's Medicaid/CHIP Division also monitors implementation of MCO corrective action plans and assesses damages when necessary.

A Corrective Action Plan is a detailed written plan that may be required by HHSC to correct or resolve a deficiency, event, or breach causing the assessment of a remedy or damage against the MCO.

Remediation

HHSC has the authority to terminate or replace an MCO or its subcontractor(s), according to managed care contracts, if either are convicted of a criminal offense related to the neglect or abuse of members in connection with the delivery of an item or service. If an MCO fails to meet contractual requirements related to protection against or reporting of abuse, neglect, or exploitation, such as contracting with provider agencies that fail to meet standards outlined in Sections A and B, then HHSC has authority to use a variety of remedies, up to and including contract termination.

Member Support

Texas maintains a consumer support system that is independent of the MCOs to assist members in understanding managed care and resolution of problems regarding services, benefits, access, and rights.

Texas' independent consumer supports system consists of HHSC's Medicaid/CHIP Division, Office of the Ombudsman (Ombudsman), HHSC's managed care Enrollment Broker ("MAXIMUS"), and community support from the Aging and Disability Resource Centers. These entities operate independently of any Medicaid MCO and work with beneficiaries and MCOs to ensure beneficiaries seeking to enroll with an MCO understand the managed care program, MCO options, and the process for resolving issues. Data related to the independent consumer supports system is reported and monitored regularly, on at least a quarterly basis.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

Complaints concerning the use of restraint can be made to the MCO or the Department of Family and Protective Services. The MCO service coordinator must ensure that an individual or legally authorized representative or medical consenter is informed orally and in writing of the processes for filing complaints about the provision of MDCP services, including:

- The toll-free telephone number of the MCO to file a complaint; and
- The toll-free telephone number of Department of Family and Protective Services Statewide Intake to file a complaint of abuse, neglect, or exploitation.

HHSC surveys licensed provider agencies for compliance with licensure requirements related to restraint and seclusion. HHSC and the Department of Family Protective Services investigate reports of abuse, neglect, and exploitation related to restraint or seclusion. Pursuant to federal and state rules, a waiver recipient has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation (see: 42 CFR §438.100 (relating to Enrollee Rights) and TAC Title 1 §353.202 (relating to Member Bill of Rights)). Complaints or allegations related to the use of restraints by provider agencies licensed by HHSC can be made to HHSC or the Department of Family and Protective Services for investigation.

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

- b. Use of Restrictive Interventions.** (*Select one*):

The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

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.

A provider agency must not use a restrictive intervention to modify or control a Member's behavior, for disciplinary purposes, for convenience, or as a substitute for an effective, less restrictive method. The primary function for the use of restrictive interventions is for safety and positioning in specific circumstances once the use of non-aversive methods have failed and been clearly documented.

Prior to authorizing the use of restrictive interventions, the provider must:

- Conduct an assessment of the Member's needs;
- Consider less restrictive methods that, if effective, would accomplish the purpose of the restrictive intervention
- Document in the case record the reasons why less restrictive methods would not be effective;
- Have a physician order for the use of restrictive interventions;
- Have the Home and Community Support Services Agency registered nurse with input from the Member, the Member's legally authorized representative, the Member's service planning team, and other professional personnel develop a written service plan and include it in the service plan, signed by the physician that describes:
 - o The type of device and the circumstances under which it may be used;
 - o How to use the protective device and any contraindications specific to the Member;
 - o How and when to document the use of the protective device;
 - o How to monitor the protective device; and
 - o When and whom the staff must notify of a protective device's use.
- Have the service planning team review and approve the written service plan;
- Obtain and retain in the case record written consent of the Member or the Member's legally authorized representative to use a protective device;
- Provide verbal and written notification to the Member or the Member's legally authorized representative of the right to withdraw the consent for the use of the restrictive intervention at any time;
- Ensure that each service provider who will use a restrictive intervention has been trained in the proper use of restrictive interventions and the training is documented in the service provider's record.

A service provider that uses a restrictive intervention must:

- Document in the provider case record any use of a protective device in accordance with the written service plan;
- Ensure that a Home and Community Support Services Agency registered nurse, with input from the member's service planning team and other professional personnel, at least annually, and as the Member's needs change:
- Evaluate and document in the provider agency's case record the effects of the protective device on the Member's health and welfare;
- Review the use of a protective device to determine its effectiveness and the need to continue the protective device; and
- Ensure that a Home and Community Support Services Agency registered nurse revises the service plan when the Member's service planning team and practitioner determine that a protective device is not effective or needed.

The MCO monitors potential improper and unauthorized use of restrictive interventions through on-site complaint investigations. Complaints concerning the use of restrictive interventions may be made to HHSC, the MCO or the Department of Family and Protective Services. HHSC refers complaints to the Department of Family and Protective Services Statewide Intake for investigation by HHSC Provider Investigations. The MCO service coordinator must ensure that a Member, a Member's legally authorized representative, or medical consentor is informed verbally and in writing of the processes for filing complaints about the provision of MDCP services including the use of restrictive interventions.

MCOs must provide trainings to providers on topics that include providers' obligation to identify and report a critical event or incident, including restraints, and abuse, neglect, and exploitation to HHSC related to long-term services and supports delivered in the STAR Kids program.

The MCO service coordinator must know how to identify and report critical events or incidents. The MCO service coordinators must take 16 hours of training on how to identify critical incidents.

- 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:

The MCO monitors potential improper and unauthorized use of restrictive interventions through on-site complaint investigations. Complaints concerning the use of restrictive interventions can be made to HHSC, the MCO or the Department of Family and Protective Services. The MCO service coordinator must ensure that a Member, a Member's legally authorized representative, or medical consentor is informed verbally and in writing of the processes for filing complaints about the provision of MDCP services including the use of restrictive interventions.

The following information is included:

- The toll-free telephone number of HHSC Ombudsman to file a complaint; and
- STAR Kids MDCP / Deaf Blind Multiple Disabilities (DBMD) Escalation Line, and
- The toll-free telephone number of the Department of Family and Protective Services Statewide Intake to file a complaint of abuse, neglect, or exploitation.

STAR Kids MCOs are responsible for investigating critical events and incidents and must report to the state on a quarterly basis, on the Uniformed Managed Care Manual 5.18 Critical Incidents and Abuse, Neglect, and Exploitation Quarterly Report. HHSC intends to review and compare this report with the abuse, neglect, and exploitation report sent from the Department of Family and Protective Services and follow up as needed.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

HHSC does not permit the use of seclusion as it relates to services delivered through Managed Long-Term Services and Supports. All allegations of improper seclusion of Members receiving Managed Long-Term Services and Supports by provider agencies licensed by HHSC are referred to HHSC and the Department of State Health Services for investigation. Members receiving services from home health agencies, licensed as Home and Community Support Services Agencies, have the right to be free from seclusion when it is for someone else's convenience or is meant to force the Member to do something, or punish the Member (see: TAC Title 1, Chapter 353, Subchapter C (relating to Member Bill of Rights and Responsibilities)).

Complaints concerning any use of seclusion can be made to HHSC, the MCO, or the Department of Family and Protective Services Statewide Intake. The MCO service coordinator and the MDCP provider agency must ensure that the Member, the Member's legally authorized representative, or medical consentor is informed orally and in writing of the processes for filing complaints about the provision of MDCP services including: the toll-free telephone number of the HHSC Ombudsman to file a complaint; and the toll-free telephone number of the Department of Family and Protective Services Statewide Intake to file a complaint of abuse, neglect, or exploitation.

STAR Kids MCOs are responsible for investigating critical events and incidents and must report to the state on a quarterly basis on the Uniform Managed Care Manual 5.18 Critical Incidents and Abuse, Neglect and Exploitation Quarterly Report. HHSC intends to review and compare this report with the abuse, neglect and exploitation report sent from the Department of Family and Protective Services and follow up as needed.

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.

When a camp provider or nursing facility, while providing out-of-home respite, administers or supervises a Member's medication, the camp provider or nursing facility are required to monitor all aspects of the Member's medication. Registered nurses review the Member's medications upon admission and upon significant change in the Member's condition.

The Department of Family and Protective Services monitors medication management and administration by child-placing agencies who provide respite through an agency foster home, in accordance with Title 26 of the Texas Administration Code, Part 19, Chapter 749, Subchapter J.

MDCP provider agencies holding a Home and Community Support Services Agency license must administer medications in accordance with their licensure requirements. HHSC conducts surveys of Home and Community Support Services Agencies licensed provider agencies who administer medications to ensure they have policies for maintaining a current medication list and a medication administration record.

HHSC Long-Term Care Regulation performs licensing surveys that include medication management, specifically medication administration by the Home and Community Support Services Agencies is responsible for management of the medication. 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. 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.

- 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 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 and 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 Regulatory Services surveyors may conduct follow-up surveys and inspections to ensure the provider agency has effectively implemented any corrective action plan required due to cited violations.

Nursing Facilities Providing Out-of-Home Respite

HHSC Regulatory Services licenses and surveys nursing facilities. Medication management is part of the license requirements for these provider agencies. HHSC oversees medication management provided by nursing facilities through licensure surveys and complaint investigations. HHSC requires the submission of corrective action plans, or imposes administrative penalties and license revocation when harmful medication management practices are detected.

Department of Family and Protective Service Agency Foster Home

The Department of Family and Protective Services is the agency responsible for follow-up and oversight, in accordance with Title 26 of the Texas Administrative Code, Part 19, Chapter 749, Subchapter J. The HHSC Child Care Licensing monitors child-placing agencies annually, identifying harmful practices, and uses that information to improve quality. HHSC Child Care Licensing uses methods specific to the agency such as technical assistance or corrective action plans. Annually, HHSC will obtain data from the Department of Family and Protective Services on child-placing agencies serving members in MDCP. HHSC reviews the Department of Family and Protective Services' actions regarding violations.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

- ii. State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

MDCP provider agencies must administer medications as required by applicable licensure. Licensure regulations only allow licensed nurses, certified medication aids (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.

The Home and Community Support Services Agencies are required to review and update a Member's service plan, including medications, at least every six months. Home and Community Support Services Agencies must report to the supervisor any unusual medication reactions.

iii. Medication Error Reporting. *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the state:

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

Any type of medication error, regardless of severity, must be recorded and the provider agency must make information available to HHSC Long-Term Care Regulation upon request during licensure surveys. If a medication error rises to the level of abuse or neglect, the provider agency must report to HHSC based on licensure requirements. The medication error may also be reported to the Department of Family and Protective Services Abuse Hotline for HHSC Provider Investigations to investigate if the medication was not administered, or unknown if it was, under the clinical duties of the provider agency.

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.

Medication errors are considered a critical event or incident by contract definition. Thus, MCOs must provide trainings to providers that include: the providers' obligation to identify and report a critical event or incidents such as abuse, neglect, or exploitation to HHSC related to long-term services and supports delivered in the STAR Kids program.

The MCO Member services representative (call line) must be knowledgeable about identifying and reporting a critical event or incident such as abuse, neglect, or exploitation to HHSC related to long-term services and supports delivered in the STAR Kids program.

MCO service coordinators must complete training that includes identifying and reporting critical events or incidents such as abuse, neglect, or exploitation and educating Members on protections.

The MCOs also have to submit quarterly reports, specifically, the Critical Incidents and Abuse, Neglect, and Exploitation Report. Medicaid MCOs must submit a quarterly report that includes the number of critical incidents and abuse, neglect, and exploitation reports received from HHSC Provider Investigations for Members receiving long-term services and supports as well as the final status of each reported allegation. For the abuse, neglect, or exploitation allegations confirmed by HHSC Provider Investigations, the MCO must also report to HHSC the type of remediation taken by the contracted provider agency.

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 instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:

G.a.1 Number and percent of enrolled individuals who were free from confirmed allegations of abuse. N: Number of enrolled 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 Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Department of Family Protective Services</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

G.a.2 Number and percent of enrolled individuals who were free from confirmed allegations of neglect. N: Number of enrolled 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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

G.a.3 Number and percent of enrolled individuals who were free from confirmed allegations of exploitation. N: Number of enrolled 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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid	Weekly	100% Review

Agency		
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Department of Family Protective Services"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

G.a.4 Number and percent of enrolled individuals who were free from all allegations of abuse, neglect, and exploitation. N: Number of enrolled individuals who were free from all allegations of abuse, neglect, and 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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">Department of Family Protective Services</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

	Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 10px;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 240px; margin-top: 10px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 240px; margin-top: 10px;"></div>

Performance Measure:

G.a.5 Number and percent of reported deaths of individuals free from previous confirmed allegations of abuse, neglect, or exploitation within the last three months.

N: Number of reported deaths of individuals free from previous confirmed allegations of abuse, neglect, or exploitation within the last three months. **D:** Number of reported deaths.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Quality Assurance and Improvement Data Mart

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Department of Family Protective Services"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<div style="border: 1px solid black; height: 30px; width: 100%;"></div>

Performance Measure:

G.a.6 Number and percent of managed care organizations with approved manuals that include information on reporting abuse, neglect, and exploitation. N: Number of managed care organizations with approved manuals that include information on reporting abuse, neglect, and exploitation. **D:** Number of managed care organizations.

Data Source (Select one):

Presentation of policies or procedures

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Other Specify:	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

G.a.7 Number and percent of service coordinators trained on recognizing and reporting abuse, neglect, exploitation, and unexplained death. N: Number of service coordinators trained on recognizing and reporting abuse, neglect, exploitation, and unexplained death. D: Number of service coordinators.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

HHS TexConnect Portal

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative

		Sample Confidence Interval = <div></div>
Other Specify: <div>Managed Care Organizations</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:**G.a.8 Number and percent of confirmed ANE allegations remediated by the provider.****N:** Number of confirmed ANE allegations remediated by the provider. **D:** Number of confirmed ANE allegations.**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

HHS TexConnect Portal

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 = <input type="text"/>
Other Specify: <input type="text" value="Managed Care Organizations"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

G.a.9 Number and percent of ANE incidents reported by the provider within the specified timeframe. **N:** Number of ANE incidents reported by the provider within the specified timeframe. **D:** Number of ANE incidents reported by the provider.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Critical Incident Management System

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
Other	Annually	Stratified

Specify: Managed Care Organizations		Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

- b. Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

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

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

Performance Measure:

G.b.1 Number and percent of provider-reported critical incidents for which the 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:

HHS TexConnect Portal

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 = <input type="text"/>
Other Specify: <input type="text" value="Managed Care Organizations"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div>

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:

HHS Enterprise Administrative Report and Tracking System (HEART); HHS TexConnect Portal

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 120px; margin-top: 5px;"></div>

Other Specify: <div>Managed Care Organizations</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

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 enrolled individuals free from unauthorized restraint.

N: Number of enrolled individuals free from unauthorized restraint. D: Number of enrolled individuals.

Data Source (Select one):

Other

If 'Other' is selected, specify:

HHS TexConnect Portal

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 = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; padding: 2px;">Managed Care Organizations</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

G.c.2 Number and percent of enrolled individuals free from seclusion. N: Number of enrolled individuals free from seclusion. D: Number of enrolled individuals.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

HHS TexConnect Portal

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other	Annually	Stratified

Specify: Managed Care Organizations		Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other 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 MCOs who met or exceeded HHSC minimum standards on 2/3 or more of the STAR Kids Performance Indicator Dashboard measures. N: Number of MCOs who met or exceeded HHSC minimum standards on 2/3 or more of the STAR Kids Performance Indicator Dashboard measures. D: Number of managed care organizations.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Institute for Child Health Policy

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 = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; padding: 2px; width: 100%;">Institute for Child Health Policy</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- 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.

Specific to MCO-reported data for appendix G measures regarding abuse, neglect, and exploitation, HHSC receives both self-reported data from the MCOs and investigative reports from HHSC Provider Investigations. Data received from the MCOs is compared by HHSC against the data from the HHSC Provider Investigations reports. When questions or concerns are identified, HHSC follows up with MCOs to obtain additional information and follows up accordingly to ensure confirmed allegations of abuse, neglect, and exploitation are appropriately remediated.

HHSC's Managed Care Compliance Operations unit conducts on-site operational reviews of each MCO at least biennially to ensure the MCOs are following their documented policies and procedures and that those policies and procedures continue to align with HHSC's contractual requirements.

HHSC's Quality Review Team, which consists of representatives from several units within the HHS enterprise, meets on a quarterly basis to review comprehensive quality reports generated by the Quality Reporting Unit. The reports generated by the Quality Reporting Unit summarize data from units within HHSC as well as self-reported data collected from MCOs. These reports include quarterly and annual scores as well as remediation activities per performance measure. HHSC staff present the reports and recommendations to the Quality Review Team. Priorities for further scrutiny, revisions to requirements, and follow-up with Quality Improvement Projects are established during these meetings.

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 has the authority to terminate or replace an MCO or its subcontractor(s), according to managed care contracts, if either are convicted of a criminal offense related to the neglect or abuse of members in connection with the delivery of an item or service. If an MCO fails to meet contractual requirements related to protection against or reporting of abuse, neglect, or exploitation, such as contracting with long-term services and supports providers that fail to meet standards, then HHSC has authority to use a variety of remedies, up to and including contract termination. Remedies include the following:

- Corrective action plan;
- Assessment of liquidated damages;
- Accelerated monitoring of the MCO, which includes more frequent or extensive monitoring by HHSC;
- Requiring additional financial or programmatic reports to be submitted by the MCO;
- Requiring additional or more detailed financial or programmatic audits or other reviews of the MCO;
- Terminating or declining to renew or extend an MCO contract;
- Appointing temporary MCO management under the circumstances described in 42 CFR §438.706;
- Suspending member enrollment;
- Withholding or recouping payment to the MCO; and
- Requiring forfeiture of all or part of the MCO's performance bond.

ii. Remediation Data Aggregation

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

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

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.

MDCP transitioned into managed care in November 2016, and HHSC has incorporated MDCP into its managed care quality strategy. In accordance with Title 42, CFR, Section 438.340, the state must implement a quality strategy for assessing and improving the quality of healthcare and services provided through managed care. The state must review and update every three years or whenever a significant changes is made. A significant change includes:

- Adding new populations to the managed care programs;
- Expanding managed care programs to new parts of the state; and
- Carving new services into the managed care programs.

The managed care quality strategy was last updated in July 2021, and can be accessed on the HHSC website at <https://www.hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/tx-managed-care-quality-strategy-july-2021.pdf>

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.

HHSC articulated the vision and infrastructure for the quality improvement strategy for HCBS 1915(c) waivers internally approved by HHSC in 2010. The Quality Improvement Strategy is currently being revised to ensure continuous quality improvement as outlined in the CMS 2014 Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers. The quality improvement strategies submitted in each HCBS §1915(c) waiver application or renewal, approved in or after federal fiscal year (FFY) 2017, defines HHSC staff performance improvement roles and determines HHSC quality policies and procedures relevant to HCBS waiver performance standards. Central to the Quality Improvement Strategy is the Quality Review Team, which consists of representatives from several units within HHSC who review MDCP data to establish priorities and direct the improvement activities for the waiver program. The Quality Review Team oversees the ongoing implementation of the quality oversight plan and all related processes. By providing recommendations for new or revised quality measures, identifying and facilitating access to new data sources, identifying new internal and external processes impacting all phases of quality in the waiver program, and conducting other necessary actions, the Quality Review Team ensures continuous and ongoing programmatic improvement of the MDCP waiver program. Additionally, the Quality Review Team reviews the Quality Improvement Strategy at least every three years. Revisions to the quality improvement Strategy will be approved by HHSC leadership.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: <div></div>	Other Specify: <div></div>

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.

HHSC's Quality Review Team (QRT), which consists of representatives from several units within the HHS enterprise, meets on a quarterly basis to review comprehensive quality reports generated by the Quality Reporting Unit. The reports generated by the Quality Reporting Unit summarize data from units within HHSC as well as self-reported data collected from MCOs. These reports include quarterly and annual scores as well as remediation activities per performance measure. HHSC staff present the reports and recommendations to the Quality Review Team. Priorities for further scrutiny and follow-up with Quality Improvement Projects are established in these meetings.

The STAR Kids Managed Care Advisory Committee was established by Senate Bill 7, 83rd Texas Legislature, Regular Session, 2013 and in compliance with Texas Government Code Section 533.00254 to advise the Texas Health and Human Services Commission (HHSC) on the establishment and implementation of the STAR Kids managed care program. Members of the committee include a variety of stakeholders including families of children with disabilities receiving services under STAR Kids, physicians, home health providers, managed care organizations (MCO), and organizations representing children with disabilities. The diversity of the committee lends a unique perspective on how the program is functioning across Texas and generates ideas and recommendations for improvements. The committee has been a critical partner to HHSC and has identified and advised HHSC on issues that have led to policy changes and improvements to the program.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

At least every three years, HHSC staff will evaluate the processes and indicators of the Quality Improvement Strategy. HHSC staff will examine issues such as whether the indicators are providing substantive information for each sub-assurance and whether the Quality Review Team composition is inclusive of key internal stakeholders. If areas for improvement exist, HHSC staff will make recommendations for changes to the Quality Review Team, and the Quality Review Team will approve or revise recommended changes. In addition to the Quality Improvement Strategy, HHSC incorporated MDCP into its Managed Care Quality Strategy.

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*):

NCI Child and Family Survey

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).

The delivery of 1915(c) MDCP Waiver services is completed under a combination of the 1115 Waiver, 1915(a), and the 1915(c) Waiver authorities. The contracted MCOs that deliver Medicaid benefits under the STAR Kids and STAR Health Managed Care models are responsible for contracting with and monitoring the network providers of all Medicaid benefits, including those services that are included under the 1915(c) Waiver.

HHSC requires the MCO to provide financial information on a quarterly basis. That information is validated through a variety of ways, including audits of claims data by contractors hired by HHSC and submission of encounter data by the MCO to HHSC. There are no additional requirements specific to the 1915(c) Waiver.

Costs related to the 1915(c) Waiver are included in the development of the capitation payment to the MCO.

HHSC contracts with MCOs who in turn contract with, credential, and monitor MDCP provider agencies. In order to ensure the financial integrity of the program, HHSC contracts with external auditors (DK Partners and Myers and Stauffer) to conduct annual audits of the financial statistical reports (FSR) submitted by the participating MCOs, which include the 1915(c) MDCP Waiver services. The audit process may include on-site visits to verify maintenance of financial records and a review of a statistically valid sample of claims. The claims review verifies that each claim is paid in accordance with Member eligibility and the terms of the provider contractor. The audit findings are utilized to address compliance issues with the individual health plans as well as to complete a final calculation of the profit-sharing Experience Rebate due for each State Fiscal Year.

In addition, the HHSC Provider Finance Department conducts quarterly desk reviews and analysis of the financial statistical reports (FSR), which are submitted by the MCOs. The objective of this analysis is to reconcile the submitted FSR to known data to identify and resolve inconsistencies; to communicate with the MCOs regarding data reporting issues; to improve the accuracy of the data submission and reporting process; to identify and communicate financial trends and potential issues to internal HHSC Plan Management, Medicaid/CHIP Division Management, HHSC Actuarial Analysis, and others; and to make the FSR a more reliable data source as input to other processes, including the rate setting process.

Once data is available, HHSC will validate the paid claims reported by the MCOs on their FSR, and HHSC reconciles the MCO's encounter data to the aggregate dollars reported in the paid claims section of the FSR. This process is conducted to ensure that the paid claims reported on the FSR are supported by the encounters submitted (allowable variance of +/- two percent).

Further substantive tests of the underlying medical records that support claims billed to MCOs by provider agencies are conducted by HHSC's External Quality Review Organization (EQRO). The EQRO conducts an Annual Encounter Data Validation, which is a process that compares the encounter data of record with actual content of the Member's medical records to determine validity, accuracy, and completeness.

If at any time there is a report of a provider having committed suspected Medicaid fraud, waste, and/or abuse, the Office of the Attorney General will investigate the suspected offense. The Office of the Attorney General Medicaid Fraud Control Unit (MFCU) coordinates the investigation of suspected Medicaid fraud, waste, and abuse with the HHSC Office of the Inspector General pursuant to Texas Government Code §531.103. Investigations are conducted in the same manner and pursuant to the same regulations for fee-for-service and managed care allegations. MFCU investigations are conducted in compliance with the requirements of Title 42 of the Code of Federal Regulations, Part 455. MCOs must provide information requested by the MFCU pursuant to Title 1 of the Texas Administrative Code Part 15, Chapter 352.

To comply with §1903(l) of the Social Security Act, as added by the 21st Century Cures Act, HHSC requires program providers, Financial Management Services Agencies (FMSAs) and Consumer Directed Services (CDS) employers to use electronic visit verification (EVV) for the services described in Title 1 of the Texas Administrative Code, Part 15, Chapter 354, Subchapter O.

The use of EVV will be enforced through an automated matching process which compares an accepted EVV visit transaction to a program provider's or FMSA's service claim before the payment of the claim. If critical data elements on the visit transaction and claim do not match, the claim will be denied.

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 Number and percent of per member per month capitated payments paid to managed care organizations for eligible Medicaid individuals. N: Number of per member per month capitated payments paid to managed care organizations for eligible Medicaid individuals. D: Number of per member per month capitated payments paid to managed care organizations.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

Premium Payable System (PPS)

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 = <div style="border: 1px solid black; height: 30px; width: 100px; margin-top: 5px;"></div>
Other	Annually	Stratified

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- 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 changes made to rate methodology during the reporting period that were submitted via a contract amendment for CMS approval prior to implementation. N: Number of changes made to rate methodology during reporting period that were submitted via a contract amendment for CMS approval prior to implementation. D: Number of changes made to rate methodology.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

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 = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- 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.

Individual problems may be discovered during monitoring activities by HHSC or any entities that have been delegated certain functions within the performance measures of this appendix. Those responsible for conducting the monitoring and frequency are described in each performance measure of this appendix. The options for remediation are listed below:

If HHSC discovers that a capitated payment was made to an MCO for a non-eligible Member, HHSC recoups the funds from the MCO. At the end of the month in which the Member became ineligible, the member is disenrolled from the program.

ii. Remediation Data Aggregation

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

<i>Responsible Party (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i>	<i>Annually</i>

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

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.

MDCP transitioned into managed care in November 2016, and HHSC has incorporated MDCP into its managed care quality strategy. In accordance with Title 42, CFR, Section 4328.340, the state must implement a quality strategy for assessing and improving the quality of healthcare and services provided through managed care. The state must review and update the quality strategy no less than every three years or whenever a significant changes is made. A significant changes includes:

- Adding new populations to the managed care programs;
- Expanding managed care programs to new parts of the state; and
- Carving new services into the managed care programs.

The managed care quality strategy was last updated in July 2021, and can be accessed on the HHSC website at <https://www.hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/tx-managed-care-quality-strategy-july-2021.pdf>

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).

As described in the 1115 Transformation waiver, HHSC's Actuarial Analysis calculates the capitated premium rates paid to the Medicaid and CHIP MCOs. HHSC uses an external actuary to certify these rates as meeting the actuarial soundness guidelines established by CMS. HHSC Actuarial Analysis is also involved with benefit and rate changes, program expansions, and legislative mandates that affect capitation rates paid to the MCOs. Finally, HHSC Actuarial Analysis provides actuarial support services for other HHSC activities, including initiatives related to the 1115 Transformation Waiver. Key quality-related activities with which HHSC Actuarial Analysis is involved include financial incentive programs and implementation of provider-level and MCO-level disincentives related to potentially preventable events.

- 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:

This waiver uses a managed care delivery system with capitated premiums. If the Member is eligible for Medicaid for the month, the MCO is paid a capitated premium per Member per month rate.

The 1915(c) Waiver services are included in the scope of services that the MCOs are required to deliver under their contract. The MCO establishes provider agreements, and all payments are made directly from the MCO to the network provider.

Direct billing is not available. Because MDCP will be operated under a managed care model, MDCP provider agencies must contract with and bill MCOs for services.

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:

HHSC determines which consumers are eligible for 1915(c) Waiver services and provides this information to the MCO. The MCO is contractually required to only provide services to eligible Members enrolled in the MCO.

- 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:

The MCO is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

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.

All payments for 1915(c) Waiver costs are included in the capitation payment to the MCO and no additional payments are made by HHSC for 1915(c) Waiver services.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

There is no reduction or return to HHSC.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements**i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:**

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how

payments to these plans are made.

This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. Select one:

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home

of the individual.

- b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

Payment of the cost of room and board is only provided under the waiver as part of out-of-home respite services.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

- a. Co-Payment Requirements.** Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

- a. Co-Payment Requirements.
- ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

- a. Co-Payment Requirements.
- iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

- a. Co-Payment Requirements.
- iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

- b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor

D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Hospital, Nursing Facility

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	14001.53	144522.88	158524.41	100383.97	116065.60	216449.57	57925.16
2	15789.82	152081.29	167871.11	103295.10	119431.50	222726.60	54855.49
3	16603.99	160034.31	176638.30	106187.36	122775.58	228962.94	52324.64
4	17466.87	168402.59	185869.46	109160.61	126213.30	235373.91	49504.45
5	18371.75	177209.27	195581.02	112217.11	129747.27	241964.38	46383.36

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:	Level of Care:
		Hospital	Nursing Facility
Year 1	6796	1	6795
Year 2	6796	1	6795
Year 3	6796	1	6795
Year 4	6796	1	6795
Year 5	6796	1	6795

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The Public Health Emergency (PHE) due to COVID-19 and the related Maintenance of Effort (MOE) policy that suspends disenrollment beginning March 2020 has attributed to variances in enrollment and utilization for updated projections. As part of the budgeting process, the state must update MDCP enrollment (recipient month) projections based on actual enrollment data, legislation directions, and set enrollment targets. However, WY1 (SFY2023) through WY5 (SFY2027) enrollment is based on prior renewal period WY5 enrollment levels.

The State calculates the average length of stay (in months) as dividing the total recipient months (average monthly recipients times twelve) by the annual unduplicated participants for a specified year. The State then converts the length of stay unit from months to days by multiplying by a factor of 30.4 (365 days divided by 12). A constant ALOS of 324.3 is assumed for WY1 through WY5.

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 Factor D estimates are based on utilization data for State Fiscal Year (SFY) 2020 using managed care encounters payment data and actual premium rates for STAR Kids MDCP. MDCP services are paid on a capitated per member per month basis. The estimated premium rates attributable to MDCP waiver services are multiplied by the estimated enrollee count. Costs associated with capitation (administration, risk margin, and premium tax) that are not client service specific are removed for an accurate client service cost and utilization estimates. The net capitation cost is then divided by the total estimated unduplicated participants for each waiver year. The overall cost growth assumption for waiver services is 5.25% for WY1 through WY5. Services such as Supported Employment, Employment Assistance and Transition Assistance Services had no utilization in the base year encounter data. Since there is no historical utilization, a standard healthcare price index trend, "Health Consumption" (IHS Global Insight, October 2021, "Short Term Forecast for the U.S. Economy") of 3% for WY1 and WY2, 2.9% for WY3 and 2.8% for WY4 and WY5 were used as opposed to the standard trend of 5.25% that other services received.

The number of unduplicated participants is assumed to be 6,796 for WY1 through WY5 and is based on prior renewal period WY5 enrollment levels.

The legislature appropriated funds for a wage increase for community attendants effective 9/1/2023 for the state fiscal year biennium of 2024-2025. Services affected include Flexible Family Support, Flexible Family Support CDS, Respite, and Respite CDS. For these services, the State estimated preliminary rates which are subject to change before effective date 9/1/2023. The State incorporated these rates into WY 2024 - 2027. Average cost per unit for Flexible Family Support increased 9.5% to \$12.57, for Flexible Family Support CDS it increased 10.3% to \$12.14, for Respite it increased 4.4% to \$17.85, and for Respite CDS it increased 10.7% to \$11.93. No change to utilization or client count assumptions were made from the original renewal submission.

Incorporating rate increases based on legislative appropriations results in an estimated increase in Factor D of 7.2% compared to the previously approved Factor D.

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor D' estimates are based on actual premium rates for STAR Kids MDCP excluding the waiver services portion of the premium rates. Under the managed care model, MDCP participants also receive state plan benefits (such as acute care, CFC services, and pharmacy benefits) through health plans. All MDCP services are paid on a capitated per member per month basis.

The State estimates the non-waiver capitation amounts and nets out costs associated with capitation that are not client service specific (including administration, risk margin, and premium tax). The State calculates Factor D' as dividing net non-waiver capitation amounts by annual unduplicated participants counts for SFY 2020. The overall cost growth assumption for MDCP premium rates is 5.25% for WY1 through WY5.

- 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:

Claims and encounter payment data for February 2019 through January 2020 is used as the base period for WY1 through WY5. The State estimated the SFY 2020 average G cost per patient day for individuals under age 21 and trended the figure by "Healthcare" price deflators (IHS Global Insight, October 2021, "Short Term Forecast for the U.S. Economy"). WY 1 average G cost per patient day was trended using the price deflator for SFY 2021 (2.9%), SFY 2022 (2.2%), and SFY 2023 (2.9%) to account for the three-year gap between the base year of SFY 2020 and WY 1 (SFY 2023). WY2 used as price deflator of 2.9%, and WY3 through WY5 used a price deflator of 2.8%. Factor G for WY1 through 5 were derived by multiplying the estimated G cost per patient day and ALOS for the waiver population of the specified WY. For WY1 through WY5, an ALOS of 324.3 days was assumed.

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:

Claims and encounter payment data for February 2019 through January 2021 is used for WY1 through WY5. The State estimated the SFY 2020 average G' cost per patient day for individuals under 21 years and trended the figure by "Healthcare" price deflators (IHS Global Insight, October 2021, "Short Term Forecast for the U.S. Economy"). WY1 average G cost per patient day was trended using the price deflator for SFY 2021 (2.9%), SFY 2022 (2.2%), and SFY 2023 (2.9%) to account for the three-year gap between the base year of SFY 2020 and WY1 (SFY 2023). WY2 used a price deflator of 2.9%, and WY3 through WY5 used a price deflator of 2.8%. Factor G for WY1 through 5 were derived by multiplying the estimated G' cost per patient day and ALOS for the waiver population of the specified WY. For WY 1 through 5, an ALOS of 324.3 days was assumed.

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	
Respite	
Supported Employment	
Financial Management Services	
Adaptive Aids	
Employment Assistance	
Flexible Family Support Services	
Minor Home Modifications	
Transition Assistance Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** 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. If applicable, check the capitation box next to that service. 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	Capi- tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							85311652.72
GRAND TOTAL:							95154408.74
Total: Services included in capitation:							95154408.74
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							6796
Factor D (Divide total by number of participants):							14001.53
Services included in capitation:							14001.53
Services not included in capitation:							
Average Length of Stay on the Waiver:							324

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite		per hour	2346	960.54	16.24	36595651.88	
Respite - Consumer Directed		per hour	2889	1645.13	10.25	48716000.84	
Supported Employment Total:							18649.26
Supported Employment- Consumer Directed		per hour	1	369.00	25.27	9324.63	
Supported Employment		per hour	1	369.00	25.27	9324.63	
Financial Management Services Total:							7315642.22
Financial Management Services		per month	3104	32.45	72.63	7315642.22	
Adaptive Aids Total:							718185.14
Adaptive Aids - Consumer Directed		per item	12	26.54	1127.52	359092.57	
Adaptive Aids		per item	12	26.54	1127.52	359092.57	
Employment Assistance Total:							11219.88
Employment Assistance- Consumer Directed		per hour	1	222.00	25.27	5609.94	
Employment Assistance		per hour	1	222.00	25.27	5609.94	
Flexible Family Support Services Total:							300779.35
Flexible Family Support Services		per hour	15	1232.22	10.91	201652.80	
Flexible Family Support Services - Consumer Directed		per hour	9	1050.96	10.48	99126.55	
Minor Home Modifications Total:							1472963.60
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							95154408.74 95154408.74 6796 14001.53 14001.53 324

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Minor Home Modifications - Consumer Directed		per item	13	38.51	1471.11	736481.80	
Minor Home Modifications		per item	13	38.51	1471.11	736481.80	
Transition Assistance Services Total:							5316.56
Transition Assistance Services		per item	1	1.00	2658.28	2658.28	
Transition Assistance Services - Consumer Directed		per item	1	1.00	2658.28	2658.28	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							95154408.74 95154408.74 6796 14001.53 14001.53 324

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							96924341.29
Respite		per hour	2346	960.54	17.85	40223669.09	
Respite - Consumer Directed		per hour	2889	1645.13	11.93	56700672.20	
Supported Employment Total:							19210.14
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							107307632.32 107307632.32 6796 15789.82 15789.82 324

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment- Consumer Directed		per hour	1	369.00	26.03	9605.07	
Supported Employment		per hour	1	369.00	26.03	9605.07	
Financial Management Services Total:							7694367.47
Financial Management Services		per month	3104	32.45	76.39	7694367.47	
Adaptive Aids Total:							755886.80
Adaptive Aids - Consumer Directed		per item	12	26.54	1186.71	377943.40	
Adaptive Aids		per item	12	26.54	1186.71	377943.40	
Employment Assistance Total:							11557.32
Employment Assistance- Consumer Directed		per hour	1	222.00	26.03	5778.66	
Employment Assistance		per hour	1	222.00	26.03	5778.66	
Flexible Family Support Services Total:							347162.97
Flexible Family Support Services		per hour	15	1232.22	12.57	232335.08	
Flexible Family Support Services - Consumer Directed		per hour	9	1050.96	12.14	114827.89	
Minor Home Modifications Total:							1549780.27
Minor Home Modifications - Consumer Directed		per item	13	38.51	1547.83	774890.13	
Minor Home Modifications		per item	13	38.51	1547.83	774890.13	
Transition Assistance Services Total:							5326.06
GRAND TOTAL:							107307632.32
Total: Services included in capitation:							107307632.32
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							6796
Factor D (Divide total by number of participants):							15789.82
Services included in capitation:							15789.82
Services not included in capitation:							
Average Length of Stay on the Waiver:							324

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transition Assistance Services		per item	1	1.00	2663.03	2663.03	
Transition Assistance Services - Consumer Directed		per item	1	1.00	2663.03	2663.03	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							107307632.32 107307632.32 6796 15789.82 15789.82 324

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							101919224.40
Respite		per hour	2346	960.54	18.78	42319356.06	
Respite - Consumer Directed		per hour	2889	1645.13	12.54	59599868.35	
Supported Employment Total:							19763.64
Supported Employment-Consumer Directed		per hour	1	369.00	26.78	9881.82	
Supported Employment		per hour	1	369.00	26.78	9881.82	
Financial Management Services Total:							8093237.68
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							112840700.83 112840700.83 6796 16603.99 16603.99 324

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Financial Management Services		per month	3104	32.45	80.35	8093237.68	
Adaptive Aids Total:							795575.78
Adaptive Aids - Consumer Directed		per item	12	26.54	1249.02	397787.89	
Adaptive Aids		per item	12	26.54	1249.02	397787.89	
Employment Assistance Total:							11890.32
Employment Assistance- Consumer Directed		per hour	1	222.00	26.78	5945.16	
Employment Assistance		per hour	1	222.00	26.78	5945.16	
Flexible Family Support Services Total:							365041.47
Flexible Family Support Services		per hour	15	1232.22	13.22	244349.23	
Flexible Family Support Services - Consumer Directed		per hour	9	1050.96	12.76	120692.25	
Minor Home Modifications Total:							1630632.01
Minor Home Modifications - Consumer Directed		per item	13	38.51	1628.58	815316.01	
Minor Home Modifications		per item	13	38.51	1628.58	815316.01	
Transition Assistance Services Total:							5335.52
Transition Assistance Services		per year	1	1.00	2667.76	2667.76	
Transition Assistance Services - Consumer Directed		per item	1	1.00	2667.76	2667.76	
GRAND TOTAL:							112840700.83
Total: Services included in capitation:							112840700.83
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							6796
Factor D (Divide total by number of participants):							16603.99
Services included in capitation:							16603.99
Services not included in capitation:							
Average Length of Stay on the Waiver:							324

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (8 of 9)****d. Estimate of Factor D.**

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							107216890.08
Respite		per hour	2346	960.54	19.76	44527714.36	
Respite - Consumer Directed		per hour	2889	1645.13	13.19	62689175.72	
Supported Employment Total:							20317.14
Supported Employment- Consumer Directed		per hour	1	369.00	27.53	10158.57	
Supported Employment		per hour	1	369.00	27.53	10158.57	
Financial Management Services Total:							8513260.10
Financial Management Services		per month	3104	32.45	84.52	8513260.10	
Adaptive Aids Total:							837341.25
Adaptive Aids - Consumer Directed		per item	12	26.54	1314.59	418670.62	
Adaptive Aids		per item	12	26.54	1314.59	418670.62	
Employment Assistance Total:							12223.32
Employment Assistance- Consumer Directed		per hour	1	222.00	27.53	6111.66	
Employment Assistance		per hour				6111.66	
GRAND TOTAL:							118704854.10
Total: Services included in capitation:							118704854.10
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							6796
Factor D (Divide total by number of participants):							17466.87
Services included in capitation:							17466.87
Services not included in capitation:							
Average Length of Stay on the Waiver:							324

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			1	222.00	27.53		
Flexible Family Support Services Total:							383758.23
Flexible Family Support Services		per hour	15	1232.22	13.90	256917.87	
Flexible Family Support Services - Consumer Directed		per hour	9	1050.96	13.41	126840.36	
Minor Home Modifications Total:							1715719.09
Minor Home Modifications - Consumer Directed		per item	13	38.51	1713.56	857859.54	
Minor Home Modifications		per Item	13	38.51	1713.56	857859.54	
Transition Assistance Services Total:							5344.90
Transition Assistance Services		per year	1	1.00	2672.45	2672.45	
Transition Assistance Services - Consumer Directed		per item	1	1.00	2672.45	2672.45	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							118704854.10 118704854.10 6796 17466.87 17466.87 324

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:							112769810.51
Respite		per hour	2346	960.54	20.79	46848744.00	
Respite - Consumer Directed		per hour	2889	1645.13	13.87	65921066.51	
Supported Employment Total:							20885.40
Supported Employment- Consumer Directed		per hour	1	369.00	28.30	10442.70	
Supported Employment		per hour	1	369.00	28.30	10442.70	
Financial Management Services Total:							8955441.97
Financial Management Services		per month	3104	32.45	88.91	8955441.97	
Adaptive Aids Total:							881304.23
Adaptive Aids - Consumer Directed		per item	12	26.54	1383.61	440652.11	
Adaptive Aids		per item	12	26.54	1383.61	440652.11	
Employment Assistance Total:							12565.20
Employment Assistance- Consumer Directed		per hour	1	222.00	28.30	6282.60	
Employment Assistance		per hour	1	222.00	28.30	6282.60	
Flexible Family Support Services Total:							403777.50
Flexible Family Support Services		per hour	15	1232.22	14.63	270410.68	
Flexible Family Support Services - Consumer Directed		per hour	9	1050.96	14.10	133366.82	
Minor Home Modifications							1805281.79
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							124854421.16 124854421.16 6796 18371.75 18371.75 324

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Minor Home Modifications - Consumer Directed		per item	13	38.51	1803.01	902640.90	
Minor Home Modifications		per item	13	38.51	1803.01	902640.90	
Transition Assistance Services Total:							5354.56
Transition Assistance Services		per year	1	1.00	2677.28	2677.28	
Transition Assistance Services - Consumer Directed		per item	1	1.00	2677.28	2677.28	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							124854421.16 124854421.16 6796 18371.75 18371.75 324