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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Home and Community-based Services (HCS) Program

C. Waiver Number:TX.0110
Original Base Waiver Number: TX.0110.

D. Amendment Number:TX.0110.R06.05

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

08/30/15

Approved Effective Date: 08/30/15
Approved Effective Date of Waiver being Amended: 09/01/13

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The purpose of this amendment is to make the following changes:

Appendix B:
• Remove mandatory participation requirements because DADS chose not to implement mandatory participation rules.
• Add allowance for family members of the military to remain on the H CS interest list while temporarily residing outside the State due to military assignments.
• Correct a typographical error made in Amendment 3 and 4 by removing the check mark from Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act).
• Remove the requirement for HCS program providers to request DADS approve a gap in authorization of the level of care. Lapses in level of care may result in individuals not being eligible to enroll in or maintain eligibility for acute care services through the STAR+PLUS Program.

Appendix C:
• Remove the requirement that respite services be provided in non-routine circumstances. Limiting respite to non-routine circumstances is an unnecessary restriction on the use of the service.
• Add the requirement that service providers of behavioral support services receive certain training prescribed by DADS to

clarify training requirements for service providers of behavioral support services.
• Reduce the service limit for Transition Assistance Services (TAS) for individuals moving into companion care to $1,000. DADS determined that the TAS service limit for a companion care setting should be the same as the limit for the host home setting because DADS data system does not distinguish between these settings and very rarely does an individual move into a companion care setting.
• Remove the cost of pre-enrollment minor home modifications from the calculation of an individual's $7,500 lifetime limit for minor home modifications. The cost of pre-enrollment minor home modification assessments will not be included in the calculation of the individual's MHM lifetime limit of $7,500 because currently the cost of assessments for post enrollment MHMs are not included in this calculation
• Amend the specifications of service providers of TAS to require HCS Providers to provide TAS or contract with a TAS provider (including contracting with a TAS provider of the individual's or legally authorized representative (LAR)'s choice) because TAS providers are not able to bill in CARE due to system restraints.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☐ **Waiver Application**	
☐ **Appendix A – Waiver Administration and Operation**	
☑ **Appendix B – Participant Access and Eligibility**	B-1, B-3, B-4, B-6
☑ **Appendix C – Participant Services**	C-1/C-3
☐ **Appendix D – Participant Centered Service Planning and Delivery**	
☐ **Appendix E – Participant Direction of Services**	
☐ **Appendix F – Participant Rights**	
☐ **Appendix G – Participant Safeguards**	
☐ **Appendix H**	
☐ **Appendix I – Financial Accountability**	
☐ **Appendix J – Cost-Neutrality Demonstration**	

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:
Update the HCBS Transition Plan and remove Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act) from the Medicaid eligibility groups served in the waiver because this group was added as an error during the system's approval of TX 0110.06.03.

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*):
Home and Community-based Services (HCS) Program

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: TX.0110
Waiver Number:TX.0110.R06.05
Draft ID: TX.028.06.05

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

E. Proposed Effective Date of Waiver being Amended: 09/01/13
Approved Effective Date of Waiver being Amended: 09/01/13

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

☐ **Nursing Facility**

Select applicable level of care

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

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

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

1. Request Information (3 of 3)

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

- [x] **Not applicable**
- [ ] **Applicable**

Check the applicable authority or authorities:

- [ ] **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
- [ ] **Waiver(s) authorized under §1915(b) of the Act.**

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

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

  - [ ] **§1915(b)(1) (mandated enrollment to managed care)**
  - [ ] **§1915(b)(2) (central broker)**
  - [ ] **§1915(b)(3) (employ cost savings to furnish additional services)**
  - [ ] **§1915(b)(4) (selective contracting/limit number of providers)**
- [ ] **A program operated under §1932(a) of the Act.**

  Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
- [ ] **A program authorized under §1915(i) of the Act.**
- [ ] **A program authorized under §1915(j) of the Act.**
- [ ] **A program authorized under §1115 of the Act.**

  Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

- [x] **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 Home and Community-based Services (HCS) waiver, first authorized September 1, 1985, provides community-based services and supports to individuals with intellectual and developmental disabilities or a related condition living in a variety of residential settings including an individual's own home, family home, a host home/companion care setting, or a three or four person group home setting. Services and supports are intended to enhance quality of life, functional independence and health and well-being in community-based living as an alternative to institutional living. HCS makes all services available through the provider-managed service delivery option. Using consumer directed services, individuals may choose to self-direct the services of supported home living, respite, nursing, employment assistance, supported employment, and cognitive rehabilitation therapy. Individuals enrolling in the waiver are assisted by a service coordinator employed by one of the State's 39 local authorities. The local authority serving the geographic area in which the individual lives conducts all enrollment activities in accordance with its performance contract with the Texas Department of Aging and Disability Services (DADS), and with DADS rules governing the waiver. The service coordinator, using a person-directed planning process, is responsible for facilitating enrollment activities. These include coordinating the development of the individual's initial service plan; informing the individual of the service delivery options (consumer directed and provider managed) for services in the plan; assisting the individual in accessing non-waiver services; and the provision of a list of qualified HCS providers in the individual's area. In conjunction with the service planning team, the service coordinator develops the service plan which describes the waiver and non-waiver services the individual will receive.

Once an individual is enrolled in the HCS waiver, ongoing service coordination is provided by the local authority and the provision of waiver services to the individual is the responsibility of the HCS provider. Service coordination is provided under the State's Targeted Case Management strategy and is not a service included in the waiver service array. Service coordination includes service planning activities and the coordination and monitoring of both waiver services and non-

waiver services an individual may receive. The HCS provider is responsible for providing all waiver services identified in an individual's service plan.

The service coordinator is responsible for service coordination tasks that include: facilitating the development of the individual's service plan using a person-directed focus; identifying, advocating, and collaborating with non-waiver services the individual has an identified need for and linking the individual to those supports; on-going monitoring of both waiver and non-waiver services the individual may receive; recording the individual's progress or lack of progress toward the attainment of desired outcomes from waiver services as identified in the service plan; and record keeping in accordance with waiver requirements. The service coordinator must facilitate revisions to the individual's service plan when the individual's needs change, when the individual or their legally authorized representative indicate a need for a change in the individual's desired outcome for services, or provide other information to the service coordinator that indicates revision of the plan is appropriate.

The HCS provider is responsible for providing all HCS services to an individual as identified in the individual's service plan; to coordinate and monitor the delivery of those services; to integrate various aspects of services delivered through the waiver and from non-waiver sources when necessary; to record the individual's progress or lack of progress toward the attainment of desired outcomes from waiver services as identified in the service plan; and record keeping in accordance with waiver requirements.

The local authority must ensure that the service coordinator utilizes a person-directed planning process for service planning that is consistent with DADS' Person-Directed Planning Guidelines for Individuals with Intellectual and Developmental Disabilities.

The single State Medicaid Agency, the Texas Health and Human Services Commission (HHSC), exercises administrative discretion in the administration and supervision of the waiver. HHSC directly performs financial eligibility determinations for prospective enrollees; develops the reimbursement rate methodology and sets reimbursement rates; and conducts Medicaid Fair Hearings in accordance with 42 CFR §431, Subpart E.

HHSC delegates routine functions necessary for the operation of the waiver to the operating agency, DADS. These functions include managing waiver enrollment against approved limits; individual waiver enrollment; monitoring waiver expenditures against approved levels; conducting level of care evaluation activities; 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 on behalf of HHSC; developing rules, policies, procedures, and information governing the waiver; and quality assurance and quality improvement activities.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

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

- ◉ **No**
- ○ **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

I. Public Input. Describe how the State secures public input into the development of the waiver:
HHSC distributed the HCS Amendment 5 Tribal Notification to the tribal representatives on March 10, 2015, in compliance with the 60 day federal and state requirements. The Tribal Notification provided contact information to request copies of the amendment from the State via email, mail, or telephone. The State provides copies free of charge. The State did not receive any comments from the tribal representatives or requests for copies.

The Public Notice of Intent (PNI) was published in the Texas Register on April 10, 2015, page 2116

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

Additionally, on March 24, 2015, HHSC sent a request to the HHSC Office of Social Services to distribute notice of the amendment to 290 local eligibility offices with instructions to post the notice in public areas.

State staff posted the HCS Waiver Amendment 5, including the HCS Settings Transition Plan, on the HCS Waiver page on the DADS website http://www.dads.state.tx.us/providers/hcs/ on April 16, 2015. During the public comment period, the State received one comment regarding Amendment 5 and no comments regarding the HCS Settings Transition Plan.

A summary of the comment received during the public notice and input period, reasons why the comment were not adopted, and any modifications to the amendment based upon the comment follows:

Comment: The commenter suggested either implementing mandatory participation or considering alternatives to address program provider concerns.

State Response: The State continues to work with stakeholders to establish rules and policies to protect the health and safety of individuals enrolled in HCS and assist program providers to implement these services in a safe and effective manner. When the State is able to establish mandatory participation policies appropriate for individuals and program providers, the State will initiate waiver and rule amendments.

The State conducts Intellectual and Developmental Disability Systems Improvement Workgroup meetings at least monthly, for the purpose of evaluating current stakeholder experience, evolving needs, model design, barriers to participation, and new initiatives. In addition, communications with advocate groups are ongoing. The State also assures multiple opportunities for stakeholder and public comment in the formal rule promulgation process.

Health and Human Services Commission facilitates the State's Consumer Direction Workgroup, which meets quarterly to discuss and recommend improvements in the consumer directed services option offered through DADS and other community-based programs.

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:

Williamson
First Name:

Dana
Title:

Manager, Policy Development Support
Agency:

Texas Health and Human Services Commission
Address:

4900 North Lamar Blvd.
Address 2:

Mail Code H-620
City:

Austin
State:
Texas
Zip:

78751

Phone:

(512) 462-6287 **Ext:** ☐ **TTY**

Fax:

(512) 730-7472

E-mail:

dana.williamson@hhsc.state.tx.us

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

Woodall
First Name:

Amanda
Title:

Lead Home and Community-based Services and Texas Home Living Policy Specialist, Center for Policy and Innovat
Agency:

Texas Department of Aging and Disability Services
Address:

P.O. Box 149030

Address 2:

Mail Code W-521

City:

Austin

State:

Texas

Zip:

78714-9030

Phone:

(512) 438-3693 **Ext:** ☐ **TTY**

Fax:

(512) 438-5135

E-mail:

amanda.woodall@dads.state.tx.us

8. Authorizing Signature

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

Signature:

Micah Erwin

State Medicaid Director or Designee

Submission Date:

Aug 7, 2015

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

Last Name:

Ghahremani

First Name:

Kay

Title:

State Medicaid Director

Agency:

Texas Health and Human Services Commission

Address:

4900 North Lamar Blvd.

Address 2:

Mail Code H-620

City:

Austin

State:

Texas

Zip:

78751

Phone:

(512) 462-6205 **Ext:** ☐ **TTY**

Fax:

(512) 730-7472

E-mail:

kay.ghahremani@hhsc.state.tx.us

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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

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

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

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301 (c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

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

HCS Settings Transition Plan

Rule Overview

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

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

HCS Waiver

The State administers the Home and Community-based Services (HCS) program that provides home and community-based services to individuals with an intellectual disability as an alternative to living in an intermediate care facility for individuals with intellectual disabilities. Recipients can live in their own homes, their families' homes, in host home/companion care settings, or in residences with no more than three others who receive similar services. HCS rules require providers to justify any restriction of rights and support the principles set forth in the new HCBS regulations.

A comprehensive list of settings for HCS waiver services (which can be found in 40 TAC §9.174) is as follows:

waiver participant’s own home or family home;

provider owned or operated residences (host home/companion care setting or 3-person or 4-person residences in which residential support services);

day habilitation settings; and

non-residential community/public settings (including but not limited to libraries, parks, shopping centers, offices);

The State presumes that settings consisting of the individual's own home or family home or a public place are compliant. All other settings in the HCS waiver will be assessed for compliance with the HCBS final rule as part of the assessment process described below and referenced as "HCS waiver settings."

HCS Settings Transition Plan

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

Assessment Process:

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

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

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

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

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

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

In the first phase of the assessment process, Texas conducted a systemic/internal review of current waiver program rules and policies identifying areas that were in compliance with the new regulation, non-compliant, or silent. In addition, the State reviewed oversight processes to determine if revisions were needed to ensure ongoing compliance with new HCBS rules. The results of the systemic/internal review of rules and policies yielded an assessment document for the 1915(c) waivers operated by the Texas Department of Aging & Disability Services (DADS) that outlined areas of compliance and non-compliance across all of the waiver programs, including the HCS waiver. The document indicated whether the rules and policies were silent, non-compliant or partially compliant. DADS has concluded from the first phase of the assessment process that continued assessment of settings for compliance with federal requirements is indicated. The assessment document titled "Impact of Federal HCBS Rules on DADS 1915(c) Waiver Process," is posted on the DADS website at http://www.dads.state.tx.us/providers/HCBS/hcbs-settingsassessment.pdf allowing ongoing input on the assessment process. The Texas Health & Human Services Commission (HHSC) website (http://www.hhsc.state.tx.us/medicaid/hcbs/index.shtml) also links to the DADS website to support access to the assessment document.

In July 2014 the State gave public notice for a preliminary settings transition plan for the HCS waiver. Comments received were considered for incorporation into the assessment. The HCS portion of the preliminary plan was submitted to CMS with HCS Waiver Amendment 3 on August 29, 2014, and CMS approved the Amendment on November 26, 2014.

The State presumes that settings consisting of the individual's own home or family home or a public place are compliant. Provider-owned and -operated settings will be assessed by December 2015 (the end of the assessment phase).

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

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

-The State sought public input on the waiver specific preliminary settings transition plans for all of the 1915(c) waivers through an open meeting for stakeholders and the general public on October 13, 2014. The meeting was also webcast to allow for greater participation across the state. The State accepted public testimony on waiver specific preliminary settings transition plans and additional recommendations for improving the assessment process for all of the 1915(c) waivers.

- Provider self-assessment surveys: In order to validate the results of the first assessment phase, DADS is releasing a provider self-assessment survey to a representative sample of providers. The survey will be based on the exploratory questions provided by CMS with input from external stakeholders. The provider self-assessment survey will be developed in conjunction with providers, provider associations and advocacy organizations to ensure a comprehensive approach. Providers who are not a part of the sample can still obtain and complete a self-assessment survey on the agency websites and provide data that will be considered as the State moves forward. Based on the results of the survey, ongoing remediation strategies and the assessment document will be updated.

- Participant surveys: In order to validate the provider self-assessment surveys, DADS is releasing a participant survey to a representative sample of individuals receiving services. The survey will be based on the questions asked in the provider self-assessment. Participants who are not a part of the sample can still obtain and complete a participant survey on the agency websites and provide data that will be considered as the State moves forward. Based on the results of the survey, ongoing remediation strategies and the DADS assessment document will be updated.

- Stakeholder meetings: The State is developing a plan for holding meetings around the state to allow providers, advocates, individuals receiving services, legally authorized representatives and other interested parties the opportunity to comment on all 1915(c) waiver programs and any concerns regarding compliance with the new regulations.

- National Core Indicators (NCI) Data: The State is in the process of analyzing NCI data and will consider using it in the assessment process.

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

Third Phase of Assessment [June 2015-May 2016]

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

Remedial Strategy:

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

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

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

State Activity
Texas has identified a number of remediation strategies to address issues of potential non-compliance:

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

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

Texas does not have any settings in the current 1915(c) Medicaid waivers that are presumed not to be community-based settings according to the regulations. The only possible exception may be day habilitation sites. However, if the State determines the need to submit evidence to CMS for the application of heightened scrutiny for settings that are presumed not to be home and community- based, the Settings Transition Plan will be amended to rebut the presumption or provide a transition plan for the individuals.

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

Public Input and Notice:

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

The public input process requires the State to provide at least a 30-day public notice and comment period regarding the Statewide Settings Transition Plan that the State intends to submit to CMS for review and consideration. The State must provide a minimum of two statements of public notice and public input procedures. The State must ensure that the Statewide Settings Transition Plan is available to the public for public comment. The State must consider and modify the Statewide

Settings Transition Plan, as the State deems appropriate, to account for public comment. Upon submission of the Statewide Settings Transition Plan to CMS, the State must include evidence of compliance with the public notice requirements and a summary of the comments received during the public notice period, why comments were not adopted, and any modifications to the Statewide Settings Transition Plan based upon those comments.

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

State Activity

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

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

The public had an opportunity to make comments on the HCS preliminary settings transition plan published in July 2014 and the Texas Statewide Settings Transition Plan (which included the HCS waiver settings transition plan) in November 2014.

HHSC distributed the Texas Statewide Settings Transition Plan Tribal Notification to the tribal representatives on October 20, 2014, in compliance with the 60 day federal and state requirements. The Tribal Notification provided contact information for requesting additional information from the State via email, mail, or telephone. The State provides copies free of charge. The State did not receive any comments from the tribal representatives or requests for copies.

The Public Notice of the Texas Statewide Settings Transition Plan was published in the Texas Register on November 7, 2014, allowing a 30 day comment period in compliance with federal and state requirements. The Texas Register is published weekly and is the journal of state agency rulemaking for Texas. In addition to activities related to rules, the Texas Register publishes various public notices including attorney general opinions, gubernatorial appointments, state agency requests for proposals and other documents, and it is used regularly by stakeholders. HHSC publishes all Medicaid waiver submissions in the Texas Register in addition to many other notices. The publication is available online and in hard copy at the Texas State Library and Archives Commission, the State Law Library, the Legislative Reference Library located in the State Capitol building, and the University of North Texas libraries. All of these sites are located in Austin, except for the University of North Texas, which is located in Denton. Printed copies of the Texas Register are also available statewide through paid subscription; subscribers include cities, counties and public libraries throughout the state. The PNI provided contact information to request copies of the amendment from the State via email, mail, or telephone. The State provides copies free of charge.

The public notice provided information about the Texas Statewide Settings Transition Plan. The State provides copies free of charge. The "Statewide Settings Transition Plan" was posted on the HHSC, DADS and DSHS websites. The websites also provided links to make comments.

o http://www.hhsc.state.tx.us/medicaid/hcbs/index.shtml
o http://www.dshs.state.tx.us/mhsa/yes/
o http://www.dads.state.tx.us/providers/HCBS/index.cfm

The "HCS Settings Transition Plan" (which was taken from the Texas Settings Transition Plan) was posted on the DADS website in November 2014.

The State received comments and submitted comments specific to the HCS waiver program from the July 2014 preliminary plan public notice and submitted those comments and responses with HCS Amendment 3, on August 29, 2014. The amendment, including the preliminary plan, was approved on November 26, 2014.

State staff posted an updated HCS Settings Transition Plan with HCS Amendment 5 on the DADS website

http://www.dads.state.tx.us/providers/hcs/ on April 16, 2015. During the public comment period, no comments were received.

DADS concluded from the first phase of the assessment process that continued assessment of settings for compliance with federal requirements is indicated. The settings assessment document, titled "Impact of Federal HCBS Rules on DADS 1915 (c) Waiver Process," is posted on the DADS website at http://www.dads.state.tx.us/providers/HCBS/hcbs-settingsassessment.pdf allowing ongoing input on the assessment process. The Texas Health & Human Services Commission (HHSC) website (http://www.hhsc.state.tx.us/medicaid/hcbs/index.shtml) also links to the DADS website to support access to the assessment documents.

In addition, the State has implemented the following public input strategy, aimed at achieving optimum public input:

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

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

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

- Feedback mechanism: Dedicated electronic mail boxes and websites for HHSC and DADS are available to provide information about the new rules and accept feedback. The websites and the option to make comments will remain active throughout the transition and the State will take any comments received into consideration, until the State completes the transition. State websites are located at the following:

http://www.hhsc.state.tx.us/medicaid/hcbs/index.shtml

http://www.dads.state.tx.us/providers/HCBS/index.cfm

- Presentations at statutorily mandated committees: The State regularly provides updates to the following groups and offers them opportunities to comment on ongoing assessment and remediation activities:
-Promoting Independence Advisory Committee: comprised of individuals receiving services, advocacy organizations, and providers across target populations.
-Employment First Task Force: comprised of advocates and providers interested in employment issues.
-Texas Council on Autism and Pervasive Developmental Disorders: comprised of parents of individuals with autism and professionals.
-IDD Redesign Advisory Committee: comprised of individuals receiving services, advocacy organizations and providers.

- Presentations at agency workgroups: The agencies also have agency-established workgroups comprised of advocates and providers whose purpose is to examine ongoing rule and policy issues. Staff will provide updates on HCBS transition activities and provide the workgroup members the opportunity to provide comments.
- Presentations at conferences: Provider associations hold annual conferences and State staff have been invited to speak at these conferences. This provides access to a large number of providers for purposes of education, coordination and input regarding changes being made to rules and policy.

For more information or to obtain free copies of the HCS Settings Transition Plan, you may contact Micah Erwin by mail at Texas Health and Human Services Commission, P.O. Box 13247, Mail Code H-370, Austin, Texas, 78711-3247 phone (512) 424-6549, fax (512) 730-7472 or by email at TX-_Medicaid_Waivers@hhsc.state.tx.us.

Timeline of HCS Settings Transition Plan
*Represents milestone activities

ASSESSMENT OF HCS WAIVER SETTINGS

* Phase I: March 2014 - September 2014

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

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

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

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

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

* Phase II: September 2014 - December 2015

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

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

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

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

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

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

7) The State will update the assessment after completion of the entire assessment phase.
The update to the assessment will be posted on the agency websites. If, As a result of the assessment, there was a change in assessment findings, or the State has added additional remedial action and milestones, the State will submit an amendment or modification to the transition plan, after the required public notice and comment period.

Phase III: January 2015 - May 2016

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

2) July 2015 – May 2016: A representative sample of provider self-assessments will be verified by a representative sample of participant surveys.

PUBLIC INPUT

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

2) July 18, 2014: Preliminary Settings Transition Plan for HCS available for public comment through posting on the DADS website. 1) *July 2014 – September 2014: Internal assessment document outlining compliance and non-compliance with settings requirements across all 1915(c) waivers operated by DADS posted for public input.

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

Stakeholders will have multiple opportunities to provide input.

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

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

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

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

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

8) April 2015- May 2015: The HCS Settings Transition Plan posted for public comment. The following forms of public notice were utilized: notice in the Texas Register, on the DADS website, and a request sent to the HHSC Office of Social Services to distribute notice of the amendment to 290 local eligibility offices with instructions to post the notice in public areas.

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

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

State websites are located at the following:

http://www.hhsc.state.tx.us/medicaid/hcbs/index.shtml

http://www.dads.state.tx.us/providers/HCBS/index.cfm

REMEDIATION OF HCS WAIVER SETTINGS

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

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

3)* January 2016 – May 2017: Amend HCS program rules and Chapter 49 contracting rules to address all HCS waiver settings. Stakeholder input is actively solicited during the rule making process.

4) June 2016 – May 2017: Revise the HCS policy manual, including rights and responsibilities forms/publications and billing guidelines to further outline HCBS requirements for all HCS waiver settings.

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

6) December 2016 – July 2017: Revise residential review process to incorporate focus on HCBS setting requirements based on rule revisions. Residential reviewers monitor HCS providers annually to ensure compliance with the program rules.

7) December 2016 – July 2017: Revise certification review process for all HCS waiver settings, to incorporate focus on HCBS setting requirements based on rule revisions. Certification reviewers monitor HCS providers to ensure compliance

with program rules.

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

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

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

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

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

13) June 2017 – September 2018: Revise certification review process to incorporate focus on HCBS setting requirements based on day habilitation rule revisions. Residential reviewers monitor HCS providers annually to ensure compliance with program rules.

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

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

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Bi-monthly (every two months), the State must report, in writing, to CMS the entrance/enrollment values for each affected 1915(c) waiver as follows:
- the actual number of individuals enrolled as of the last date of the reporting period (Point-In-Time value);
- the number of unduplicated individuals served during the reporting period (Factor C value);
- the number of slots released to the waiver, during the reporting period, reported by first-come-first serve and reserved capacity group(s); and
- the number of individuals newly enrolled onto the waiver during the reporting period, reported by first-come first-serve and reserved capacity group(s).

The reports:
- must be submitted to CMS on the first of the month, every other month allowing for two months of lag time from the reporting period to submittal; and
- must include an explanation of the State's efforts to ensure continuous enrollment until all appropriated slots are filled.

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

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

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   In 2004, the Texas Legislature consolidated 10 health and human service agencies into four agencies (including DADS) to operate under the authority and oversight of the Health and Human Services Commission (HHSC). In accordance with Title 42 of the Code of Federal Regulations, Section 431.10, HHSC is designated as the single State Medicaid Agency and, therefore, has administrative authority over the waiver programs. The Texas Legislature gave HHSC plenary authority to supervise and operate the Medicaid program, including monitoring and ensuring the effective use of all federal funds received by the state's health and human services agencies.

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

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

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

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

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

However, all of the forgoing functions are subject to HHSC's ultimate approval authority consistent with Title 42 of the Code of Federal Regulations, Section 431.10(e)(1).

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

Annual monitoring by HHSC includes reviewing data from the quality measures and CMS-372 reports and implementing the Quality Review Team processes, the key formal mechanism for monitoring DADS' performance. The Quality Review Team meets quarterly and reviews comprehensive quality reports from each waiver at least annually. These reports include data on all of the waiver's quality improvement strategy measures. These reports also include remediation activities and outcomes. Improvement plans are developed as issues are identified, and the Quality Review Team reviews, modifying if needed, and approves all improvement plans. All active improvement plans for all waivers are monitored at each quality review team meeting. HHSC formally communicates the results from its monitoring to CMS and the public via the evidentiary review and annual report processes.

HHSC reviews and approves all waiver renewals, amendments and renewals and the CMS-372 reports that are developed by DADS. In addition, HHSC reviews all waiver program policies and operations that impact the waiver application and may request that DADS modify, clarify, or provide additional information in considering approval or disapproval of proposed changes.

Many of the functions listed above are addressed in quality measures related to waiver assurances. For example, "level of care evaluation" is addressed by the quality measures in Appendix B regarding the level of care assurance. DADS will also provide supplemental status reports to HHSC for each of the waivers. These status reports augment the annual comprehensive report, providing additional detail for functions that are not clearly subsumed by a particular assurance and related measures. HHSC will analyze the status reports at least annually to monitor compliance with waiver assurances and performance.

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

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

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):
   - ○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
     Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   - ◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):
   - ◉ **Not applicable**
   - ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
     - ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

       Specify the nature of these agencies and complete items A-5 and A-6:
     - ☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative

functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. **Performance Measures**

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

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver

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

Where possible, include numerator/denominator.

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

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

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

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

Data Aggregation and Analysis:

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
DADS quality reports

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
A.a.4 Number and percent of individuals enrolled at or below CMS approved level. N: Number of individuals including aggregate of new enrollees from beginning of waiver year. N: Number of unduplicated individuals approved by CMS (Factor C).

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

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

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Client Assignment and Registration system

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

		☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Client Assignment and Registration system; Quality Assurance and Improvement Data Mart

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

Data Aggregation and Analysis:

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

Performance Measure:
A.a.7 Number and percent of case records reviewed by DADS as part of Regulatory Services initial and annual certification visits in accordance with HHSC/DADS Executive Directive. N: Number of case records reviewed by DADS as part of

Regulatory Services initial and annual certification visits in accordance with HHSC/DADS Executive Directive. D: Number of case records required to be reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DADS Waiver Survey and Certification database; Client Assignment and Registration system

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

Data Aggregation and Analysis:

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Client Assignment and Registration system; Quality Assurance and Improvement Data Mart

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

Data Aggregation and Analysis:

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
DADS Utilization Review database

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

Data Aggregation and Analysis:

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
A.a.12 Number and percent of Medicaid provider agreements/contracts without the actions of imposed sanctions or denial of certification taken by DADS based upon results of Regulatory Services certification reviews. N: Number and percent of contracts without the actions of imposed sanctions or denial of certification taken. D: Number of contracts reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DADS Waiver Survey and Certification database; Client Assignment and Registration system

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

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
DADS Waiver Survey and Certification database; Client Assignment and Registration system

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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
HHSC and DADS hold regular status and update meetings directed at evaluating current quality systems and identifying and prioritizing enhancements. HHSC has formal processes to ensure that the waiver renewal,

waiver amendments, CMS-372 reports, Request for Evidentiary Information reports, and all state rules for waiver program operations are reviewed and approved by HHSC.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
HHSC and DADS hold regular status and update meetings directed at evaluating current quality systems and identifying and prioritizing enhancements. These meetings have resulted in plans to enhance data reporting by DADS to HHSC, establish a baseline for current activities, and develop a quality management strategy that spans more than one waiver and potentially other types of long-term care services. Additionally, HHSC has formal processes to ensure that the initial waiver, renewals, subsequent amendments, CMS-372, and Request for Evidentiary Information reports, and all state rules for waiver program operations are reviewed and approved by HHSC.

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

Informal conversations

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

Waiver Strategic Planning meetings

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

Elevated conversations

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

Action memos

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

Corrective Action Plan

HHSC may require DADS to develop a written plan to correct or resolve issues with performance. The corrective action plan must provide a detailed explanation of the reasons for the cited deficiency; an assessment or diagnosis of the cause; a specific proposal to cure or resolve a deficiency, including the date by which the deficiency will be cured; and a timetable including intermediate steps leading to the cure of the deficiency.

The corrective action plan must be submitted by the deadline set forth in HHSC's request for a corrective action plan. The corrective action plan is subject to approval by HHSC. Additionally, HHSC may require DADS to produce reports to demonstrate that the deficiency has been corrected and to monitor DADS' performance for a specified period of time.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☑ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☑	Developmental Disability	0		☑
	☑	Intellectual Disability	0		☑
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

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

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

  Specify the percentage:

- ◉ **Other**

  Specify:

  The cost limit is 200% of the institutional average as of August 31, 2010. The cost limit for the waiver is based on the level of need of the individual being served. The cost limit based on level of need is as

follows:

Intermittent (Level of Need 1), Limited (Level of Need 5), and Extensive (Level of Need 8): $167,468

Pervasive (Level of Need 6): $168,615

Pervasive plus (Level of Need 9): $305,877

Level of Need 2,3,4, or 7 do not exist. At the time the LON assignments were designed, information technology limited the numbering to 1,5,6 and 9.

An individual's level of need is reassessed at least annually and as the individual's needs change.

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

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

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

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:

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

The waiver is intended to serve individuals who would require institutionalization in an intermediate care facility if the waiver services and supports were not available to them. All individuals must have a plan of care at a cost within the cost limit. For individuals with needs that exceed the cost limit, the State has a process to ensure their needs are met. The process includes examining third-party resources, possible transition to another waiver, or institutional services.

An applicant whose request for eligibility for the waiver is denied or is not acted upon with reasonable promptness is entitled to a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A. For an applicant whose request for eligibility for the waiver is denied, DADS sends written notification to the applicant or the applicant's legally authorized representative, indicating the applicant's right to a fair hearing and the process to follow to request a fair hearing. The procedures for a fair hearing are provided in Appendix F of this waiver application. The individual 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.

The State will not terminate waiver eligibility for an individual based on the service limits that became effective December 1, 2011. If the individual, legally authorized representative, or other member of the individual's service planning team believes the service limit for a service will not meet the individual's needs, the HCS provider may request DADS grant an exception to the service limit.

Exceptions to the service limits will be granted on an individual basis if justified by the service planning team. Justification for an exception must be primarily based on evidence that exceeding the service limit is necessary to protect the individual's health and welfare. If an exception is granted, it is subject to the individual cost limit for the waiver.

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:

The process which ensures that individuals' health and welfare needs are met includes:
- examining the availability of non-waiver resources
- transitioning the individual to another waiver or to institutional services, or
- possible use of state funds to cover costs above the cost limit.

If the State proposes to terminate the individual's waiver eligibility or reduce services, the State gives the individual the opportunity to request a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A.

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	21927
Year 2	21945
Year 3	21945
Year 4	21945
Year 5	21945

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	21381
Year 2	21381
Year 3	21381
Year 4	21381
Year 5	21381

Appendix B: Participant Access and Eligibility

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

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

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

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

Purpose(s) the State reserves capacity for:

Purposes	
Individuals under age 22 leaving a nursing facility (MFP)	
Individuals under age 22 leaving a medium or small intermediate care facility (MFP)	
Individuals who previously moved from a state supported living center to a community ICF/IID	
Individuals currently residing in an institution scheduled for closure, or an out-of-state intermediate care facility losing funding (MFP)	
Individuals leaving state conservatorship	
Individuals at risk of institutionalization in a state supported living center	
Individuals leaving a state hospital	
Individuals with level of care I or VIII residing in a nursing facility (MFP)	
Individuals who previously moved from a state supported living center to a community ICF/IID	
Individuals leaving a large intermediate care facility, including a state supported living center (MFP)	
Children in conservatorship leaving a general residential operation	
Individuals at risk of imminent institutionalization	

Appendix B: Participant Access and Eligibility

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

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

Individuals under age 22 leaving a nursing facility (MFP)

Purpose *(describe):*

This Money Follows the Person target group reserves capacity for individuals under the age of 22 years who are receiving services in a nursing facility and who are registered as waiting for waiver services.

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	0
Year 4	0
Year 5	0

Appendix B: Participant Access and Eligibility

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

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

Individuals under age 22 leaving a medium or small intermediate care facility (MFP)

Purpose *(describe):*

This Money Follows the Person target group reserves capacity for individuals under the age of 22 years leaving a medium or small intermediate care facility.

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved
Year 1	30
Year 2	30
Year 3	0
Year 4	0
Year 5	0

Appendix B: Participant Access and Eligibility

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

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

Individuals who previously moved from a state supported living center to a community ICF/IID

Purpose *(describe):*

This target group reserves capacity for individuals who moved from a state supported living center into a community intermediate care facility for individuals with intellectual disabilities and choose to enter into the HCS waiver within three years of their community placement from the state supported living center.

Describe how the amount of reserved capacity was determined:

The State reserves capacity for this target group in accordance with direction from the DADS Deputy Commissioner using historical data of discharges from state supported living centers.

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

Waiver Year	Capacity Reserved
Year 1	20
Year 2	20
Year 3	12
Year 4	12
Year 5	12

Appendix B: Participant Access and Eligibility

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

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

Individuals currently residing in an institution scheduled for closure, or an out-of-state intermediate care facility losing funding (MFP)

Purpose *(describe):*

This Money Follows the Person target group reserves capacity for individuals receiving services in an institutional community-based program that is scheduled for closure or who occupy an out-of-state intermediate care facility placement for which the State will discontinue funding. This target group also includes closures of ICF/IID settings that result in individuals moving into HCS using Money Follows the Person funds.

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	0
Year 4	0
Year 5	0

Appendix B: Participant Access and Eligibility

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

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

Individuals leaving state conservatorship

Purpose *(describe):*

This target group reserves capacity for children aging out of the State's conservatorship who qualify for HCS services.

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved
Year 1	96
Year 2	96
Year 3	0
Year 4	0
Year 5	0

Appendix B: Participant Access and Eligibility

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

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

Individuals at risk of institutionalization in a state supported living center

Purpose *(describe):*

This target group is for individuals at risk of institutionalization in a state supported living center. The individuals do not have to be on the HCS interest list and will receive a diversion slot.

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved
Year 1	150
Year 2	150
Year 3	0
Year 4	0
Year 5	0

Appendix B: Participant Access and Eligibility

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

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

Individuals leaving a state hospital

Purpose *(describe):*

This target group reserves capacity for individuals who have chosen waiver services at the time of their discharge from a multiple disabilities unit of a state hospital operated by the Texas Department of State Health Services. A vacancy resulting from the discharge of an individual in this target group may be filled only by a member of this target group.

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved
Year 1	15
Year 2	15
Year 3	0
Year 4	0
Year 5	0

Appendix B: Participant Access and Eligibility

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

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

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

Purpose *(describe):*

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

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved
Year 1	195
Year 2	313
Year 3	0
Year 4	0
Year 5	0

Appendix B: Participant Access and Eligibility

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

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

Individuals who previously moved from a state supported living center to a community ICF/IID

Purpose *(describe):*

This target group reserves capacity for individuals who moved from a state supported living center into a community intermediate care facility for individuals with intellectual disabilities and choose to enter into the HCS waiver within three years of their community placement from the state supported living center.

Describe how the amount of reserved capacity was determined:

The State reserves capacity for this target group in accordance with direction from the DADS Deputy Commissioner using historical data of discharges from state supported living centers.

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

Waiver Year	Capacity Reserved
Year 1	20
Year 2	20
Year 3	12
Year 4	12
Year 5	12

Appendix B: Participant Access and Eligibility

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

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

Individuals leaving a large intermediate care facility, including a state supported living center (MFP)

Purpose *(describe):*

This Money Follows the Person target group reserves capacity for individuals leaving a large intermediate care facility, including a state supported living center.

Describe how the amount of reserved capacity was determined:

The State reseves 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	160
Year 2	160
Year 3	0
Year 4	0
Year 5	0

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):*

Children in conservatorship leaving a general residential operation

Purpose *(describe):*

This target group reserves capacity for children under the age of 18 with intellectual disabilities in the Department of Family and Protective Services conservatorship leaving a general residential operation.

Describe how the amount of reserved capacity was determined:

The Promoting Independence Advisory Committee recommended that the State set aside waiver slots for children in general residential operation.

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

Waiver Year	Capacity Reserved
Year 1	12
Year 2	13
Year 3	0
Year 4	0
Year 5	0

Appendix B: Participant Access and Eligibility

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

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

Individuals at risk of imminent institutionalization

Purpose *(describe):*

This target group reserves capacity for individuals who are at imminent risk of institutionalization and are registered as waiting for HCS services.

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved
Year 1	50
Year 2	50
Year 3	0
Year 4	0
Year 5	0

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 seeking waiver services are placed on an interest list. Each local authority interest list is automatically merged into a statewide interest list and is sorted by order of request date in the Client Assignment and Registration system. Documentation is maintained in the statewide interest list of the specific local authority that registered each applicant. Offers of waiver enrollment are released by DADS to the local authorities that registered the applicants based on the oldest request date on the statewide interest list. DADS notifies a local authority, in writing, of a waiver vacancy and directs the local authority to offer the vacancy to the applicant. If an individual seeking entrance into HCS meets the criteria for one

of the reserved capacity groups they bypass the interest list as long as there are reserved waiver capacity slots available.

Military family members will not be removed from the HCS interest list for temporarily moving outside of the state of Texas due to the military member's assignment. If an applicant who is a military family member is offered enrollment while temporarily living outside of Texas they shall retain their position on the interest list for up to one year after their family's military service ends.

If an applicant is denied waiver enrollment based on diagnosis, level of care, or other functional eligibility requirements, a DADS representative notifies the applicant (or the applicant's legally authorized representative) that, if he or she chooses, his or her name will be registered on one or more other waiver 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**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

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

  Specify percentage: [ ]

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

Specify:

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

- Title IV-E-- Adoption Assistance 435.145
- Mandatory Parents and Caretaker Relatives 1931 & 435.110
- Pregnant Woman and Children 435.116
- Children 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 Widows and Widowers Ineligible for SSI due to Increase in OASDI: 1634(b); 42 CFR 435.137
- Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security: 42 CFR 435.138; 1634(d)
- 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:

- [x] **A special income level equal to:**

Select one:

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

Specify percentage: [ ]

- ( ) **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

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

Select one:

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

- [x] **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.** *Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

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

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

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

  - ○ **Use spousal post-eligibility rules under §1924 of the Act.** *(Complete Item B-5-b (SSI State) and Item B-5-d)*
  - ◉ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)** *(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*
- ○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.** *(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

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

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

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

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

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

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

  Select one:

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

    (*select one*):

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

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

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

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

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

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

  Specify:
- ( ) **Other**

  Specify:

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

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

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

  Specify:

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

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

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

  Specify:
- ( ) **Other**

  Specify:

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

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

Select one:

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

  Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

  Select one:

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

    (*select one*):

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

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

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

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

Specify:

○ **The following dollar amount**

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

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

Specify:

○ **Other**

Specify:

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

◉ **Not Applicable**

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

Specify:

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

○ **SSI standard**

○ **Optional State supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

Not Applicable. The State does not give a spousal allowance because we follow spousal posteligibility
per the requirements of 2404 of ACA.

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

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

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

  Specify:
- ○ **Other**

  Specify:

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

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

Select one:

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

  Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage:

- ○ **The following dollar amount:**

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

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

  Specify formula:

- ○ **Other**

  Specify:

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

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

- ○ **Other**

Specify:

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

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver individuals are:
• RN licensed by the State,
• Licensed Social Worker,
• Psychologist,
• Psychological Associate, or
• Qualified Intellectual Disability Professional as defined in Title 42 of the Code of Federal Regulations, Section 483.430(a).

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

The required ICF/IID level of care I is defined in Title 40 of the Texas Administrative Code, Chapter 9, Subchapter E, as follows:

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

(1) Meet the following criteria:

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

(b) Have a full scale IQ score of 75 or below, obtained by administering a standardized individual intelligence test, and have a primary diagnosis by a licensed physician of a related condition that is included on the DADS Approved Diagnostic Codes for Persons with Related Conditions, available at this link:
http://www.dads.state.tx.us/providers/guidelines/ICD-9-CM_Diagnostic_Codes.pdf.

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

If it is difficult or not possible to obtain a level of care determination for an individual using the standard testing methods, these alternative evaluation options may be utilized:

1. If a person has a sensory or motor deficit for which a specially standardized intelligence test or a certain portion of a standardized intelligence test is appropriate, the appropriate score should be used.
2. If a full-scale IQ score cannot be obtained from a standardized intelligence test due to age, functioning level, or other severe limitations, an estimate of a person's intellectual functioning should be documented with clinical justification. The level of care is assigned based on information submitted electronically by the local authorities providing service coordination to the individual via the Client Assignment and Registration system utilizing the Intellectual Disability/Related Condition Assessment. The Intellectual Disability/Related Condition Assessment includes all factors that are assessed in evaluating a level of care determination: diagnostic information that includes age of onset of the condition, results of standardized intelligence testing, and assessments of adaptive behavior; measures from the Inventory for Client and Agency Planning; behavioral status; and information regarding day services.

The required ICF/IID level of care VIII is defined in Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter E, as follows:

To meet the level of care VIII criteria, an individual must:
(1) have a primary diagnosis by a licensed physician of a related condition that is included on the DADS Approved Diagnostic Codes for Persons with Related Conditions, available at this link:
http://www.dads.state.tx.us/providers/guidelines/ICD-9-CM_Diagnostic_Codes.pdf; and
(2) have an adaptive behavior level of II, III, or IV (i.e., moderate to extreme deficits in adaptive behavior) obtained

by administering a standardized assessment of adaptive behavior.

Individuals with a level of care VIII can only enter the waiver through the reserve capacity group "Individuals with level of care I or VIII residing in a nursing facility." Individuals with a level of care VIII were initially enrolled into the HCS waiver based upon a past legislative mandate requiring the State to serve individuals with a level of care VIII who chose waiver services. Title 7 of the Texas Health and Safety code Subtitle A, §533.0355, added by House Bill 2292 of the 78th Legislature, redefined the responsibilities of local authority program in a manner that resembles the HCS waiver. In order for the State to comply with the statutory requirements, the State proposed amendments that permitted individuals receiving local authority program services to continue to receive services under the HCS waiver and consolidated the HCS-O (HCS-Ombudsman Reconciliation Act of 1990) with the HCS waiver effective September 1, 2003. Individuals with a level of care VIII who were previously served in the HCS-O program were offered services in the HCS waiver at that time. The State continues to serve individuals in HCS who were enrolled as a result of this merger.

All standardized intelligence tests are administered by licensed psychologists, licensed psychological associates, certified psychologists, or individuals working under the direct supervision of one of the above individuals in the course of completing a Determination of Intellectual Disability. Endorsements or validation of other professionals qualified to administer individual intelligence tests (Educational Diagnostician, Licensed Specialist in School Psychology, etc.) may be an integral part of the Determination of Intellectual Disability.

Adaptive behavior assessments (Vineland Adaptive Behavior Scales [VABS], AAMD Adaptive Behavior Scales [AAMD ABS], Inventory for Client and Agency Planning and other standardized instruments are used in conjunction with professional judgment to determine Adaptive behavior levels. These are typically completed by professionals in the field of psychology, but may also be completed by other professionals as listed above. The Inventory for Client and Agency Planning, which is also used by Texas to determine level of need and funding allocations for certain services, may also be administered by non-professional staff, as indicated in the Inventory for Client and Agency Planning instruction manual.

The local authority conducts all portions of the evaluations described.

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

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

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

The service coordinator, employed by the local authority, completes the initial Intellectual Disability/Related Condition Assessment form using the results of the evaluations performed by qualifed professionals. The service coordinator requests an initial level of care determination for an applicant by electronically submitting the initial Intellectual Disability/Related Condition Assessment, via the Client Assignment and Registration system, indicating the recommended initial level of care. The local authority maintains the initial signed Intellectual Disability/Related Condition Assessment and documentation supporting the recommended level of care in the applicant's record. Once the enrollment process is complete the HCS provider is responsible for completing the Intellectual Disability/Related Condition Assessment annually and recommending a level of care. The HCS provider must maintain the signed Intellectual Disability/Related Condition Assessment and documentation supporting the recommended level of care in the individual's record. For all re-determinations of an individual's level of care, the service coordinator at the local authority reviews the assessment and the recommended level of care for agreement or disagreement. The service coordinator documents agreement or disagreement in the Client Assignment and Registration system prior to the recommendation being transmitted to DADS. If a service coordinator disagrees with an individual's

recommended level of care, the service coordinator must notify, in writing, the individual or their legally authorized representative, the HCS provider, and DADS of the reason for the disagreement.

A level of care determination must be made by DADS in accordance with criteria specified in Section D of this Appendix and is assigned based on information submitted electronically via the Client Assignment and Registration system utilizing the Intellectual Disability/Related Condition Assessment. Information on the Intellectual Disability/Related Condition Assessment must be supported by current data obtained from standardized evaluations and formal assessments that measure physical, emotional, social, and cognitive factors. The electronically transmitted Intellectual Disability/Related Condition Assessment must contain information identical to that on the signed Intellectual Disability/Related Condition Assessment. DADS authorizes the recommended level of care in the Client Assignment and Registration system or denies the recommended level of care and sends written notification to the service coordinator or HCS provider that a level of care has been denied. Because denial of the recommended level of care results in denial of request for eligibility, DADS also sends written notification to the applicant/individual or the applicant's/individual's legally authorized representative, indicating the right to a fair hearing and the process to follow to request a fair hearing. The procedures for a fair hearing are provided in Appendix F of this waiver application.

A level of care determination is valid for 364 calendar days after the level of care effective date determined by DADS.

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

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

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:

Reevaluations of level of care are conducted at least annually and when an individual's needs change significantly and require that level of care be reevaluated. The Inventory for Client and Agency Planning, which is used by the State to determine level of need and funding allocations for certain services and is based on the individual's current functioning level, is administered by non-professional staff, as indicated in the Inventory for Client and Agency Planning instruction manual. If the individual's health condition changes and there is a demonstrated need to revise the current service plan, a reevaluation would be conducted and the service plan revised to reflect the current situation of the individual. If an individual's level of need decreases to the lowest level (level of need 1), DADS requires the local authority to complete a new determination of intellectual disability and Intellectual Disability/Related Condition Assessment with a recommendation for a level of care. DADS will review the determination of intellectual disability report, supporting documentation, Intellectual Disability/Related Condition Assessment, and level of care recommendation. DADS authorizes the recommended level of care in the Client Assignment and Registration system or denies the recommended level of care.

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:

The educational/professional qualifications of persons performing re-evaluations of level of care for waiver individuals are:
• RN licensed by the State,

• Licensed Social Worker,
• Psychologist,
• Psychological Associate, or
• Qualified Intellectual Disability Professional as defined in Title 42 of the Code of Federal Regulations, Section 483.430(a).
• A person who has a minimum of three years work experience in planning and providing direct services to people with an intellectual disability or another developmental disability as verified by written professional references to oversee the provision of direct services to individuals.

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

The State employs the following procedures to ensure timely reevaluations of level of care:
• Edits in the automated Client Assignment Registration system;
• Annual reviews of local authorities; and
• Annual reviews of HCS providers.

The Client Assignment and Registration system provides HCS providers with information on upcoming Intellectual Disabilities/Related Condition Assessments so they can plan their workload.

The Client Assignment and Registration system also allows an HCS provider to enter a renewal Intellectual Disability/Related Condition Assessment 90 days prior to the new service plan's begin date.

The HCS provider requests level of care renewals electronically in the Client Assignment and Registration system. To prevent gaps in eligibility after enrollment, the Client Assignment and Registration system only authorizes level of care renewals from the first day after the expiration of the previous level of care, for each renewal period, not to exceed a 12 month period.

The Inventory for Client and Agency Planning, which is used by Texas to determine level of need and funding allocations for certain services, and is based on the individual's current functioning level, is administered by non-professional staff, as indicated in the Inventory for Client and Agency Planning instruction manual. If an individual's level of need decreases to the lowest level (level of need 1), DADS requires the local authority to complete a new determination of intellectual disability and Intellectual Disability/Related Condition Assessment with a recommendation for a level of care. DADS reviews the Determination of Intellectual Disability report, supporting documentation, Intellectual Disability/Related Condition Assessment, and level of care recommendation. DADS authorizes the recommended level of care in the Client Assignment and Registration system or denies the recommended level of care.

The Client Assignment and Registration system produces daily reports of all pending level of care determinations. This report is used to initiate reviews of all pending levels of care. The Client Assignment and Registration system prevents the delivery of services prior to the State's authorization of the level of care. In the event of a system failure in which an individual was enrolled without an authorized level of care, DADS would require immediate submission and evaluation of a level of care. If the individual was determined to meet the level of care for eligibility in the HCS waiver, services would continue. If the individual was determined not to meet the level of care for eligibility in the HCS waiver, the individual would be terminated from the HCS waiver and the provider would not receive Medicaid payment. The individual would be given the right to appeal the termination of HCS waiver services.

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:

Level of care re-evaluations are completed on an annual basis, when an individual's needs change significantly to warrant an additional reevaluation, and when an individual's level of need changes to the lowest need level. Records in the Client Assignment and Registration system are kept indefinitely, beginning from the time of enrollment. Paper copies are kept for five years by the local authority and by DADS.

Quality Improvement: Level of Care

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
B.a.1 Number and percent of individuals for whom level of care is completed prior to receipt of first service. N: Number of new enrollees whose level of care was completed prior to receipt of first service. D: Number of new enrollees.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Client Assignment and Registration system; Quality Assurance and Improvement Data Mart

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

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

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

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

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

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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
All level of care redeterminations are ultimately submitted through and approved by the Client Assignment and Registration system. This system contains edits that flag any level of care redetermination submission that contains a change in primary diagnosis, date of onset, or IQ score. A report is generated from the Client Assignment and Registration system that identifies level of care redeterminations that include any of these changes. For these redeterminations, DADS reviews the Intellectual Disability/Related Condition assessment and appropriate documentation to ensure the level of care is appropriate. Additionally, the Client Assignment and Registration system tracks level of care history of individuals and level of care denials system-wide.

100 percent of initial level of care determinations are reviewed by DADS staff that is qualified as a RN, licensed social worker, or qualified intellectual disability professional to ensure that the processes and instruments have been applied correctly to determine the individual's level of care. The DADS psychologist also reviews the initial Intellectual Disability/Related Condition Assessment and appropriate documentation to verify that the individual meets the level of care criteria for the waiver prior to enrollment.

b. Methods for Remediation/Fixing Individual Problems

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

The service coordinator is responsible for monitoring the individual's needs and service plan at least every 90 days. If a service coordinator determines that an individual's needs change significantly, the service coordinator notifies the individual's HCS provider that a new level of care must be completed. At least annually and as an individual's needs change significantly, the HCS provider is responsible for completing a level of care assessment and submit this to the local authority for review and entry into the Client Assignment and Registration system for DADS determination of level of care. If the service coordinator disagrees with the level of care determination, the service coordinator indicates this in the system. DADS Regulatory Services conducts annual reviews of all HCS providers and DADS Contract Accountability and Oversight unit conducts annual reviews of all local authorities.

The Client Assignment and Registration system produces daily reports of all pending level of care determinations. This report is used to initiate reviews of all pending levels of care. The Client Assignment and Registration system prevents the delivery of services prior to DADS authorization of the level of care. If a level of care is not approved, the local authority service coordinator receives the denial and works with the individual and the individual's natural supports to assist with linkage to non-waiver services and supports. DADS also has a process for supervisory review of a sample of level of care determinations made each quarter by DADS staff. If DADS determines that the initial level of care does not meet eligibility requirements the individual's enrollment is denied. The information is communicated immediately upon that determination to the local authority and individual is supported by the local authority services coordinator to obtain non-waiver supports as required.

DADS conducts monthly scan calls with the local authorities to provide technical assistance and updated information, including assistance and information related to level of care processes. DADS offers technical assistance to HCS providers and service coordinators on a day-to-day basis through the Program Enrollment/Utilization Review unit; updates the waiver manual as needed; conducts a training session regarding the level of care process for service coordinators and Qualified Intellectual Disabilities Professionals during each annual conference for intermediate care facility providers; and conducts a training session regarding the level of care process at statewide Medicaid waiver conferences.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

A local authority staff member presents the applicant with program information for both the HCS waiver and intermediate care facilities. The Verification of Freedom of Choice form is presented and reviewed with the individual or legally authorized representative by the local authority staff member at the time of enrollment. Following the presentation of this information, the staff member offers the applicant the opportunity to make an informed choice between the two programs and documents the applicant's decision to accept or refuse the offer of waiver services on the Verification of Freedom of Choice form. At the annual service planning team meeting, the local authority service coordinator informs the individual that they have a right to choose among any certified HCS provider at any time.

Individuals are given a complete listing of qualified HCS providers by the service coordinator upon enrollment and at any time upon request. An individual in the HCS waiver may select any qualified contracted provider to furnish waiver services. The Texas Administrative Code requires the HCS provider to serve an eligible applicant who has selected the HCS provider unless the provider's enrollment has reached its service capacity. If a provider that had not reached its service capacity declined to serve an individual who had selected the provider the State would handle the provider's denial of choice through the complaint process. Complaints are reported directly to the DADS Consumer Rights and Services department, which assigns a rights representative for follow-up investigation of the complaint. The follow-up investigation by DADS Consumer Rights and Services may result in a referral to DADS Regulatory Services division for further investigation and monitoring.

DADS Communications Office, Language Services Unit coordinates translations for DADS. DADS routinely provides Spanish translation of forms and letters and is responsive to other translation needs. Local authority service coordinators and HCS providers must assure that interpreter services are available, if needed, to individuals during service planning and service delivery.

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

The local authority retains the Verification of Freedom of Choice form in the applicant's record for five years. DADS maintains these forms for five years in the Client Assignment and Registration system.

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):
Each DADS program, activity, and provider must offer a variety of methods to ensure access to services in a timely manner by providing language assistance services to applicants, recipients, and stakeholders who are Limited English Proficient or illiterate.

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

The service coordinator meets with the individual and/or legally authorized representative to explain the necessary forms and information to the individual or legally authorized representative. Regardless of the language spoken by an individual, the local authority must enroll an eligible individual within the timeframes according to policy and must assure that interpreter services are available to individuals, if needed. Other than Spanish, no other languages are routinely presented. If other languages are required, the local authority coordinates translation on a local level on an individual basis.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Day Habilitation		
Statutory Service	Respite		
Statutory Service	Supported Employment		
Extended State Plan Service	Adaptive Aids		
Extended State Plan Service	Audiology		
Extended State Plan Service	Occupational Therapy		
Extended State Plan Service	Physical Therapy		
Extended State Plan Service	Prescribed Drugs		
Extended State Plan Service	Speech and Language Pathology		
Supports for Participant Direction	Financial Management Services		
Supports for Participant Direction	Support Consultation		
Other Service	Behavioral Support		
Other Service	Cognitive Rehabilitation Therapy		
Other Service	Dental Treatment		
Other Service	Dietary Services		
Other Service	Employment Assistance		
Other Service	Minor Home Modifications		
Other Service	Nursing		
Other Service	Residential Assistance (Host Home/Companion Care, Supervised Living, Residential Support Services)		
Other Service	Social Work		
Other Service	Supported Home Living		
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:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope)*:

Day habilitation provides individuals assistance with acquiring, retaining, or improving self-help, socialization, and adaptive skills necessary to live successfully in home and community-based settings. Day habilitation provides individualized activities in environments designed to promote the development of skills and behavior supportive of greater independence and personal choice and consistent with achieving the outcomes identified in the individual's service plan. If the individual's personal goals or current needs as they may relate to long term employment goals can be met through day habilitation, this choice is an option. These environments might be facilities, but if justified by the preferences of the individual the service can be provided in a non-facility environment.

The facilities are program sites operated by HCS providers or other providers under contract with HCS providers for service provision. School-aged children are given the opportunity to participate in day habilitation

on days when school is not in session (holidays, summer, etc.,). Individuals aged 17 or older may choose to discontinue school and participate in day habilitation.

Activities are also designed to reinforce therapeutic outcomes targeted by other waiver services, school, or other support providers. Day habilitation is normally furnished in a group setting other than the individual's residence. Day habilitation includes personal assistance for individuals who cannot manage their personal care needs during the day habilitation activity and assistance with medications and the performance of tasks delegated by an RN in accordance with the Texas Board of Nursing rules as defined by Title 22 of the Texas Administrative Code, Part 11, Chapter 225. This service also provides transportation during day habilitation activities necessary for the individual's participation in those activities.

Transportation required once the individual has arrived at the day habilitation service site is included in the reimbursement rate for day habilitation. Transportation to and from a day habilitation site from the individual's residence is billable as supported home living for individuals who live in their own home/family home and is included in the rate paid for the residential
services.

Day habilitation does not include services funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Supported home living and respite cannot be provide simultaneously with day habilitation.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:
Agency
Provider Type:
Agencies holding a HCS Medicaid provider agreement
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
Certified by DADS as HCS Provider
Other Standard *(specify)*:
The day habilitation provider must be at least 18 years of age. The provider must have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including the ability to

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

Transportation of individuals must be provided in accordance with applicable state laws.

Assisting with tasks delegated by a RN must be in accordance with state law. Title 22 of the Texas Administrative Code, Part 11, Chapter 225, §225.10 specifies the Board of Nursing requirements for delegation and specifies the tasks which may be delegated and tasks which do not require delegation. RNs must adhere to the Board of Nursing requirements regarding delegation.

The provider of day habilitation must complete initial and periodic training provided by the HCS provider in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D, §9.177.

The HCS provider must implement and maintain a plan for initial and periodic training of service providers. Periodic training is determined by the HCS provider, as needed, to make sure service providers are qualified to provide HCS services in accordance with state and federal laws and the current needs and characteristics of the individuals to whom they deliver services. The HCS provider must also ensure that service providers are knowledgeable of acts which constitute abuse, neglect, and exploitation; methods to prevent the occurance of abuse, neglect, and exploitation; and the proper reporting of possible instances of abuse, neglect, and exploitation.

DADS Regulatory Services' annual certification reviews are outcome-based. During a review of a HCS provider, 100 percent of service providers serving an individual within the representative sample are reviewed for qualifications, including training qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

HCS provider

DADS

Frequency of Verification:

HCS provider prior to hiring.

DADS during annual on-site reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Respite is provided for the planned or emergency short-term relief of the unpaid primary caregiver of an individual who lives in their family home. Respite is provided intermittently when the primary caregiver is temporarily unavailable to provide supports. This service provides an individual with personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of behavioral support or specialized therapies activities; assisting an individual with administration of certain medications or
with supervision of self-medication in accordance with the Texas Board of Nursing rules as defined by Title 22 of the Texas Administrative Code, Part 11, Chapter 225; and supervision as needed to ensure the individual's health and safety.

This service includes habilitation activities that facilitate the individual's inclusion in community activities, use of natural supports and typical community services available to all people, social interaction and participation in leisure activities, and development of socially valued behaviors and daily living and functional living skills. Respite is provided in the residence of the individual or in other locations, including residences in which supervised living or residential support is provided, camps or in a respite facility that meets HCS waiver requirements and afford an environment that ensures the health, safety, comfort, and welfare of the individual. The provider of respite must ensure that respite is provided in accordance with the individual's service plan and implementation plan, and with Appendix C of the HCS waiver application approved by CMS.

Transportation costs associated with the respite service are included in the respite rate. Transportation to and from the respite service site is not a billable service for the respite service but is included in the billable service for supported home living.

Examples of approvable routine, intermittent circumstances for which respite may be used include, but are not limited to:
• weekly counseling for the caregiver;
• caregiver attending church when the individual does not want to attend;

• caregiver attending counseling appointments; or
• weekly outing for caregiver and spouse.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Reimbursement for respite is limited to 300 hours annually for in-home respite, 30 of days out-of-home respite or a combination of both, not to exceed the annual limit for this service. All other waiver and non-waiver services indicated on the individual's service plan may be provided during the period of respite, except that hourly-reimbursed respite may not be provided at the same time supported home living, supported employment, or day habilitation is provided. Respite is not a reimbursable service for individuals receiving host home/companion care, supervised living, or residential support. Federal financial participation will not be claimed for the cost of room and board except when provided as part of respite furnished in a facility approved by the State that is not a private residence. Each 24-hour day of out-of-home respite is paid at the rate of 10 hours of in-home respite. If necessary, an individual's local authority service coordinator or HCS provider assists the individual in locating additional resources through family or local community organizations, and other natural supports.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer directed services direct service provider
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual

Provider Type:
Consumer directed services direct service provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
The provider of respite must be at least 18 years of age.

The provider must be an employee of the employer; have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served as demonstrated through a written competency-based assessment; and at least three personal references from persons not related by blood that evidence

the ability to provide a safe and healthy environment for the individual(s) to be served; camps must be accredited by the American Camping Association.

The RN must assess the competency of any service provider to supervise an individual's self-administration of medication or the competency of the service provider to receive delegation. Title 22 of the Texas Administrative Code, Part 11, Chapter 225, §225.10 specifies the Board of Nursing requirements for delegation and specifies the tasks which may be delegated and tasks which do not require delegation. RNs must adhere to the Board of Nursing requirements regarding delegation.

Title 40 of the Texas Administrative Code, Chapter 9, Part 1, Subchapter D specifies that service providers must be knowledgeable about the individual needs of each individual served and be knowledgeable about what constitutes abuse, neglect, and exploitation and how to report abuse, neglect, and exploitation. Frequency of periodic training is not prescribed, but must ensure that service providers can demonstrate this knowledge during DADS Regulatory Services reviews.

Transportation of individuals must be provided in accordance with applicable state laws.

Assisting with tasks delegated by a RN must be in accordance with state law.

The provider of respite must not live with the individual. The individual's guardian, designated representative, or spouse of the designated representative may not be the provider of respite services for the individual.

The provider of respite must complete initial and periodic training provided by the individual in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D, §9.177.

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer and financial management services agency

DADS

Frequency of Verification:

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

DADS during on-site and desk reviews conducted at a minimum every three years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Agencies holding a HCS Medicaid provider agreement

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Certified by DADS as HCS provider

Other Standard *(specify)*:

The provider of respite must be at least 18 years of age.

The provider may be an employee or under contract with the HCS provider; must have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a

proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served as demonstrated through a written competency-based assessment; and at least three personal references from persons not related by blood that evidence the ability to provide a safe and healthy environment for the individual(s) to be served; camps must be accredited by the American Camping Association.

The RN must assess the competency of any service provider to supervise an individual's self-administration of medication or the competency of the service provider to receive delegation. Title 22 of the Texas Administrative Code, Part 11, Chapter 225, §225.10 specifies the Board of Nursing requirements for delegation and specifies the tasks which may be delegated and tasks which do not require delegation. RNs must adhere to the Board of Nursing requirements regarding delegation.

Transportation of individuals must be provided in accordance with applicable state laws.

Assisting with tasks delegated by a RN must be in accordance with state law.

The provider of respite must not live with the individual.

Title 40 of the Texas Administrative Code, Chapter 9, Part 1, Subchapter D specifies that service providers must be knowledgeable about the individual needs of each individual served and be knowledgeable about what constitutes abuse, neglect, and exploitation and how to report abuse, neglect, and exploitation. Frequency of periodic training is not prescribed, but must ensure that service providers can demonstrate this knowledge during DADS Regulatory Services reviews.

The provider of respite must complete initial and periodic training provided by the HCS provider in accordance with Title 40 of the Texas Administrative Code, Part 1, Subchapter D, §9.177.

Verification of Provider Qualifications

Entity Responsible for Verification:

HCS provider

DADS

Frequency of Verification:

HCS provider prior to hiring.

DADS during annual on-site reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

Transporting an individual to support the individual to be self-employed, work from home, or perform in a work setting is billable within the service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
In the state of Texas, this service is not available to individuals receiving these services under a program funded under section 110 of the Rehabilitation Act of 1973. Documentation is maintained in the individual's record that the service is not available to the individual under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.).

This service may not be provided to the individual with the individual present at the same time that day habilitation, supported home living, employment assistance, or respite is provided.

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

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

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

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer directed services direct service provider
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Individual
Provider Type:
Consumer directed services direct service provider
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
The supported employment service provider must be at least 18 years of age and meet one of the following qualifications:
Option 1:
- have a bachelor's degree in rehabilitation, business, marketing, or a related human services field and one year's paid or unpaid experience providing employment services to people with disabilities;

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

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

The service provider may not be the individual's legally responsible person.

Verification of Provider Qualifications
Entity Responsible for Verification:
Individual/employer
Financial management services agency
DADS
Frequency of Verification:
Individual/employer and financial management services agency prior to hiring.
DADS during on-site and desk reviews conducted a minimum of every three years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:
Agencies holding a HCS Medicaid provider agreement
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
Certified by DADS as HCS provider
Other Standard *(specify)*:
The supported employment service provider must be at least 18 years of age and meet one of the following qualifications:
Option 1:
- have a bachelor's degree in rehabilitation, business, marketing, or a related human services field and one year's paid or unpaid experience providing employment services to people with disabilities;

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

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

The service provider may not be the individual's legally rsponsible person.
Verification of Provider Qualifications
Entity Responsible for Verification:
HCS provider and DADS
Frequency of Verification:
HCS provider prior to hiring.

DADS during annual on-site reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Extended State Plan Service
Service Title:
Adaptive Aids

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
This service provides devices, controls, appliances, or items that are necessary to address specific needs identified by the individual's service plan. Adaptive aids enable individuals to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live.

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

An adaptive aid is provided for a specific individual and becomes the exclusive property of that individual.

Adaptive aids are limited to the following categories including repair and maintenance not covered by warranty:
(A) Lifts, including vehicle lifts
(B) Mobility Aids
(C) Positioning Devices
(D) Control switches/pneumatic switches and devices
(E) Environmental control units
(F) Medically necessary supplies
(G) Communication aids (including batteries)
(H) Adaptive/modified equipment for activities of daily living
(I) Safety restraints and safety devices

Excluded are those items and supplies, which are not of direct medical or remedial benefit to the individual and items and supplies that are available to the individual through the Medicaid State Plan, through other governmental programs, or through private insurance.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Any item or service not listed in Appendix VII of the HCS Billing Guidelines, Billable Adaptive Aids, is not billable as an adaptive aid.

Adaptive aids may not exceed $10,000 per service plan year and is subject to the individual total annual service cost limit of the waiver.

Adaptive aids are provided under this waiver when no other financial resource for such aids is available or when other available resources have been used. Individuals who are under 21 years of age must access benefits through the Texas Health Steps--Comprehensive Care Program before adaptive aids may be provided under this waiver. The HCS provider must obtain one of the following as proof of non-coverage by Medicaid:

A letter from Texas Medicaid Healthcare Partnership that includes a statement that the requested adaptive aid is denied under the Texas Medicaid Home Health Services or the Texas Health Steps programs; and the reason for the denial, which must not be one of the following: Medicare is the primary source of coverage; information submitted to TMHP to make payment was incomplete, missing, insufficient or incorrect; the request was not made in a timely manner; or the adaptive aid must be leased;

A letter from TMHP stating that the adaptive aid is approved and the amount to be paid, which must be less than the cost of the requested adaptive aid; or

A provision from the current Texas Medicaid Providers Procedure Manual stating that the requested adaptive aid is not covered by the Texas Medicaid Home Health Services or the Texas Health Steps programs.

The individual, legally authorized representative and HCS provider must agree on the necessity of all adaptive aids. Items costing more than $500.00 must be agreed upon by the individual, legally authorized representative, and HCS provider based upon written evaluations and recommendations by the individual's physician, a licensed occupational or physical therapist, a psychologist or behavior analyst, a licensed nurse, a licensed dietician, or a licensed audiologist or speech/language pathologist qualified to assess the individual's need for the specific adaptive aid. The written evaluation and recommendation must document the necessity and appropriateness of the adaptive aid to meet the specific needs of the individual. All proposed service plans, including proposed service plans that include the cost for adaptive aids, must be reviewed in the Client Assignment and Registration system by the local authority service coordinator, who agrees or disagrees with the service plan prior to the service plan being transmitted to DADS. If the service coordinator disagrees with a proposed service plan, the service coordinator must indicate to DADS, in writing, the reason for their disagreement.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Adaptive Aids

Provider Category:
Agency

Provider Type:
Agencies holding a HCS Medicaid provider agreement
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Certified by DADS as HCS provider
Other Standard *(specify):*
Adaptive aids must be provided by contractors/suppliers capable of providing aids meeting applicable standards of manufacture, design, and installation.
Verification of Provider Qualifications
Entity Responsible for Verification:
HCS provider

DADS
Frequency of Verification:
HCS provider prior to completing service agreement with service provider.

DADS during annual on-site reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Extended State Plan Service
Service Title:
Audiology

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope)*:
Audiology provides assessment and treatment by licensed audiologist and includes:

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Audiology is provided under this waiver when no other financial resource for such therapies is available or when other available resources have been used. Individuals who are under 21 years of age must first access benefits through the Texas Health Steps--Comprehensive Care Program (EPSDT) before audiology may be provided under this waiver.

A HCS provider must have written documentation to support a service claim to obtain reimbursement for a payment made toward a deductible, co-payment or denied service for a professional therapy service covered by any third-party resource, including the State Plan.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Audiology

Provider Category:
Agency
Provider Type:
Agencies holding a HCS Medicaid provider agreement
Provider Qualifications
License *(specify)*:
The audiologist must be licensed under Title 3 of the Texas Occupations Code, Subtitle G, Chapter 401.

Certificate *(specify):*
Certified by DADS as HCS provider
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
HCS provider

DADS
Frequency of Verification:
HCS provider prior to completing service agreement with service provider and on an ongoing basis to ensure appropriate licensure is maintained.

DADS during annual on-site reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Extended State Plan Service
Service Title:
Occupational Therapy

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Occupational therapy provides assessment and treatment by licensed occupational therapist and includes:

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Occupational therapy is provided under this waiver when no other financial resource for such therapies is available or when other available resources have been used. Individuals who are under 21 years of age must first access benefits through the Texas Health Steps--Comprehensive Care Program before occupational therapy may be provided under this waiver.

A HCS provider must have written documentation to support a service claim to obtain reimbursement for a payment made toward a deductible, co-payment or denied service for a professional therapy service covered by any third-party resource, including the State Plan.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Agency
Provider Type:
Agencies holding a HCS Medicaid provider agreement
Provider Qualifications
License *(specify):*
The occupational therapist must be licensed under Title 3 of the Texas Occupations Code, Subtitle H, Chapter 454.
Certificate *(specify):*
Certified by DADS as HCS provider
Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

HCS provider

DADS

Frequency of Verification:

HCS provider prior to completing service agreement with service provider and on an ongoing basis to ensure appropriate licensure is maintained.

DADS during annual on-site reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Physical therapy provides assessment and treatment by licensed physical therapist and includes:

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Physical therapy services are provided under this waiver when no other financial resource for such therapies is available or when other available resources have been used. Individuals who are under 21 years of age must first access specialized therapy benefits through the Texas Health Steps--Comprehensive Care Program before specialized therapies may be provided under this waiver.

A HCS provider must have written documentation to support a service claim to obtain reimbursement for a payment made toward a deductible, co-payment or denied service for a professional therapy service covered by any third-party resource, including the State Plan.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:
Agency
Provider Type:
Agency holding a HCS Medicaid provider agreement
Provider Qualifications
License *(specify):*
The physical therapist must be licensed under Title 3 of the Texas Occupations Code, Subtitle H, Chapter 453.
Certificate *(specify):*
Certified by DADS as HCS provider
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

HCS provider

DADS
Frequency of Verification:
HCS provider prior to completing service agreement with service provider and on an ongoing basis to ensure appropriate licensure is maintained.

DADS during annual on-site reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Extended State Plan Service
Service Title:
Prescribed Drugs

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Unlimited prescribed medications beyond the three per month limit available under the Texas Medicaid State Plan are provided to individuals enrolled in the waiver, unless the individual is eligible for both Medicaid and Medicare (dually eligible). An individual who is dually eligible must obtain prescribed medications through the Medicare Prescription Drug Plan or, for certain medications excluded from Medicare, through the Texas Medicaid State Plan.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Pharmacies holding a Medicaid provider agreement- Vendor Drug with HHSC

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Pharmacies holding a Medicaid provider agreement- Vendor Drug with HHSC

Provider Qualifications

License *(specify)*:
The pharmacy must be licensed by the Texas State Board of Pharmacy under Title 22 of the Texas Administrative Code, Part 15, Chapter 291.

Certificate *(specify)*:

Other Standard *(specify)*:
Must hold Vendor Drug Medicaid provider agreement with HHSC.

Verification of Provider Qualifications

Entity Responsible for Verification:
Texas State Board of Pharmacy

Frequency of Verification:
Biennially

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Speech and Language Pathology

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Speech and language pathology provides assessment and treatment by licensed speech and language pathologists and includes:

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

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

Speech and language pathology services are provided under this waiver when no other financial resource for such therapies is available or when other available resources have been used. Individuals who are under 21 years of age must first access benefits through the Texas Health Steps--Comprehensive Care Program before speech and language pathology may be provided under this waiver.

A HCS provider must have written documentation to support a service claim to obtain reimbursement for a payment made toward a deductible, co-payment or denied service for a professional therapy service covered by any third-party resource, including the State Plan.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech and Language Pathology

Provider Category:
Agency
Provider Type:
Agencies holding a HCS Medicaid provider agreement
Provider Qualifications
License *(specify)*:
The speech-language pathologist must be licensed under Title 3 of the Texas Occupations Code, Subtitle G, Chapter 401.
Certificate *(specify)*:
Certified by DADS as HCS provider
Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
HCS provider

DADS
Frequency of Verification:
HCS provider prior to completing service agreement with service provider and on an ongoing basis to ensure appropriate licensure is maintained.

DADS during annual on-site reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Supports for Participant Direction

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

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope)*:

Financial management services provides assistance to individuals with managing funds associated with consumer directed services. The service includes initial orientation and ongoing training that is limited to budget development and management as well as the legal and programmatic requirements of being an employer. The financial management services provider, referred to as the financial management services agency also provides assistance in the development, monitoring, and revision of the individual's budget for each service delivered through the consumer directed services option and must maintain a separate account for each individual's budget. The financial management services agency provides assistance in determining staff wages and benefits subject to state limits, assistance in hiring by verifying employee's citizenship status and qualifications, and conducting required background checks. The financial management services agency verifies and maintains documentation of employee qualifications, including citizenship status, and documentation of services delivered. The financial management services agency also collects timesheets, processes timesheets of employees, processes payroll, withholding, filing and payment of applicable federal, state, and local employment-related taxes and insurance. The financial management services agency makes payments directly to the consumer directed services employee. The financial management services agency tracks disbursement of

funds and provides periodic reports to the individual of all expenditures and the status of the individual's consumer directed services budget.

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

The financial management services agency must not provide other waiver services to the individual other than support consultation. The financial management services agency must not provide service coordination to the individual.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial management services agencies holding a Medicaid provider agreement

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Financial management services agencies holding a Medicaid provider agreement

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

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

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

operational issues. Training and technical assistance are often provided on those calls.

The financial mangement services agency service provider must be at least 18 years of age and must not be the individual's legal guardian, the spouse of the individual's legal guardian, the individual's designated representative, or the spouse of the individual's designated representative.

On request of an individual or an individual's legally authorized representative, the financial management services agency must have support consultation services available.

Verification of Provider Qualifications

Entity Responsible for Verification:

DADS

Frequency of Verification:

DADS conducts monitoring reviews of financial management services agencies to determine compliance with the Medicaid provider agreement and HCS rules and requirements. These reviews are conducted via desk review or at the location where the financial management services agency is providing financial management services. Texas monitors 100 percent of the financial management services agencies at a minimum every three years. DADS reports the results of the monitoring to HHSC. DADS assesses a financial managment services agency's performance by using a standardized monitoring tool to:

1. Measure adherence to rules as described in the Texas Administrative Code;
2. Ensure the required background and registry checks were conducted prior to hire of the consumer directed services option employee;
3. Match payroll, optional benefits, and tax deposits to time sheets;
4. Assess adherence to state and federal tax laws specific to operating as a vendor fiscal/employer agent;
5. Ensure that the hours worked and the rate of pay are consistent with individual budgets;
6. Review administrative payments; and
7. Review the Medicaid provider agreements.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Support Consultation

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Support consultation is an optional service that offers practical skills training and assistance to enable an individual or legally authorized representative to successfully direct those services the individual or the legally authorized representative elect for consumer direction. This service is provided by a certified support advisor, and includes skills training related to recruiting, screening, and hiring workers; preparing job descriptions; verifying employment eligibility and qualifications; completion of documents required to employ an individual; managing workers; and development of effective backup plans for services considered critical to the individual's health and welfare in the absence of the regular provider or an emergency situation. Skills training involves such activities as training and coaching the employer regarding how to write an ad, how to interview potential job candidates, and role-play in preparation for interviewing potential employees. In addition, the support advisor assists the individual or legally authorized representative to determine staff duties, to orient and instruct staff in duties, and to schedule staff. Support advisors also assist the individual or legally authorized representative with activities related to the supervision of staff, the evaluation of the job performance of staff, and the discharge of staff when necessary. This service provides sufficient information and assistance to ensure that individuals and their representatives understand the responsibilities involved with consumer direction. Support consultation does not address budget, tax, or workforce policy issues. The State defines support consultation activities as the types of support provided beyond that provided by the financial management services provider. The scope and duration of support consultation will vary depending on an individual's need for support consultation.

Support consultation may be provided by a certified support advisor associated with a financial managment services agency selected by the individual/employer or by an independent certified support advisor hired by the individual/employer. Support consultation has a specific reimbursement rate and is a component of the individual's service budget. In conjunction with their local authority service coordinator, individuals or legally authorized representatives determine the level of support consultation necessary for inclusion in each individual's service plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The support advisor does not provide service coordination or any other waiver service except for financial management services to the individual.

The support advisor cannot be the individual's legal guardian; the spouse of the individual's legal guardian; the individual's designated representative; or the spouse of the individual's designated representative.

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

- [x] **Participant-directed as specified in Appendix E**

☑ **Provider managed**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:
Individual

Provider Type:
Consumer directed services direct service provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
Individual provider must have Support Advisor certificate issued by DADS to indicate successful completion of required training conducted or approved by DADS.

Other Standard *(specify)*:
The certified support advisor must be at least 18 years of age. The support advisor must have a high school diploma or Certificate of High School Equivalency (GED credentials); pass a criminal background check; complete initial training required by and conducted or authorized by DADS and pass a competency test based on the initial training; and complete any ongoing training as required by DADS.

The support advisor must complete initial and periodic training provided by the employer. Support consultation may be provided by a qualified individual associated with a financial management services agency selected by the individual, or by an independent individual hired by the individual.

The support advisor does not provide service coordination or any other waiver service except for financial management services to the individual.

The support advisor cannot be the individual's legal guardian; the spouse of the individual's legal guardian; the individual's designated representative; or the spouse of the individual's designated representative.

Verification of Provider Qualifications

Entity Responsible for Verification:
Individual/employer

financial management services agency

DADS

Frequency of Verification:
Individual/employer and financial management services agency prior to completing service agreement with the service provider.

DADS during on-site and desks reviews of financial management services agencies conducted at a minimum every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavioral Support

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope)*:

Behavioral support provides specialized interventions that assist an individual to increase adaptive behaviors to replace or modify maladaptive or socially unacceptable behaviors that prevent or interfere with the individual's inclusion in home and family life or community life. This service includes assessment and analysis of assessment findings of the behavior(s) to be targeted so that an appropriate behavioral support plan may be designed; development of an individualized behavioral support plan consistent with the outcomes identified in

the individual's person-directed plan; training of and consultation with family members or other support providers and, as appropriate, with the individual in the purpose/objectives, methods and documentation of the implementation of the behavioral support plan or revisions of the plan; monitoring and evaluation of the success of the behavioral support plan implementation; and modification, as necessary, of the behavioral support plan based on documented outcomes of the plan's implementation.

Behavioral support services include:
• Screening and assessment;
• Development of therapeutic treatment plans;
• Direct therapeutic intervention;
• Assistance, and training with adaptive aids and augmentative communication devices;
• Consulting with and training other service providers and family members; and
• Participating on the service planning team, when appropriate.

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Support

Provider Category:
Agency

Provider Type:
Agencies holding a HCS Medicaid provider agreement

Provider Qualifications

License *(specify)*:
Licensed as a:
- Licensed Clinical Social Worker under Title 3 of the Texas Occupations Code, Subtitle I, Chapter 505;
- Psychologist under Title 3 of the Texas Occupations Code, Subtitle I, Chapter 501;
- Psychological Associate under Title 3 of the Texas Occupations Code, Subtitle I, Chapter 501; or
- Licensed Professional Counselor under Title 3 of the Texas Occupations Code, Subtitle I, Chapter 503.

Certificate *(specify)*:
Or certified as a:
- DADS-certified Psychologist in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 5, Subchapter D, Section 5.161;
- Behavior Analyst by the Behavior Analyst Certification Board, Inc.

Certified by DADS as HCS provider
Other Standard *(specify):*
Legally authorized representatives and persons related to the individual within the fourth degree of consanguinity or within the second degree of affinity may not provide behavioral support services for the individual.

Behavioral support providers must follow service specifications in Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D.

The behavioral support service provider must receive certain training prescribed by DADS.

Verification of Provider Qualifications

Entity Responsible for Verification:
HCS provider

DADS
Frequency of Verification:
HCS provider prior to completing service agreement with service provider and on an ongoing basis to ensure appropriate licensure or certification is maintained.

DADS during annual on-site reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Cognitive Rehabilitation Therapy

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope)*:
Cognitive rehabilitation therapy is a service that assists an individual in learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry in order to enable the individual to compensate for the lost cognitive functions. Cognitive rehabilitation therapy is provided when determined to be medically necessary through an assessment conducted by an appropriate professional. Cognitive rehabilitation therapy is provided in accordance with the plan of care developed by the assessor, and includes reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The assessment is provided through the Medicaid State plan and is not included under this waiver.

The service provider may not be the individual's spouse, parent, primary caregiver, designated representative, legal guardian, or the spouse of the legal guardian, managing conservator, and persons related to the individual within the fourth degree of consanguinity or within the second degree of affinity.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a HCS Medicaid provider agreement
Individual	Consumer directed services direct service provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Cognitive Rehabilitation Therapy

Provider Category:
Agency
Provider Type:
Agencies holding a HCS Medicaid provider agreement
Provider Qualifications
License *(specify)*:

Psychologists licensed under Texas Occupations Code Chapter 501.

Speech and language pathologists licensed under Title 3 of the Texas Occupations Code, Subtitle G, Chapter 401.
Occupational therapists licensed under Title 3 of the Texas Occupations Code, Subtitle H, Chapter 454.

Certificate *(specify):*

Other Standard *(specify):*
The service provider may not be the individual's spouse, parent, primary caregiver, designated representative, legal guardian, or the spouse of the legal guardian, managing conservator, and persons related to the individual within the fourth degree of consanguinity or within the second degree of affinity.

Verification of Provider Qualifications

Entity Responsible for Verification:
HCS Provider
DADS

Frequency of Verification:
HCS provider prior to hiring and on an ongoing basis to ensure appropriate licensure is maintained.

DADS during annual on-site reviews.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Cognitive Rehabilitation Therapy

Provider Category:
Individual

Provider Type:
Consumer directed services direct service provider

Provider Qualifications

License *(specify):*
Psychologists licensed under Texas Occupations Code Chapter 501.

Speech and language pathologists licensed under Title 3 of the Texas Occupations Code, Subtitle G, Chapter 401.
Occupational therapists licensed under Title 3 of the Texas Occupations Code, Subtitle H, Chapter 454.

Certificate *(specify):*

Other Standard *(specify):*
The service provider may not be the individual's spouse, parent, primary caregiver, designated representative, legal guardian or the spouse of the legal guardian, managing conservator, and persons related to the individual within the fourth degree of consanguinity or within the second degree of affinity.

Verification of Provider Qualifications

Entity Responsible for Verification:
Individual/employer
Financial management services agency
DADS

Frequency of Verification:

Individual/employer and financial management services agency prior to hiring and on an ongoing basis to ensure appropriate licensure is maintained.

DADS during on-site and desk reviews conducted a minimum of every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Dental Treatment

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Elements of this service include the following:

(A) Emergency dental treatment. Those procedures necessary to control bleeding, relieve pain, and eliminate acute infection; operative procedures that are required to prevent the imminent loss of teeth; and treatment of

injuries to the teeth or supporting structures.

(B) Preventive dental treatment. Examinations, oral prophylaxes, and topical fluoride applications.

(C) Therapeutic dental treatment. Treatment that includes, but is not limited to, pulp therapy for permanent and primary teeth; restoration of carious permanent and primary teeth; maintenance of space; and limited provision of removable prostheses when masticatory function is impaired, when an existing prosthesis is unserviceable, or when aesthetic considerations interfere with employment or social development. For example, an individual who has a severe dental deformity may receive aesthetic treatment to enhance their opportunities for community integration.

(D) Orthodontic dental treatment. Procedures that include treatment of retained deciduous teeth; cross-bite therapy; facial accidents involving severe traumatic deviations; cleft palates with gross malocclusion that will benefit from early treatment; and severe, handicapping malocclusions affecting permanent dentition with a minimum score of 26 as measured on the Handicapping Labio-lingual Deviation Index.

Cosmetic orthodontia is excluded from the dental treatment service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Dental treatment is provided under this waiver when no other financial resource for such treatment is available or when other available resources have been exhausted. Individuals who are under 21 years of age must first access benefits through the Texas Health Steps--Comprehensive Care Program (EPSDT) before dental treatment may be provided under this waiver.

The total amount allowable for the dental treatment service is limited to a maximum expenditure of $1,000 per individual per service plan year.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dental Treatment

Provider Category:
Agency
Provider Type:
Agencies holding a HCS Medicaid provider agreement
Provider Qualifications
License *(specify)*:
The person providing dental treatment must be licensed as a dentist under Title 3 of the Texas Occupations Code, Subtitle D, Chapter 251.
Certificate *(specify)*:
Certified by DADS as HCS provider

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

HCS provider

DADS

Frequency of Verification:

HCS provider prior to completing service agreement with service provider and on an ongoing basis to ensure appropriate licensure is maintained.

DADS during annual on-site reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Dietary Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Dietary services include:
• Screening and assessment;
• Development of therapeutic treatment plans;
• Direct therapeutic intervention;
• Assistance and training with adaptive aids relative to eating;
• Consulting with other service providers and family members; and
• Participating on the service planning team, when appropriate.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dietary Services

Provider Category:
Agency
Provider Type:
Agencies holding a HCS Medicaid provider agreement
Provider Qualifications
License *(specify):*
The dietician must be licensed under Title 3 of the Texas Occupations Code, Subtitle M, Chapter 701.
Certificate *(specify):*
Certified by DADS as HCS provider
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
HCS provider

DADS

Frequency of Verification:
HCS provider prior to completing service agreement with service provider and on an ongoing basis to ensure appropriate licensure is maintained.

DADS during annual on-site reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Employment Assistance

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Employment assistance is assistance provided to an individual to help the individual locate paid employment in the community. Employment assistance includes:

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

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

Documentation is maintained in the individual's record that the service is not available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service may not be provided to the individual with the individual present at the same time that day habilitation, supported home living, or respite is provided.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a HCS Medicaid provider agreement
Individual	Consumer directed services direct service provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Employment Assistance

Provider Category:
Agency
Provider Type:
Agencies holding a HCS Medicaid provider agreement
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
Certified by DADS as a HCS provider
Other Standard *(specify)*:

The employment assistance service provider must be at least 18 years of age and meet one of the following qualifications:
Option 1:
- have a bachelor's degree in rehabilitation, business, marketing, or a related human services field and one year's paid or unpaid experience providing employment services to people with disabilities;

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

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

The service provider may not be the individual's legally responsibile person.

Verification of Provider Qualifications

Entity Responsible for Verification:
HCS provider and DADS

Frequency of Verification:
HCS provider prior to hiring.

DADS during annual on-site reviews.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Employment Assistance

Provider Category:
Individual

Provider Type:
Consumer directed services direct service provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
The employment assistance service provider must be at least 18 years of age and meet one of the following qualifications:
Option 1:
- have a bachelor's degree in rehabilitation, business, marketing, or a related human services field and one year's paid or unpaid experience providing employment services to people with disabilities;

Option2:
- have an associate's degree in rehabilitation, business, marketing, or a related human services field and two years' paid or unpaid experience providing employment services to people with disabilities; or

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

The service provider may not be the individual's legally responsibile person.

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer

Financial management services agency

DADS

Frequency of Verification:

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

DADS during on-site and desk reviews conducted a minimum of every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Minor Home Modifications

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
This service provides physical adaptations to an individual's home to address specific needs identified by an individual's service plan. Minor home modifications are necessary to ensure the health, welfare, and safety of the individual, or to enable the individual to function with greater independence in his or her home. Modifications may include the installation of ramps and grab-bars, widening of doorways, and other specialized accessibility adaptations, modification of kitchen and bathroom facilities, or safety adaptations necessary for the welfare of the individual.

Minor home modifications must be provided in accordance with applicable state or local building codes and are limited to the following categories, including the repair and/or maintenance of modifications:
(A) Construction or repair of wheelchair ramps and/or landings to A.D. A. specifications
(B) Modifications to bathroom facilities
(C) Modifications to kitchen facilities
(D) Specialized accessibility and safety adaptations

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

The service coordinator aids in the identification of the need for minor home modifications; however, it is the responsibility of the HCS provider to perform all related contacts with non-HCS suppliers of minor home modifications to procure items in accordance with an individual's identified needs.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Only minor home modifications listed in Appendix X of the HCS Billing Guidelines are billable through the HCS waiver.

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

If an enrollee has an identified need for minor home modifications that exceed the lifetime maximum benefit, the local authority will work with the HCS provider, the individual, and the individual's legally authorized adult if one is designated, to identify non-waiver resources to assist the individual to address the identified need.

The individual, legally authorized representative, and HCS provider must agree on the necessity of all minor home modifications. Any modification or combination of modifications costing more than $1000.00 must be agreed upon as necessary by the individual, legally authorized representative, and HCS provider based on prior written evaluations and recommendations from the individual's physician, a licensed occupational or physical therapist, a psychologist, or behavior analyst qualified to assess the individual's need for the specific minor home modification. The written evaluation must document the necessity and appropriateness of the minor home modification to meet the specific needs of the individual.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Minor Home Modifications

Provider Category:
Agency
Provider Type:
Agencies holding a HCS Medicaid provider agreement
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Certified by DADS as HCS provider
Other Standard *(specify):*
Qualified contractors provide minor home modifications in accordance with state and local building codes and other applicable regulations.
Verification of Provider Qualifications
Entity Responsible for Verification:
HCS provider

DADS
Frequency of Verification:
HCS provider.

DADS during annual on-site reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Nursing

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope)*:
Nursing provides treatment and monitoring of medical conditions prescribed by a physician/medical practitioner and/or required by standards of professional practice or state law to be performed by licensed nursing personnel.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Nursing is provided under this waiver when no other financial resource for such service is available or when other available resources have been used. Individuals who are under 21 years of age must access benefits through the Texas Health Steps-- Comprehensive Care Program (EPSDT) before nursing may be provided under this waiver.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer directed services direct service provider
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing

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

License *(specify):*
The nurse must be licensed as a Registered Nurse or Licensed Vocational Nurse under Title 3 of the Texas Occupations Code, Subtitle E, Chapter 301.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Individual/employer
Financial management services agency
DADS
Frequency of Verification:
Individual/employer and financial management services agency prior to hiring and on an ongoing basis to ensure appropriate licensure is maintained.

DADS during on-site and desk reviews conducted a minimum of every three years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing

Provider Category:
Agency
Provider Type:
Agencies holding a HCS Medicaid provider agreement
Provider Qualifications
License *(specify):*
The nurse must be licensed as a Registered Nurse or Licensed Vocational Nurse under Title 3 of the Texas Occupations Code, Subtitle E, Chapter 301.
Certificate *(specify):*
Certified by DADS as HCS provider
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
HCS provider

DADS
Frequency of Verification:
HCS provider prior to completing service agreement with service provider or prior to employment and on an ongoing basis to ensure appropriate licensure is maintained.

DADS during annual on-site reviews.

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:

Residential Assistance (Host Home/Companion Care, Supervised Living, Residential Support Services)

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Residential assistance is provided as one of three residential services in the service array as follows:

Host home/companion care provides individuals with personal assistance with activities of daily living (grooming, eating, bathing, dressing and personal hygiene) and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of behavioral support or specialized therapies activities; assistance with medications based upon the results of an RN assessment the performance of tasks delegated by a RN in accordance with the Texas Board of Nursing rules as defined by Title 22 of the Texas Administrative Code, Part 11, Chapter 225; and supervision of the individual's safety and security. This service includes habilitation activities that facilitate the individual's inclusion in community activities, use of natural supports and typical community services available to all people, social interaction and participation in leisure activities, and development of socially

valued behaviors and daily living and functional living skills. Individuals receiving either Adult Foster Care or Texas Department of Family and Protective Services foster care services may not receive host home/companion care through this waiver. Host home/companion care is provided in a private residence meeting HCS requirements by a host home or companion care provider who lives in the residence. Host home/companion care is combined because the actual services provided are identical. The only distinction is which individual has the property interest in the home in which the services are being provided. In a host home arrangement, the host home provider owns or leases the residence. In a companion care arrangement, the residence may be owned or leased by the companion care provider or may be owned or leased by the individual.

Supervised living provides individuals with personal assistance with activities of daily living (grooming, eating, bathing, dressing and personal hygiene)and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of behavioral support or specialized therapies activities; assistance with medications based upon the results of an RN assessment, the performance of tasks delegated by a RN in accordance with the Texas Board of Nursing rules as defined by Title 22 of the Texas Administrative Code, Part 11, Chapter 225; and supervision of the individual's safety and security. This service includes habilitation activities that facilitate the individual's inclusion in community activities, use of natural supports and typical community services available to all people, social interaction and participation in leisure activities, and development of socially valued behaviors and daily living and functional living skills. Supervised living provides residential assistance as needed by individuals who live in residences in which the HCS provider holds a property interest and that meet program certification standards. This service is provided to individuals by direct service providers who are not awake during normal sleep hours. Supervised living providers provide services and supports as needed by individuals and are present in the residence and able to respond to the needs of individuals during normal sleeping hours.

Residential support service provides individuals with personal assistance with activities of daily living (grooming, eating, bathing, dressing and personal hygiene)and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of behavioral support or specialized therapies activities; assistance with medications based upon the results of an RN assessment, the performance of tasks delegated by a RN in accordance with the Texas Board of Nursing rules as defined by Title 22 of the Texas Administrative Code, Part 11, Chapter 225. Transportation costs are included in the rate for all types of residential services. Type and frequency of supervision is determined on an individual basis based on the level of need for each individual.

The HCS provider must implement and maintain a plan for initial and periodic training of staff members and service providers that ensures staff members and service providers are qualified to deliver services as required by the current needs and characteristics of the individuals to whom they deliver services and are knowledgeable of acts that constitute abuse, neglect, or exploitation of an individual and methods to prevent the occurrence of abuse, neglect, and exploitation.

Periodic training is determined by the HCS provider, as needed, to ensure service providers are qualified to provide HCS services in accordance with state and federal laws and regulations); and supervision of the individual's safety and security. This service includes habilitation activities that facilitate the individual's inclusion in community activities, use of natural supports and typical community services available to all people, social interaction and participation in leisure activities, and development of socially valued behaviors and daily living and functional living skills. Residential support provides residential assistance to individuals who require supervision and support from direct service providers who are awake and present in the residence whenever an individual is present in the residence. Residential support is provided in residences in which the HCS provider holds a property interest and that meet certification standards. Services and supports are provided by residential support providers assigned on a shift schedule that includes at least one complete change of staff each day.

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

Payments for residential assistance services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. An individual may receive only one type of residential assistance at a time. Supervised living can serve up to 3 people; residential support services can serve up to 4 people; and host home/companion care can serve up to 3 people.

Residential assistance services cannot be provided at the same time as day habilitation services.

Individuals who receive residential assistance under this waiver are not eligible to receive either supported home living or respite, as these services are available only to individuals who live in their own or family home.

Individuals receiving either Adult Foster Care or Department of Family and Protective Services foster care services may not receive residential assistance through this waiver. Waiver funds cannot be used to pay for residential assistance for children under state conservatorship receiving state foster care and does not supplant the state's responsibilities under Titles IV-E and B.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Assistance (Host Home/Companion Care, Supervised Living, Residential Support Services)

Provider Category:
Agency

Provider Type:
Agencies holding a HCS Medicaid provider agreement

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
Certified by DADS as HCS provider

Other Standard *(specify)*:
The provider of the residential assistance service must be at least 18 years of age. The provider must have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served as demonstrated through a written competency-based assessment; and at least three personal references from persons not related by blood that evidence the ability to provide a safe and healthy environment for the individual(s) to be served.

Transportation of individuals must be provided in accordance with applicable state laws.

Assisting with tasks delegated by a Registered Nurse must be in accordance with state law.

The provider of residential assistance must complete initial and periodic training provided by the HCS provider in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D, §9.177.

The HCS provider must implement and maintain a plan for initial and periodic training of service providers. Periodic training is determined by the HCS provider, as needed, to make sure service providers are qualified to provide HCS services in accordance with state and federal laws and the current needs and characteristics of the individuals to whom they deliver services. The HCS provider must also ensure that service providers are knowledgeable of acts that constitute abuse, neglect, and exploitation; methods to prevent the occurrence of abuse, neglect, and exploitation; and proper reporting of possible instances of abuse, neglect, and exploitation.

Verification of Provider Qualifications

Entity Responsible for Verification:

HCS provider

DADS

Frequency of Verification:

HCS provider prior to hiring or completing service agreement with service provider.

DADS during annual on-site reviews

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Social Work

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Social work services include:

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

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Social Work

Provider Category:
Agency
Provider Type:
Agencies holding a HCS Medicaid provider agreement
Provider Qualifications
License *(specify):*
Licensed Social Worker under Title 3 of the Texas Occupations Code, Subtitle I, Chapter 505.
Certificate *(specify):*

Other Standard *(specify):*
Guardians and persons related to the individual within the fourth degree of consanguinity or within the second degree of affinity may not provide social work services for the individual.

Verification of Provider Qualifications
Entity Responsible for Verification:

HCS provider

DADS
Frequency of Verification:
HCS provider prior to completing service agreement with service provider or prior to employment and on an ongoing basis to ensure appropriate licensure is maintained.

DADS during annual on-site reviews.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Supported Home Living

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
Supported home living provides individuals with direct personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene)and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of behavioral support or specialized therapies activities; assistance with medications and the performance of tasks delegated by a registered nurse in accordance with the Texas Board of Nursing rules as defined by Title 22 of the Texas Administrative Code, Part 11, Chapter 225; and supervision as needed to ensure the individual's health and safety. and supervision as needed to ensure the individual's health and safety.; and supervision of the individual's safety and security. This service includes habilitation activities that facilitate the individual's inclusion in community activities, use of natural supports and typical community services available to all people, social interaction and participation in leisure activities, and development of socially valued behaviors and daily living and functional living skills.

Supported home living is provided to individuals residing in their own residence or the residence of their natural or adoptive families or to individuals receiving foster care from the Texas Department of Family and Protective Services. Supported home living provided to individuals residing with their family members is designed to support rather than supplant the family and natural supports. Individuals residing in their own homes receive supported home living as necessary to support them in their independent residence.

Individuals under the conservatorship of the State may receive foster care services paid for through state funds. Foster care provided by the State to individuals under state conservatorship provides services specifically to maintain these individuals and includes supports such as those provided to children by their natural parents. This service does not include the specialized supports offered through supported home living. When an individual under state conservatorship receiving state foster care enrolls in HCS, he or she is eligible to receive supported home living in the state foster care setting, the same as children living in their family home are eligible to receive this service. For individuals who are under state conservatorship, are receiving state foster care, and are diagnostically eligible for the HCS waiver, supported home living is intended to offer needed specialized "wrap-around" supports to the individual in his or her residential setting. The provision of this service does not duplicate maintenance support provided to the individual through state foster care.

Transportation provided to individuals in accordance with guidelines is a billable supported home living service. Transportation costs which are not billable, but which are incurred to provide the supported home living service, are included in the indirect portion of the rate.

Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D specifies that service providers must be knowledgeable about the individual needs of each individual served and be knowledgeable about what constitutes abuse, neglect, and exploitation and how to report abuse, neglect, and exploitation. Frequency of periodic training is not prescribed, but HCS providers must ensure that service providers can demonstrate this knowledge during DADS Regulatory Services reviews.

Title 22 of the Texas Administrative Code, Part 11, Chapter 225, §225.10 specifies the Board of Nursing requirements for delegation and specifies the tasks which may be delegated and tasks which do not require delegation. RNs must adhere to the Board of Nursing requirements regarding delegation.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Supported home living cannot be provided at the same time as day habilitation or respite.

Individuals receiving supported home living services are not eligible to simultaneously receive residential assistance 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
Agency	Agencies holding a HCS Medicaid provider agreement
Individual	Consumer directed services direct service provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Home Living

Provider Category:
Agency

Provider Type:
Agencies holding a HCS Medicaid provider agreement

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
Certified by DADS as HCS provider

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

Transportation of individuals must be provided in accordance with applicable state laws.

Assisting with tasks delegated by a RN must be in accordance with state law. Title 22 of the Texas Administrative Code, Part 11, Chapter 225, §225.10 specifies the Board of Nursing requirements for delegation and specifies the tasks which may be delegated and tasks which do not require delegation. RNs must adhere to the Board of Nursing requirements regarding delegation.
The provider of supported home living must not live with the individual.

The provider of supported home living must complete initial and periodic training provided by the HCS provider in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D, §9.177.

The HCS provider must implement and maintain a plan for initial and periodic training of service providers. Periodic training is determined by the HCS provider, as needed, to make sure service providers are qualified to provide HCS services in accordance with state and federal laws and the current needs and characteristics of the individuals to whom they deliver services. The HCS provider must also ensure that service providers are knowledgeable of acts which constitute abuse, neglect, and exploitation; methods to prevent the occurance of abuse, neglect, and exploitation; and the proper reporting of possible instances of abuse, neglect, and exploitation.

Verification of Provider Qualifications

Entity Responsible for Verification:
HCS provider

DADS

Frequency of Verification:

HCS provider prior to hiring.

DADS during annual on-site reviews.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Home Living

Provider Category:
Individual

Provider Type:
Consumer directed services direct service provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
The supported home living service provider must be at least 18 years of age. The provider must be an employee of the individual/employer and must have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served as demonstrated through a written competency-based assessment; and at least three personal references from persons not related by blood that evidence the ability to provide a safe and healthy environment for the individual(s) to be served.

Transportation of individuals must be provided in accordance with applicable state laws.

Assisting with tasks delegated by a RN must be in accordance with state law. Title 22 of the Texas Administrative Code, Part 11, Chapter 225, §225.10 specifies the Board of Nursing requirements for delegation and specifies the tasks which may be delegated and tasks which do not require delegation. RNs must adhere to the Board of Nursing requirements regarding delegation.
The provider of supported home living must not live with the individual. The individual's guardian, designated representative or spouse of the designated representative may not be the provider of supported home living services for the individual.

The provider of supported home living must complete initial and periodic training provided by the individual employer in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D, §9.177.

The individual employer must implement a plan for initial and periodic training of direct service providers. Periodic training is determined by the individual/employer, as needed, to make sure service providers are qualified to provide HCS services in accordance with state and federal law service providers that ensures direct service providers are qualified to deliver services as required by state and federal laws and must ensure that direct service providers are knowledgeable of acts that constitute abuse, neglect, or exploitation of individual; methods to prevent the occurrence of abuse, neglect, and exploitation; and proper reporting of possible instances of abuse, neglect, and exploitation.

Verification of Provider Qualifications

Entity Responsible for Verification:
Individual/employer

Financial management services agency

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

DADS during on-site and desk reviews conducted a minimum of every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Transition Assistance Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Transition assistance services pay for non-recurring set-up expenses for individuals transitioning from an intermediate care facility, a nursing facility, or a General Residential Operation into the HCS waiver. Transition assistance services are billed on or after the individual's enrollment into the waiver.

Allowable expenses are those necessary to enable individuals to establish basic households and may include: security deposits for leases on apartments or homes; essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture; window coverings; food preparation items; 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 individual's health and welfare, such as pest eradication and one-time cleaning of the residence prior to occupancy; and activities to assess need for, facilitate, arrange for, and procure needed resources, (limited to up to 180 consecutive days prior to discharge from the intermediate care facility, general residential operation, or nursing facility and entrance to the waiver); and necessary minor home modifications, as listed in Appendix X of the HCS Billing Guidelines, including assessments performed by a medical doctor, occupational therapist, physical therapist, psychologist or a behavior analyst required to obtain the minor home modifications.

Room and board are not allowable expenses.

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

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

To be eligible to receive transition assistance services the individual must be a resident of a Texas nursing facility, intermediate care facility, or General Residential Operation who wishes to be discharged from that facility; be Medicaid eligible; and be determined eligible for the HCS waiver.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Transition assistance services are one-time initial expenses for setting up an individual's household.

Transition assistance services, including minor home modifications delivered through transition assistance services, are limited to up to 180 consecutive days prior to discharge from the intermediate care facility, General Residential Operation, or nursing facility and entrance to the waiver.

The amount for allowable expenses necessary to enable individuals to establish basic households - cannot exceed $2,500 for individuals transitioning into their own home/family home. Allowable expense for this purpose include:

-Security deposits for leases on apartments or homes;
-Essential household furnishings to establish basic living arrangement and moving expenses in a community domicile, including furniture, window coverings, and food preparation items;
-Set-up fees or deposits for utility or service access, including telephone, electricity, gas, and water;
Services necessary for the individuals health and welfare such as pest eradication, allergen control, 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 institution).

The amount for personal bedroom furniture and bedroom linens cannot exceed $1,000 for individuals transitioning into a provider leased/owned living arrangement or a host home/companion care setting.

The amount for minor home modifications necessary to ensure the health, welfare, and safety of the individual, or to enable the individual to function with greater independence cannot exceed a lifetime expenditure of $7,500.

If an enrollee has an identified need for minor home modifications that exceed the lifetime maximum benefit, the local authority will work with the HCS provider, the individual, and the individual's legally authorized adult if one is designated, to identify non-waiver resources to assist the individual to address the identified need.

Physical therapy and occupational therapy assessments are provided under this waiver service when no other financial resources for such therapies is available, including the Medicaid State Plan. One-time physical therapy and occupational therapy assessments conducted to determine need for minor home modifications as part of transition assistance services will be distinct and billed separately from the extended state plan physical therapy and occupational therapy services included in the waiver.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies holding a HCS Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Assistance Services

Provider Category:
Agency

Provider Type:
Agencies holding a HCS Medicaid provider agreement

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
Certified by DADS as HCS provider or Certified by DADS as a TAS provider

Other Standard *(specify)*:
The service provider of transition assistance services must be at least 18 years of age. The provider must have a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma. The provider must not be a relative or legally authorized representative of the applicant and may not live with the applicant. The provider must be capable of providing transition assistance services and complying with the documentation requirements described in Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D, §9.174(g)(2)(A) relating to Certification Principles: Service Delivery.

Verification of Provider Qualifications

Entity Responsible for Verification:
DADS

Frequency of Verification:
HCS provider prior to completing service agreement with service provider and on an ongoing basis to ensure appropriate licensure is maintained

DADS during annual on-site reviews.

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☑ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

DADS holds performance contracts with local community centers, established in accordance with Texas Health and Safety Code, Chapter 534, and with a local Council of Government, established in accordance with Texas Local Government Code, Chapter 391. These entities have been designated by DADS as local authorities in accordance with Texas Health and Safety Code, §533.035, and serve specific geographic areas. In accordance with the state legislative mandate to transfer case management functions in HCS to the local authorities, effective June 1, 2010, these entities provide service coordination (case management) to individuals who receive HCS waiver services.

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):

HCS providers, local authorities, and individual employers conduct a statewide criminal history check in compliance with the Texas Health and Safety Code, Chapter 250 by taking the following actions regarding applicants, employees, and contractors:
(A) Obtain criminal history record information from the Texas Department of Public Safety that relates to an unlicensed applicant, employee, or contractor whose duties involve direct contact with an individual receiving waiver services; and
(B) Refrain from employing or contracting with, or immediately discharge, a person who has been convicted of an offense that bars employment under Texas Health and Safety Code, Sec. 250.006, or an offense that the HCS provider or individual employer determines is a contraindication to the person's employment or contract to provide services to the individual.

HCS providers, financial management services agencies, and local authorities are required to maintain documentation of the criminal history checks performed.

During at least annual on-site reviews of HCS providers and local authorities, DADS monitors for completion of criminal history checks as required. Contract monitoring for financial management services agencies is

conducted at a minimum every three years. Financial management services agencies are required to document and maintain
the time and the result of the registry check on DADS Form 1725 which may be reviewed by DADS during a monitoring visit related to a complaint investigation or during a desk review.

Criminal history checks are part of the licensing process for providers of skilled services. HCS providers, local authorities, individual employers, and financial management services agencies are required to verify licensure prior to hiring skilled providers and to verify renewed licensure within 30 calendar days after the expiration date of the current licensure document on file.

Providers must screen all employees and contractors for exclusion prior to hiring or contracting and on an ongoing monthly basis by searching both the state and federal lists of excluded persons and entities. If any exclusion is discovered the provider must immediately report the findings to DADS.

DADS verifies that providers have conducted screening for exclusion and performed other applicable registry checks during the regulatory surveys. Non-licensed consumer directed services agencies are monitored at least every three years.

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):

All paid or unpaid service providers who are not licensed are required to undergo Abuse Registry screenings by HCS providers. The appropriate licensure boards are responsible for monitoring licensed professionals.

HCS providers and individual employers must comply with the Texas Health and Safety Code, Chapters 250 and 253, by taking the following actions regarding applicants, employees, and contractors:
(A) Search the Nurse Aide Registry maintained by DADS in accordance with Texas Health and Safety Code, Chapter 250, and refrain from employing or contracting with, or immediately discharge, a person who is designated in the registry as having abused, neglected, or mistreated an individual of a facility or has misappropriated an individual's property; and
(B) Search the Employee Misconduct Registry maintained by DADS in accordance with Texas Health and Safety Code, Chapter 253, and refrain from employing or contracting with or immediately discharge a person whose employment involves 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.

HCS providers, financial management services agencies, and local authorities are required to maintain documentation of the Nurse Aide Registry and Employee Misconduct Registry checks performed. During at least annual on-site reviews of HCS providers and local authorities, DADS monitors for completion of required registry checks. Contract monitoring for financial management services agencies is conducted at a minimum every three years.

Appendix C: Participant Services

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

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. **Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Out-of-Home Respite	
Supervised Living	
Residential Support Services	

ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

The HCS provider must not provide out-of-home respite in an institution including and institution for mental diseases and the individual must be supported in receiving both waiver and non-waiver services included in the service plan while residing in a respite facility. Further, HCS rules address the need to support individual choices, personal relationships and desires for community inclusion while residing at a respite facility.

Residential services settings which are provider controlled, to include supervised living and residential support services, are afforded the same rights as all tenants in the State and are required to comply with Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D, as indicated by the specific rule citations: §9.172(1, 2, 4, 5), §9.173(a)(1), §9.173(b) (2, 4, 9, 10, 15, 16, 20, 22, 25, 27,29, 30, 31), §9.174(a) (4, 5, 9, 13, 15, 21, 22), §9.177(b), §9.190(7), and §9.190(e) (7 and 8) as follows:

i. The setting is integrated in, and facilitates the individual's full access to, the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, in the same manner as individuals without disabilities.

ii. The setting is selected by the individual from among all available alternatives and is identified in the person–centered service plan.

iii. An individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected.

iv. Individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented.

v. Individual choice regarding services and supports, and who provides them, is facilitated.

vi. The unit or room is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction, which are outlined in the Texas Property Code, that tenants have under the landlord/tenant law of the State, county, city, or other designated entity.

vii. Each individual has privacy in their sleeping or living unit and may request a lock on their sleeping unit through the service planning process or at any time.

viii. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time;

ix. Individuals are able to have visitors of their choosing at any time; and

x. The setting is physically accessible to the individual.

Processes are incorporated into service planning which allow appropriate restrictions of a restriction of the individuals rights as it may relate to the individual's health or safety needs. Examples of such rights restriction would include restricting the individual's right to a visitor in the middle of the night if such visits disrupted the security and comfort of other individuals in the residence, restriction of access to food if the individual were a diabetic and was not compliant with physician's orders or responsive to the training efforts of a dietician. Texas Administrative Code Title 40, Part 1, Chapter 9, SubChapter D §9.155 (5) also specifies that Home and community-based settings do not include the following:
A) an ICF/MR licensed or subject to being licensed in accordance with Texas Health and Safety Code, Chapter 252, or certified by DADS;
(B) a nursing facility licensed or subject to being licensed in accordance with Texas Health and Safety Code, Chapter 242;
(C) an assisted living facility licensed or subject to being licensed in accordance with Texas Health and Safety Code, Chapter 247;
(D) a residential child-care operation licensed or subject to being licensed by DFPS unless it is a foster family home or a foster group home;
(E) a facility licensed or subject to being licensed by the Department of State Health Services (DSHS);
(F) a facility operated by DARS;
(G) a residential facility operated by the Texas Youth Commission, a jail, or a prison
(H) a setting in which two or more dwellings, including units in a duplex or apartment complex, single family homes, or facilities listed in subparagraphs (A)-(G) of this paragraph, excluding supportive housing under Section 811 of the National Affordable Housing Act of 1990, meet all of the following criteria:
(i) the dwellings create a residential area distinguishable from other areas primarily occupied by persons who do not require routine support services because of a disability;
(ii) most of the residents of the dwellings are persons with mental retardation; and
(iii) the residents of the dwellings are provided routine support services through personnel, equipment, or service facilities shared with the residents of the other dwellings.

Further, Texas Administrative Code, Part 1, Chapter 9, Subchapter D, §9.173 (18) specifies that a program provider must protect and promote the right of the individual:
(18) to live where the individual is within proximity of and can access treatment and services that are best suited to meet the individual's needs and abilities and enhance that individual's strengths;

Since transportation of the individual served is within the billable services definition for supported home living and is included in the service definition for residential services, the individual's choice of a residence is not obstructed distance to needed treatment and service delivery sites.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Out-of-Home Respite

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Nursing	☑
Social Work	☐
Behavioral Support	☑
Speech and Language Pathology	☑
Employment Assistance	☐

Waiver Service	Provided in Facility
Financial Management Services	☑
Transition Assistance Services	☐
Dietary Services	☑
Adaptive Aids	☑
Supported Employment	☐
Support Consultation	☑
Dental Treatment	☑
Supported Home Living	☐
Occupational Therapy	☑
Audiology	☑
Day Habilitation	☑
Respite	☑
Prescribed Drugs	☑
Residential Assistance (Host Home/Companion Care, Supervised Living, Residential Support Services)	☐
Cognitive Rehabilitation Therapy	☐
Physical Therapy	☑
Minor Home Modifications	☐

Facility Capacity Limit:

Six individuals

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☐
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☐
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

DADS Regulatory Services standards are outcome-based, so that admission policies are not required. The DADS Regulatory Services standards do not prescribe a particular staff ratio but do require that the HCS provider ensure the continuous availability of trained and qualified service providers to deliver the required services as determined by the individual's needs. The respite facility must support the individual's continued use of all waiver services authorized on the individual's service plan and all non-waiver services listed on the individual's service plan. DADS Regulatory Services monitors the adequacy of staff ratios based upon the needs of individuals residing in the out-of-home respite facility.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Supervised Living

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Nursing	☑
Social Work	☐
Behavioral Support	☑
Speech and Language Pathology	☑
Employment Assistance	☐
Financial Management Services	☐
Transition Assistance Services	☐
Dietary Services	☑
Adaptive Aids	☑
Supported Employment	☐
Support Consultation	☐
Dental Treatment	☐
Supported Home Living	☐
Occupational Therapy	☑
Audiology	☑
Day Habilitation	☑
Respite	☐
Prescribed Drugs	☑
Residential Assistance (Host Home/Companion Care, Supervised Living, Residential Support Services)	☑
Cognitive Rehabilitation Therapy	☐
Physical Therapy	☑
Minor Home Modifications	☑

Facility Capacity Limit:

Three individuals

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☐
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☐
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

DADS Regulatory Services standards are outcome-based, so that admission policies are not required. The standards address the need for appropriate room and board agreements and the charges which may be assessed to individuals served. The DADS Regulatory Services standards do not prescribe a particular staff ratio but do require that the HCS provider ensure the continuous availability of trained and qualified service providers to deliver the required services as determined by the individual's needs. DADS Regulatory Services monitors the adequacy of staff ratios based upon the needs of individuals residing in the specific supervised living facility.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Residential Support Services

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Nursing	☑
Social Work	☐
Behavioral Support	☑
Speech and Language Pathology	☑
Employment Assistance	☐
Financial Management Services	☐
Transition Assistance Services	☐
Dietary Services	

Waiver Service	Provided in Facility
	☑
Adaptive Aids	☑
Supported Employment	☐
Support Consultation	☐
Dental Treatment	☐
Supported Home Living	☐
Occupational Therapy	☑
Audiology	☑
Day Habilitation	☑
Respite	☐
Prescribed Drugs	☑
Residential Assistance (Host Home/Companion Care, Supervised Living, Residential Support Services)	☑
Cognitive Rehabilitation Therapy	☐
Physical Therapy	☑
Minor Home Modifications	☑

Facility Capacity Limit:

four individuals

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☐
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☐
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

DADS Regulatory Services standards are outcome-based, so that admission policies are not required. The standards address the need for appropriate room and board agreements and the charges which may be assessed to individuals served. The DADS Regulatory Services standards do not

prescribe a particular staff ratio but do require that the HCS provider ensure the continuous availability of trained and qualified service providers to deliver the required services as determined by the individual's needs. DADS Regulatory Services monitors the adequacy of staff ratios based upon the needs of individuals residing in the specific residential support services facility.

Appendix C: Participant Services

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

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

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

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

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

- ( ) **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- (●) **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

Relatives who are not legally responsible for the individual, and who meet qualifications, may provide HCS services with the following exceptions:
-Supported home living and respite may not be provided by persons, including guardians and relatives, who live with the individual.
-Guardians and persons related to the individual within the fourth degree of consanguinity (blood relation) or within the second degree of affinity (by marriage) may not provide service coordination, residential support services, supervised living, behavioral support services, social work services, or adaptive aids for the individual.
-The spouse of an individual may not provide any waiver service to the individual.

Documentation requirements are the same for relatives and guardians who are service providers as for all other service providers. If the individual has a relative licensed by the State of Texas in that field, the State does not prohibit that relative from providing the service to the individual. HCS providers must assure completion of

required documentation and financial management services agencies require submission of required documentation before paying the service provider and submitting a billing claim.

DADS monitors compliance with policies concerning eligibility of service providers and completion of required documentation through HCS provider survey and certification reviews, billing and payment reviews of HCS providers, and contract monitoring of financial management services agencies.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The following processes are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in Title 42 of the Code of Federal Regulations, Section 431.51:

In order to obtain a Medicaid provider agreement as an HCS agency provider, a provider applicant must apply in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter Q. New HCS agency provider applications are accepted by DADS on an ongoing basis. As part of the HCS agency provider enrollment process, new HCS agency providers are required to complete new HCS agency provider training. DADS conducts new HCS agency provider training on a biannual basis.

Qualified HCS agency providers agree to provide all HCS waiver services. This model of service delivery has been approved by CMS since 1985 and is in use in other currently CMS-approved Texas home and community-based services waivers. This model of service delivery accomplishes the following for individuals receiving HCS waiver services:
- ensures the availability of each service across the state, even in rural areas where, without the use of the current definition of qualified provider, not all waiver services would be readily accessible;
- recognizes that a vast majority of individuals are not single service users, but require supports across service disciplines that must be closely integrated and coordinated to achieve beneficial outcomes;
- promotes effective response to temporary or permanent changes in individuals' service needs as HCS providers are required to make all services available when and as they are needed;
- establishes a single point of accountability for provision of needed services; and
- decreases administrative costs.

In addition to promoting efficient service delivery, the HCS waiver service delivery model does not compromise an individual's choice of qualified HCS agency providers or waiver service providers. In all 254 counties, no matter how sparsely populated, individuals have a choice between at least two HCS agency providers. In most cases, individuals have a choice among numerous HCS agency providers. With regard to an individual's choice of service providers, HCS rules at Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D, §9.173 require the HCS agency provider to protect and promote the individual's right to choose among various available service providers.

Information about obtaining a HCS Medicaid provider agreement is provided by contacting the DADS Community Services Contracts unit.

Quality Improvement: Qualified Providers

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

a. **Methods for Discovery: Qualified Providers**

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. **Sub-Assurances:**

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
C.a.1 Number and percent of newly enrolled contracted providers that initially met certification standards prior to furnishing services. N: Number of newly enrolled contracted providers that met required certification standards prior to furnishing services. D: Number of newly enrolled contracted providers.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
C.a.2 Number and percent of contracted providers that met certification standards following enrollment and continually. N: Number of enrolled contracted providers that met certification standards following enrollment and continually. D: Number of contracted providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Client Assignment and Registration system and Waiver Survey and Certification database

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

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

Data Aggregation and Analysis:

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

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

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

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

Performance Measure:
C.b.1 Number and percent of newly enrolled financial management services agencies who met initial qualifications. N: Number of new financial management services agencies who met initial qualifications D: Number of newly enrolled financial management services agencies.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
C.b.2 Number and percent of financial management services agencies who continue to meet contract requirements. N: Number of financial management services agencies who continue to meet contract requirements. D: Number of financial management services agencies monitored.

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

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

	Specify: Every three years	

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
C.c.1 Number and percent of providers for whom DADS conducted training in accordance with DADS' requirements and the approved waiver. N: Number of providers meeting provider training requirements. D: Number of providers.

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

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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
DADS monitors HCS providers for compliance with HCS certification principles, billing and payment guidelines, policies and procedures; and the terms of the Medicaid provider agreement.

DADS Regulatory Services monitors the performance of HCS providers by completing initial and annual on-site reviews to determine compliance with the HCS certification principles. DADS Regulatory Services certifies providers annually. A representative sample of service provider records are reviewed to ensure criminal background checks are performed as required. This data is reported for the quarter in which the provider is monitored resulting in no overlaps in reporting/monitoring.

DADS Regulatory Services also conducts additional reviews when significant issues or complaints are identified.
Following certification reviews, all HCS providers receive a written certification review report that details any specific areas of non-compliance found during the review and includes instruction regarding the HCS provider's responsibility with regard to the areas of deficiency. During initial on-site and annual reviews of HCS providers, DADS verifies that the HCS provider has systems in place to verify that minimum staff qualifications are met and a process to conduct required training.

100 percent of financial management services agencies are monitored every three years. DADS monitors a certain number of financial management services agencies each year. This data is reported for the year in which the provider is monitored resulting in no overlaps in reporting/monitoring.

Annual monitoring by HHSC includes reviewing data from the quarterly quality measures and annual CMS-372 reports and implementing the Quality Review Team processes, the key formal mechanism for monitoring DADS' performance. The Quality Review Team meets quarterly and reviews comprehensive quality reports from each waiver at least annually. These reports include data on all of the waiver's quality improvement strategy measures. These reports also include remediation activities and outcomes. Improvement plans are developed as issues are identified by DADS or HHSC, and the Quality Review Team reviews, modifying if needed, and approves all improvement plans. All active improvement plans for all waivers are monitored at each quality review team meeting.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
If DADS Regulatory Services determines that the HCS provider is in compliance with all certification principles at the end of the review, DADS certifies the HCS provider.

If DADS Regulatory Services determines that the HCS provider is out of compliance with 10 percent or fewer of the certification principles at the end of the review, but the HCS provider is in compliance with all principles found out of compliance in the previous review, the HCS provider must submit a corrective action plan to DADS Regulatory Services within 14 calendar days for approval. If the plan is approved by DADS Regulatory Services, the HCS provider is certified. DADS Regulatory Services evaluates and verifies success in the HCS provider's required corrective action during the first on-site review of the HCS provider after the corrective action completion date. If the HCS provider does not submit a corrective action plan as required or the plan is not approved by DADS Regulatory Services, a termination of the HCS provider's Medicaid provider agreement is initiated, a vendor hold is placed against the HCS provider, and the local authority informs the individuals served by the HCS provider of the proposed Medicaid provider agreement termination and coordinates transfer to another HCS provider if requested by the individuals.

If DADS Regulatory Services determines that the HCS provider is out of compliance with 10 percent or fewer of the certification principles at the end of the review, and one or more of the principles were found out of compliance in the previous review, DADS Regulatory Services certifies the HCS provider, if the HCS provider presents evidence that it is in compliance with all principles found out of compliance in the previous review and submits a corrective action plan addressing any new principles found out of compliance. The success of the corrective action plan is verified at the following scheduled re-certification visit by DADS.

If these conditions are not met, DADS Regulatory Services does not certify the HCS provider and initiates termination of the HCS provider's Medicaid provider agreement.

If DADS Regulatory Services determines that the HCS provider is out of compliance between 10 and 20 percent of the certification principles at the end of the review, including any principles found out of compliance in the previous review, DADS Regulatory Services does not certify the HCS provider and applies

a Level I sanction against the HCS provider. Under a Level I sanction, the HCS provider must complete corrective action within 30 calendar days after the review and DADS Regulatory Services conducts an on-site follow-up review within 30 to 45 calendar days after the review. Based on the results of the follow-up review, DADS Regulatory Services certifies the HCS provider or denies certification of and implements vendor hold against the HCS provider.

If DADS Regulatory Services implements a vendor hold against the HCS provider, DADS Regulatory Services conducts a second on-site follow-up review between 30 and 45 calendar days after the effective date of the vendor hold. Based on the results of the review, DADS Regulatory Services may certify the HCS provider and remove the vendor hold or may deny certification of the HCS provider and initiate termination of the Medicaid provider agreement.

Throughout the DADS Community Services Contracts review of financial management services agencies, technical assistance is shared with providers. If, during a contract monitoring review, a financial management services agency is discovered to not have met Medicaid provider agreement requirements the agency is required to submit a corrective action plan to DADS. The corrective action plan must contain the following elements:
- The title of the person responsible for the action;
- A description of the action to be accomplished;
- The date the action will be implemented; and
- The action to ensure compliance.

If a corrective action plan is requested from the financial management services agency, the agency is informed that they may contact DADS staff with any questions or requests for clarification of what constitutes an acceptable corrective action plan. Upon submittal, DADS reviews the corrective action plan and either approves or, if the submitted plan does not include all of the required elements, requests revisions and resubmission of the plan. Financial management services agencies are informed that their failure to ensure DADS receives an acceptable corrective action plan by the date specified by DADS may result in DADS taking adverse action against the agency, up to and including termination of the Medicaid provider agreement. DADS monitors the corrective action plan until the financial management services agency is in compliance.

DADS Community Services Contracts staff submits Medicaid provider agreement/contract action recommendations for financial management services agencies to the Sanction Action Review Committee when a complaint investigation against a financial management services agency substantiates a reported allegation or staff recommend the agency receive a contract action/sanction greater than a corrective action plan. Sanction Action Review Committee members review the monitoring review results and, if applicable, review complaint investigation findings to ensure the circumstances support the recommended provider agreement/contract action. The Sanction Action Review Committee makes a decision on the appropriate action to take, including submission of a corrective action plan; placing a hold on individual referrals for new clients; placing a hold on provider payments; financial recoupment; involuntary contract termination; and debarment.

Results of each financial management services agency contract monitoring review are documented and recorded in an Access database maintained in the state office.

ii. Remediation Data Aggregation

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

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

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

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

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
◉ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☑ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

Minor home modifications delivered through transition assistance services prior to enrollment and minor home modifications delivered after enrollment have a combined maximum lifetime expenditure of $7,500.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

DADS is still assessing settings compliance in accordance with our transition plan.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Individual Service Plan (ISP)

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*
   - ☐ **Registered nurse, licensed to practice in the State**
   - ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
   - ☐ **Licensed physician (M.D. or D.O)**
   - ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
   - ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
     Specify qualifications:
   - ☐ **Social Worker**
     Specify qualifications:
   - ☑ **Other**

Specify the individuals and their qualifications:

To support the philosophy of person-directed planning, service plans in HCS are comprised of three documents:
-the person-directed plan,
-the individual plan of care, and
-the implementation plan.

The service planning team, consisting of the local authority service coordinator, the individual, legally authorized representative, and any persons chosen by the individual or legally authorized representative, is responsible for developing the person-directed plan. The plan contains the individual's desired outcomes and identifies the waiver services the individual needs to meet their desired outcomes. The service planning team develops the individual plan of care, which clearly specifies all waiver and non-waiver services which will support the individual. The HCS provider develops the implementation plan which describes how services will be delivered and what strategies will be implemented to support the individual in accomplishing his or her outcomes.

Service coordinators must be employees of the local authorities in order to provide service coordination to individuals in this waiver and must meet the following criteria:

1. Have a bachelor's or advanced degree from an accredited college or university with a major in a social, behavioral, or human service field including, but not limited to, psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human development, gerontology, educational psychology, education, and criminal justice;

2. Have a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma with two years of paid experience as a case manager in a state or federally funded Parent Case Management Program or have graduated from Partners in Policy Making, and personal experience as an immediate family member of an individual with an intellectual or developmental disability;

3. At the discretion of the local authority, a staff person who was authorized by a local authority to provide service coordination prior to April 1, 1999, may provide service coordination without meeting the minimum qualifications described above; or

4. Until December 31, 2011, a local authority could hire a person to provide service coordination who was employed as a case manager for a HCS provider for any period of time prior to June 1, 2010, even if the person does not meet the minimum qualifications described in numbers one and two of this section.

Beginning January 1, 2012, a local authority may hire a person to provide service coordination who was hired by another local authority in accordance with number four of this section.

The Partners in Policymaking handbook found at: http://mn.gov/mnddc/pipm/index.html contains curriculum which can be utilized for an immediate family member to be eligible to provide service coordination.

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:*

Community Centers and a Council of Government are designated as local authorities. A local authority conducts all enrollment activities for waiver applicants. Applicants may request a change in service coordinators from the local authority but the service coordinator must be an employee of the local authority

serving the geographic area where the applicant will receive HCS waiver services. A local authority may also hold a HCS Medicaid provider agreement with the State. In these situations, the administrative and provider services sections are separate and distinct from one another organizationally and in practice. The service coordinator is prohibited from providing direct waiver services to the individual.

At enrollment the service coordinator must inform the individual or legally authorized representative about available services and supports and the service delivery options. If the individual accepts the offer of HCS waiver services, the individual selects a HCS provider that has a Medicaid provider agreement with the State. In the instance in which an individual has chosen the consumer directed services delivery option, the selection of an HCS provider is optional.

After the initial enrollment service plan development, the service planning team which includes individual and legally authorized representative, service coordinator, the HCS provider representatives as chosen by the individual, and other persons as chosen by the individual meet at least annually to review the individual's goals, non-waiver and waiver service needs and develop the person-centered plan. The HCS provider, individual, and legally authorized representative develop the service plan based on the person-directed plan. The service coordinator is responsible for reviewing the service plan to ensure it is reflective of the services identified in the person-centered plan. If the service coordinator determines the service plan does not reflect the services identified in the person-centered plan and disagrees with the service plan which has been submitted, the service coordinator indicates the disagreement in the Client Assignment and Registration system. The service plan, including the service coordinator's disagreement, is electronically submitted to DADS through the Client Assignment and Registration system. The safeguards are built into the role of the service coordinator and the additional oversight provided by the DADS as the operating agency.

At least annually, DADS conducts certification reviews of all HCS providers who hold Medicaid provider agreements and who are providing services to at least one individual, at which time a sample of individuals, legally authorized representatives, or both are interviewed and records are reviewed to determine whether the HCS provider is in compliance with all of the HCS certification principles. Further, DADS reviews the administrative functions of the local authority annually, including the provision of service coordination.

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.

During enrollment, the service coordinator ensures that the individual and legally authorized representative, and any other person chosen by the individual, participate in developing a person-directed plan that describes the waiver services and non-waiver services and supports necessary to protect the individual's health and safety and to achieve the desired outcomes identified by the applicant/individual or legally authorized representative.

The service coordinator also educates the individual and legally authorized representative about service delivery options and services available through the HCS waiver that will contribute to outcome achievement. The service coordinator must inform the individual and legally authorized representative, orally and in writing, of the eligibility criteria for participation in the HCS waiver; the services and supports provided by the HCS waiver, including the limits on those services and supports; and the reasons an individual's HCS waiver services may be terminated.

If the service planning team determines that transition assistance services are needed in order to meet an individual's health and safety needs at the time an individual enrolls, such services may be authorized by the service planning team prior to the individual's enrollment.

Once the enrollment process is complete, the local authority provides ongoing service coordination to the individual. The individual's service coordinator maintains current contact information for the service coordinator, the HCS provider, and the individual, including current contact information for the service coordinator's backup. The service coordinator must ensure that the individual, family, or legally authorized representative, as appropriate, have the contact information.

The service planning team meets to update the individual's person-directed plan when the individual's desired outcomes change. The service planning team consists of the individual and their legally authorized representative, the service coordinator, and any persons chosen by the individual or legally authorized representative.

Revisions to the individual's plan of care occur when the individual's needs change. A request to revise the individual plan of care may be initiated by the individual/legally authorized representative, the HCS provider, or service coordinator.

Annually, the person-directed plan and individual plan of care are updated and renewed prior to the expiration of the individual plan of care. The service planning team reviews the current person-directed plan, including the individual's desired outcomes, and updates the information as necessary. The service coordinator also provides an explanation of the individual's rights and responsibilities, which includes the right to transfer to another HCS provider or financial management services agency, and the right to change service delivery options.

The HCS provider, the service coordinator, the individual, legally authorized representative, and any persons chosen by the individual or legally authorized representative renew the individual plan of care based on the updated person-directed plan.

The HCS provider and individual/legally authorized representative are responsible for developing an implementation plan that describes the type of service, the type of service provider, the schedule of services, the location of service provision, and the amount of services provided to the individual. The implementation plan must also explain the strategies for assisting the individual in accomplishing his or her outcomes.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The service planning team develops the person-directed plan at enrollment and annually thereafter. The service planning team consists of the individual, the individual's legally authorized representative if any, the local authority service coordinator, and any other persons chosen by the individual or legally authorized representative. Person-center planning is centered on the needs of the individual and the individual's primary care giver, if applicable. Therefore, service planning meetings are scheduled by the service coordinator at a time and place that meets the needs of the individual and primary care giver, if applicable.

Based on the person-directed plan, the service coordinator, individual, legally authorized representative, and the HCS provider develop the individual plan of care. The individual plan of care identifies the amount of each authorized waiver service; identifies the non-waiver supports to be utilized by the individual; attests that the waiver services are necessary to prevent institutionalization, to live in the community, to assure the individual's health, safety, and welfare in the community, are based on outcomes on the person-directed plan, and are not available to the individual through any other source, including the Medicaid State Plan, other governmental programs, private insurance, or the individual's natural supports; and are cost effective. The individual plan of care is developed upon enrollment, at least annually, and whenever the individual's needs change to warrant a change in waiver services. When a change in the individual's plan of care occurs, the HCS provider updates the implementation plan for service delivery to address the service changes.

The service coordinator is responsible for documenting that the HCS waiver services in the individual plan of care are necessary for the individual to live in the community and to prevent his or her admission to institutional services; are sufficient, when combined with services or supports available from non-waiver resources, to assure the

individual's health and welfare in the community; are not available to the individual through any other source including the Medicaid State Plan, other governmental programs, private insurance, or the individual's natural supports; are the appropriate type and amount; and are cost effective. All third party resources, including Medicaid State Plan services, must be accessed prior to waiver services.

At a minimum, both the initial and subsequent service planning processes and resulting plans must address the following:
1) A description of the needs and preferences identified by the individual, legally authorized representative, or both;
2) A description of the services and supports the individual requires to continue living in a community-based setting;
3) A description of the individual's current existing natural supports and non-waiver services that will be or are available;
4) A description of individual outcomes to be achieved through HCS waiver services and justification for each service to be included in the individual service plan;
5) Documentation that the type, frequency, and amount of each service included in the individual's service plan do not replace existing natural supports or non-waiver sources for the services for which the applicant/individual may be eligible; and
6) A description of actions and methods to be used to reach identified desired outcomes described in the service plan, projected completion dates, and person(s) responsible for completion.

The HCS provider and individual/legally authorized representative are responsible for developing an implementation plan that describes the type of service, the type of service provider, the schedule of services, the location of service provision, and the amount of services provided to the individual. The implementation plan must also explain the strategies for assisting the individual in accomplishing his or her outcomes.

Both the service coordinator and the HCS provider support the individual's and legally authorized representative's participation in the service planning process by encouraging the expression of preferences, goals, and ambitions and providing education about the services available through the HCS waiver as well as through other non-waiver resources for which the individual may be qualified.

DADS conducts audits of the local authority service coordination functions annually and monitors whether the individuals within the audit sample were offered choice among providers upon initial enrollment an annually thereafter. Monitoring is performed by record review and interviews with individuals and LARS as indicated from record review.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

During the service planning process both the service coordinator and the HCS provider ensure consideration of information from the individual, legally authorized representative, other service planning team members, and from assessments to determine any risks that might exist to health and welfare of the individual as a result of living in the community. Strategies, including waiver services and supports and formal and informal non-waiver services and supports, are developed to mitigate these risks, and are incorporated into the service plan. The discovery process utilized by the service coordinator is designed to address all areas of an individual's life: social inclusion/relationships, health and safety, work/school, self-determination, financial security, living environment, physical/emotional/behavioral, rights/legal status, and daily living skills. Following the discovery process, the service planning team identifies and documents in the person-directed plan those services that are critical to the health and welfare of the individual for which a backup plan must be developed. Backup plans may use paid or unpaid service providers, other third party resources, and other community resources. In the HCS provider option, individuals receiving supervised living and residential support services do not require a service backup plan for those services as the consistent availability of qualified staff for these services is required by Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D. The backup plan for individuals served in host home/companion care services is identified in the provider agreement between the HCS provider and the HCS provider's contracted host home/companion care service provider and discussed as part of the service planning

meeting.

If a service has been identified as needed to ensure health and safety of the individual but the individual or their legally authorized representative refuse the offered service, the service coordinator will monitor the individuals health and safety through the service coordination function. Linkage to non-waiver services and supports may be provided. The Department of Family and Protective services may be contacted if the individual's health and safety is jeopardized.

The service planning team identifies risk factors for an individual by discussing relevant areas of an individual's life with the individual and legally authorized representative and others who provide supports to the individual and have been invited to participate in the person-centered planning process. An example of risk factors which may affect service planning might be an individual's inability to recognize the possible danger associated with certain strangers.

In the consumer directed services delivery option, the individual/employer is responsible for developing the backup plan(s) and the local authority service coordinator is responsible for reviewing the backup plan(s) to determine whether the strategies are reasonable and that viable contingencies exist in the event an individual is unable to receive a critical waiver service by their regular direct service provider. If the service coordinator determines a strategy is not reasonable or viable, the service coordinator must support the individual/employer, as needed, to revise the backup plan. The service coordinator may also suggest the individual/employer consider using support consultation to assist in the development of a backup plan. The individual/employer is responsible for providing the financial management services agency with a copy of each service backup plan after it has been approved by the service planning team. The service coordinator must conduct and document monitoring activities, including: determining whether the individual has made progress toward the outcomes identified on the person-directed plan; determining whether HCS service(s) are being delivered, including the delivery of services included in backup plans, as needed, by the HCS provider or consumer directed services direct service provider, as appropriate; determining whether non-waiver services are being delivered; ensuring coordination and compatibility of waiver and non-waiver services with the HCS provider; and determining whether the individual's health or safety is at risk in the environments where the individual receives waiver and non-waiver services and, if necessary, taking action to protect the individual's health and safety. Action may include addressing the risk with the HCS provider or notifying the appropriate authorities.

If, as a result of monitoring, the service coordinator identifies a concern with an individual's progress toward outcomes in the person-directed plan, the delivery of HCS services, including implementation of the backup plan, or the individual's health and safety, the service coordinator must communicate such concern to the HCS provider via a mechanism determined by the local authority and HCS provider. The service coordinator and the HCS provider are responsible for resolving any identified concern. If the concern cannot be resolved, the service coordinator may report the concern to DADS Consumer Rights and Services.

Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D requires the HCS provider to ensure the continuous availability of trained and qualified employees and contractors to provide the services in an individual service plan. Thus, HCS providers must implement plans that adequately prevent service interruptions or delays that may place the individual's health or safety at risk.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D requires an local authority to:
(A) provide a list to the individual or legally authorized representative with contact information for all HCS providers in the local authority's local service area;
(B) assist in educating and securing tools for use by the individual or legally authorized representative in evaluating HCS providers' experience and compatibility with the specific needs and preferences of the individual;
(C) arrange for meetings/visits with potential HCS providers as requested by the applicant or the legally authorized representative; and
(D) ensure that the applicant's or legally authorized representative's choice of a HCS provider is documented, signed by the individual or the legally authorized representative, and retained in the applicant's/individual's record;

These rules also require local authorities to be objective in assisting an individual or legally authorized representative in the selection of a HCS provider or financial management services agency. In accordance with all local authority performance contracts, local authorities are required to ensure their enrollment staff are objective in assisting an individual or legally authorized representative in selecting a HCS provider or financial management services agency and not influence the individual's or legally authorized representative's decision. The local authority provides meaningful access to its programs, services, and activities and ensures adequate communication through language assistance services for individuals and legally authorized representatives with limited English proficiency, sensory impairments, and/or speech impairments. The performance contract also prohibits a local authority's own HCS provider staff from initiating contact with the applicant/individual or legally authorized representative prior to their choice of HCS provider or financial management services agency.

At the time of enrollment and upon request, the service coordinator provides the individual or legally authorized representative with a list of all qualified providers in the individual's service area. The service coordinator may also refer the individual or legally authorized representative to resources provided by DADS to assist them in the selection of a HCS provider. These resources include the DADS Quality Reporting System website. This website includes a list of all qualified HCS providers that is searchable by city, county, or zip code and includes provider contact information, current census, and DADS Regulatory review results. DADS has also posted on its website an "interview tool" individuals and their families may tailor for their own use during the process of provider selection.

Local authorities are required to provide service coordination in accordance with the HCS certification principles located in Title 40 of the Texas Administrative Code, Chapter 9, Subchapter D which require an individual's service coordinator to manage the process to transfer the individual's HCS services from one HCS provider to another or one financial management services agency to another in accordance with DADS instructions. At least annually, the service coordinator must inform the individual or legally authorized representative of their right to transfer at any time.

DADS Contract Accountability and Oversight conducts annual local authority performance contract reviews to assess local authority compliance with contract provisions.

During all local authority performance contract reviews and HCS provider certification reviews, DADS examines evidence of the local authority's and the HCS provider's compliance with safeguarding the right of individuals and legally authorized representatives to exercise free choice of providers and the right to transfer to a new provider. DADS assesses this compliance through individual and legally authorized representative interviews and through a review of individual records. Service coordinators are also required to inform individuals and legally authorized representatives of the process for filing a complaint with DADS Consumer Rights and Services, and must provide them with the phone number for DADS Consumer Rights and Services. DADS Consumer Rights and Services follows up on all complaints received related to HCS, including those related to an individual's or legally authorized representative's right to choose from among the list of qualified providers, to ensure individuals' rights are protected.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

HHSC, the State Medicaid Agency, delineates through executive directive the roles and responsibilities of DADS, the operating agency, and HHSC. The executive directive outlines HHSC monitoring and oversight functions. HHSC has delegated the day-to-day approval of service plans to DADS. DADS reviews and approves all individual plans of care in the HCS waiver. DADS also performs at least annual certification reviews of each HCS provider and annual local authority performance contract reviews during which they review the HCS provider's and the local authority's compliance with the service planning requirements. DADS quarterly and annually aggregates data and reports to HHSC. HHSC discusses with DADS any significant findings and if necessary develops a corrective action plan that DADS implements with HHSC oversight.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. **Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☑ **Operating agency**
- ☐ **Case manager**
- ☑ **Other**

Specify:

HCS provider and local authority.

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.

HCS providers monitor implementation of individual service plans, individuals' health and welfare, and assess how well services are meeting an individual's needs and enabling the individual to achieve the specific objectives described in the service plan. The HCS provider must ensure that waiver services identified in the individual's implementation plan are provided in an individualized manner and are based on the results of assessments of the individual's and the family's strengths, the individual's personal goals and the family's goals for the individual, and the individual's needs rather than which services are available. The HCS provider must ensure that each individual's progress or lack of progress toward desired outcomes is documented in observable, measurable, or outcome-oriented terms. The HCS provider must maintain a system of delivering waiver services that is continuously responsive to changes in the individual's personal goals, condition, abilities, and needs as identified by the service planning team.

Service coordinators monitor an individual's progress toward the achievement of desired outcomes identified in the service plan and monitor the individual's continued access to non-waiver supports as those supports are necessary for the individual to reside successfully in the community. Service coordinators monitor to determine whether waiver services are being provided and ensure the individual or legally authorized representative are afforded free choice of providers upon enrollment and when a transfer is requested or when the individual moves without prior notice. The service coordinator and HCS provider take appropriate actions to address identified problems including counseling with the individual or legally authorized representative; convening a meeting to resolve problems; or advocating on the individual's behalf as necessary.

Service coordinators are required to have face-to-face contact with the individual's and to monitor an individual's outcomes identified on the service plan at least every 90 days or more frequently as necessary. Most individuals are contacted monthly by their service coordinators. When monitoring identifies changes in the individual's needs or

preferences, the local authority service coordinator and HCS provider meet to address the identified changes or confer with service providers concerning revising the individual's services or implementation strategies. A revision to the service plan is made in conjunction with the local authority service coordinator, individual or legally authorized representative, and HCS provider.

The service coordinator is responsible for asking the individual or legally authorized representative if the backup plan, developed by the consumer directed services employer or HCS provider, is effective. If the plan is not working, the service coordinator notifies the HCS provider or if under the consumer directed services option, assists the individual with revising the plan as necessary to ensure the individual's health and safety. If the person directed planning process reveals that an individual has a need for health services, the service coordinator is responsible for ensuring appropriate waiver and non-waiver services are included in the service plan to address the need and that the individual's health needs are being addressed by the HCS provider.

DADS conducts at least annual certification reviews of HCS providers and local authority performance contract reviews of local authorities. During these reviews the DADS Regulatory Services and the Contract Accountability and Oversight units ensure that the service plans were developed in accordance with the service planning process described in Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D, including that the individual or legally authorized representative agreed to the service plan. Through these reviews DADS also ensures that service plans are implemented and then monitored in accordance with HCS certification principles. DADS annually and quarterly aggregates the data and reports to HHSC. HHSC discusses with DADS any significant findings and if necessary DADS develops a corrective action plan that DADS implements with HHSC oversight.

b. Monitoring Safeguards. *Select one:*

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

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

The HCS provider is responsible for providing the full array of waiver services to the individual as necessary to meet their individual support needs. The HCS provider is responsible for monitoring the delivery of waiver services, as described in D-1-d of this appendix to ensure they are provided in accordance with the service plan. The service coordinator is responsible for determining: whether the individual has made progress toward the outcomes identified on the person-directed plan; determining whether HCS service(s) are being delivered, including the delivery of backup plans, as needed by the HCS provider or consumer directed services provider, as appropriate; determining whether non-waiver services are being delivered; ensuring coordination and compatibility of waiver and non-waiver services with the HCS provider; and determining whether the individual's health or safety is at risk in the environments where the individual receives waiver and non-waiver services and, if necessary, taking action to protect the individual's health and safety. For HCS waiver services, action may include addressing the risk with the HCS provider or notifying the appropriate authorities. For consumer directed services, action may include the development of a plan of correction with the individual employer and follow-up monitoring to determine if the consumer directed services option can ensure the individual's health and safety or notifying the appropriate authorities.

DADS performs at least annual on-site certification reviews of each HCS provider and annual performance contract reviews of each local authority. A sample of individuals receiving HCS waiver services from the HCS provider are interviewed and records are reviewed to determine that the HCS provider followed service planning requirements, including that the individual's needs are being met, service plans change as needs change, and the individual's best interests are served. A sample of records of individuals in the HCS waiver that are receiving service coordination from the local authority are reviewed to determine that the local authority is following HCS service planning requirements, including that the individuals' needs are being met and service plans change as needs change. In addition, records are reviewed to ensure compliance with the right of individuals and legally authorized representatives to exercise free choice of providers and the right to transfer to a new provider.

Following the initial on-site certification, at least annually DADS evaluates a HCS provider's compliance with the HCS certification principles during certification reviews. DADS examines evidence of compliance with safeguarding the right of individuals and legally authorized representatives to exercise free choice of providers

and the right to transfer to a new provider through interviews with individuals and legally authorized representatives and through a review of individuals' records. During any review, including a follow-up review or a review in which corrective action from a previous review is being evaluated, DADS may review the HCS services provided to any individual to determine if the HCS provider is in compliance with HCS certification principles, at which time DADS certifies a HCS provider for a period of no more than 365 calendar days after completion of an initial or annual certification review.

DADS may conduct announced or unannounced reviews of the HCS provider at any time. DADS conducts, at least annually, unannounced visits of each residence in which host home/companion care, residential support, or supervised living is provided to verify that the residence provides an environment that complies with DADS requirements.

HCS providers also must monitor that the services are being delivered in accordance with the service plan and this is reviewed by DADS Regulatory Services during annual reviews.Service coordinators are required to inform individuals and legally authorized representatives of the process for filing a complaint with DADS Consumer Rights and Services, and must provide them with the phone number for DADS Consumer Rights and Services. Evidence of compliance with this requirement is also assessed during all performance contract reviews conducted by DADS. DADS Consumer Rights and Services division follows up on all complaints received, including those related to an individual's or legally authorized representative's right to choose from among the list of qualified providers, to ensure individuals' rights are protected.

The HCS provider and the local authority service coordinator have the shared responsibility to ensure an individuals' rights are protected, service plan monitoring occurs as required by the HCS rules, that required documentation is completed, and appropriate follow-up actions on review findings are taken.

Local authorities who have chosen to contract with DADS to provide HCS services must ensure that the HCS program operation is organizationally separate from the access and intake operations. Service coordinators do not provide direct services and are not employed by the HCS provider. DADS Contract and Accountability Oversight reviews the local authority annually through performance contract reviews to ensure that enrollment, service coordination, and continuity of care functions are conducted in the best interests of the individual. DADS monitoring elements include verification of freedom of choice of providers, verification that a complete list of available providers have been given to individuals and that individuals are informed no less than annually of their right to choose another HCS provider at any time by requesting assistance from their service coordinator.

DADS utilizes the Sanction Action Review Committee (composed of a cross-departmental group of DADS staff) if DADS review staff recommend a discretionary sanction involving vendor hold or termination of an HCS provider's Medicaid provider agreement. The Sanction Action Review Committee provides an objective review of each referral for action or sanction against an HCS provider and renders an unbiased decision in the case.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. **Methods for Discovery: Service Plan Assurance/Sub-assurances**

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. **Sub-Assurances:**

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
D.a.1 Number and percent of individuals with service plans that address their assessed needs, including health and safety risk factors, and personal goals as identified in assessments. N: Number of individuals with service plans that address their assessed needs, including health and safety risk factors,and personal goals as identified in assessments. D: Number of enrolled individuals reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Survery and Certification database

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
D.b.1 Number and percent of service plans developed in accordance with policies and procedures. N: Number of service plans developed in accordance with policies and procedures. D: Number of service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Survey and Certification database

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

		Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
D.c.1 Number and percent of individuals' service plans that are reassessed and renewed annually. N: Number of individuals' service plans that are reassessed and renewed annually. D: Number of individual service plans requiring annual reassessment and renewal.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
D.c.2 Number and percent of service plans that are revised when warranted by reported changes in individuals' needs. N: Number of service plans that were revised when warranted by reported changes in individuals' needs D: Number of service plans reviewed indicating a change in the individual's needs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Client Assignment and Registration system and Waiver Survey and Certification database

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
D.d.1 Number and percent of individuals' records that reflect services are delivered in accordance with their service plan, including type, scope, amount, duration, and frequency. N: Number of individuals' records that reflect that services are delivered in accordance with their service plan, including type, scope, amount, duration, and frequency. D: Number of individuals' records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Client Assignment and Registration system, DADS Regulatory Services reviews

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

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

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
D.e.1 Number and percent of individuals who are afforded choice at enrollment between waiver services and institutional care. N: Number of individuals who are afforded choice at enrollment between waiver services and institutional care. D: Number of newly enrolled individuals.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
D.e.2 Number and percent of individuals who are afforded choice among waiver providers. N: Number individuals who are afforded choice among waiver providers. D: Number of enrolled individuals reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Client Assignment and Registration system, DADS Regulatory Services reviews, Contract Accountability and Oversight Performance Contract reviews

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.e.3 Number and percent of individuals who are afforded choice between and among waiver services. N: Number of individuals who are given a choice between and among waiver services. D: Number of enrolled individuals reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Client Assignment and Registration system, DADS Regulatory Services reviews, Contract Accountability and Oversight Performance Contract reviews

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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
100 percent of HCS providers are continuously reviewed by DADS Regulatory Services annually. A representative sample of individual records is reviewed annually during DADS Regulatory Survey certification reviews. The data is aggregated and analyzed for the quarter in which the provider is monitored.

Based upon a directive issued by the HHSC Executive Commissioner, the State has a process which requires quarterly and annual reports from DADS to HHSC. The reports include data relating to all performance measures in the waiver which include service plan development and monitoring. All quarterly and annual reports are reviewed by HHSC. Quarterly and annual reporting, allows the State to identify additional areas of remediation that require training or technical assistance based on performance measure reports that are representative of the waiver population. If HHSC identifies issues, HHSC employs a variety of mechanisms to resolve issues including informal conversations, elevated conversations, issuing an action memo, or issuing a corrective action plan.

HHSC and DADS have a process in place for the review and approval of any policy changes concerning the waivers. All policy changes, including any changes to the service planning process and provider agency monitoring, must be reviewed by HHSC prior to implementation.

HHSC and DADS meet regularly to discuss the HCS waiver. These meetings provide opportunities for DADS to report to HHSC on their performance and for HHSC to provide feedback and guidance related to DADS' performance, including service planning.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
If DADS Regulatory Services determines that the HCS provider is in compliance with all certification principles at the end of the review, DADS certifies the HCS provider.

If DADS Regulatory Services determines that the HCS provider is out of compliance with 10 percent or fewer of the certification principles at the end of the review, but the HCS provider is in compliance with all principles found out of compliance in the previous review, the HCS provider must submit a corrective action plan to DADS Regulatory Services within 14 calendar days for approval. If the plan is approved by DADS Regulatory Services, the HCS provider is certified. DADS Regulatory Services evaluates the HCS provider's required corrective action during the first on-site review of the HCS provider after the corrective action completion date. If the HCS provider does not submit a corrective action plan as required or the plan is not approved by DADS Regulatory Services, a termination of the HCS provider's Medicaid provider agreement is initiated, a vendor hold is placed against the HCS provider, and the local authority informs the individuals served by the HCS provider of the proposed Medicaid provider agreement termination and coordinates transfer to another HCS provider if requested by the individuals.

If DADS Regulatory Services determines that the HCS provider is out of compliance with 10 percent or fewer of the certification principles at the end of the review, and one or more of the principles were found out of compliance in the previous review, DADS Regulatory Services certifies the HCS provider, if the HCS provider presents evidence that it is in compliance with all principles found out of compliance in the previous review and submits a corrective action plan within 14 calendar days addressing any new principles found out of compliance. If these conditions are not met, DADS Regulatory Services does not certify the HCS provider and initiates termination of the HCS provider's Medicaid provider agreement.

If DADS Regulatory Services determines that the HCS provider is out of compliance with between 10 and 20 percent of the certification principles at the end of the review, including any principles found out of compliance in the previous review, DADS Regulatory Services does not certify the HCS provider and applies a Level I sanction against the HCS provider. Under a Level I sanction, the HCS provider must complete corrective action within 30 calendar days after the review and DADS Regulatory Services conducts an on-site follow-up review within 30 to 45 calendar days after the review. Based on the results of the follow-up review, DADS Regulatory Services certifies the HCS provider or denies certification of and implements vendor hold against the HCS provider.

If DADS Regulatory Services implements a vendor hold against the HCS provider, DADS Regulatory Services conducts a second on-site follow-up review between 30 and 45 calendar days after the effective date of the vendor hold. Based on the results of the review, DADS Regulatory Services may certify the HCS provider and remove the vendor hold or may deny certification of the HCS provider and initiate termination of the Medicaid provider agreement.

Annual monitoring by HHSC includes reviewing data from the quarterly quality measures and annual CMS-372 reports and implementing the Quality Review Team processes, the key formal mechanism for monitoring DADS' performance. The Quality Review Team meets quarterly and reviews comprehensive quality reports from each waiver at least annually. These reports include data on all of the waiver's quality improvement strategy measures. These reports also include remediation activities and outcomes. Improvement plans are developed as issues are identified by DADS or HHSC, and the Quality Review Team reviews, modifying if needed, and approves all improvement plans. All active improvement plans for all waivers are monitored at each quality review team meeting.

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

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

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

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

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. **Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their

services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Participation in the consumer directed services option provides the individual or the legally authorized representative the opportunity to be the employer of persons providing those waiver services chosen for self-direction. An individual, through the consumer directed services option, may direct supported home living, respite, or both. This option is available statewide to individuals receiving HCS waiver services who are living in their own homes, family homes, or legally authorized representatives' homes.

The traditional agency option (provider-managed service delivery method) is available to provide any services not authorized for the consumer directed services option and any services available through the consumer directed services option that the individual or legally authorized representative elects not to self-direct. Under the traditional agency option, individuals choose a HCS provider with a Medicaid provider agreement.

Each individual or legally authorized representative electing the consumer directed services option must receive support from a financial management service provider referred to as a financial mangment services agency, chosen by the individual or legally authorized representative. An individual or legally authorized representative may also self-direct support consultation, which is available only to individuals who choose the consumer directed services option.

The individual or the legally authorized representative may appoint a designated representative to assist with or perform employer responsibilities to the extent approved by the employer. DADS will not pay the individual/employer's designated representative for serving as the designated representative or for providing any services to the individual.

When choosing to self-direct authorized waiver services, the individual receiving those services or the legally authorized representative is the common-law employer of service providers and has decision-making authority over providers of those services. The employer assumes and retains responsibility to recruit, determine the competence of, hire, train, manage, and fire their employees.

In addition, the employer has budget authority over the services he or she is directing. The employer, with the assistance of the financial management services agency, budgets authorized funds for those services to be delivered through the consumer directed services option. DADS authorizes the funds for the services allocated for the consumer directed services option on the service plan.

A service coordinator from the local authority informs the individual or legally authorized representative of the option to self-direct available waiver services at the time of enrollment in the waiver, at least annually thereafter, and upon request of the individual or legally authorized representative. The individual or legally authorized representative may elect at any time to choose the consumer directed services option, terminate participation in the consumer directed services option, or to change financial management services agencies.

Entities or individuals involved in supporting the individual receiving services, or the individual's legally authorized representative who is directing services and supports, include:
(1) The individual's local authority service coordinator, who provides information about the consumer directed services option and monitors service delivery through the option. The service coordination functions are global and apply to self-directed and provider-managed waiver services and non-waiver services; and
(2) A financial management services agency, chosen by the individual or legally authorized representative, to provide financial management services. The financial management services agency must hold a Medicaid provider agreement with DADS on behalf of HHSC.

Supports may also include:
(3) A certified support advisor chosen by the individual or legally authorized representative employer if the individual or legally authorized representative has chosen to receive support consultation, who assists the individual or legally authorized representative employer in learning about and performing employer responsibilities; and
(4) A designated representative, if appointed by the individual or legally authorized representative employer, who assists in meeting employer responsibilities to the extent directed by the employer;

To participate in the consumer directed services option, an individual or legally authorized representative must:
(1) Select a financial management services agency;

(2) Participate in orientation and ongoing training conducted by the financial management services agency;
(3) Perform all employer tasks that are required for self-direction or designate a designated representative capable of performing some or all of these tasks on the individual's behalf; and
(4) Maintain a service backup plan for provision of services determined by the service planning team to be critical to the individual's health and welfare.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Individuals receiving HCS waiver services are offered the opportunity to self-direct services when:

1. They live in their own homes, the homes of family members, or the legally authorized representative's

homes; and
2. Their service plan includes supported home living, respite, supported employment, employment assistance, cognitive rehabilitation therapy, or nursing services.

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.

When an individual enrolls in the waiver, a service coordinator of the local authority provides the individual and legally authorized representative with a written and oral explanation of the consumer directed services option. Subsequent to enrollment, the service coordinator presents the information and the opportunity to participate in consumer directed services to the individual or the legally authorized representative at least annually and upon request.

Each individual or legally authorized representative is provided information sufficient to assure informed decision-making and understanding of the consumer directed services option and of the traditional provider-managed service delivery option. The information includes the responsibilities and choices individuals can make with the election of the consumer directed services option.

Information provided orally and in writing to the individual and the legally authorized representative by the service coordinator includes:

1. An overview of the consumer directed services option;
2. Explanation of responsibilities of the individual or individual's legally authorized representative and the financial management services agency in the consumer directed services option;
3. Explanation of benefits and risks of participating in the consumer directed services 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/employer relationships that prohibit employment under the consumer directed services option.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. **Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

○ **The State does not provide for the direction of waiver services by a representative.**

◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☐ **Waiver services may be directed by a legal representative of the participant.**

☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The individual or the legally authorized representative, serving as the consumer directed services employer, may appoint an adult who is not the legally authorized representative as a designated

representative to assist in performance of employer responsibilities to the extent desired by the individual or legally authorized representative. The consumer directed services employer documents the employer responsibilities that the designated representative may perform and those that the designated representative may not perform on the consumer directed services employer's behalf. The consumer directed services employer provides this documentation to the financial management services agency. The financial management services agency monitors performance of employer responsibilities performed by the individual/employer and, when applicable, the designated representative in accordance with the individual's/employer's documented directions. Neither the designated representative nor the spouse of the designated representative may be employed by, receive compensation from, or be the provider of waiver services for the individual. The consumer directed services employer may terminate the responsibilities of the designated representative at any time.

To ensure the designated representative functions in the best interests of the individual, safeguards are in place that include restrictions preventing the designated representative from:
-signing or representing himself as the employer,
-providing a waiver service, or
-being paid to perform employer responsibilities.

Applicants for employment are required to certify the status of relationship with the employer. If the person indicates that he or she is either designated representative or designated representative's spouse, the financial management services agency would not approve the applicant for hire. The financial management services agency maintains documentation of the designated representative. DADS monitors compliance during the financial management services agency contract monitoring.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Nursing	☑	☑
Employment Assistance	☑	☑
Supported Employment	☑	☑
Support Consultation	☑	☑
Supported Home Living	☑	☑
Respite	☑	☑
Cognitive Rehabilitation Therapy	☑	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

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

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

☐ **Governmental entities**
☑ **Private entities**

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

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

The waiver service entitled:
Financial Management Services

○ **FMS are provided as an administrative activity.**

Provide the following information

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

Private entities furnish financial management services. These entities, called financial management services agencies, are procured through an open enrollment process and the State has Medicaid provider agreements with multiple entities to provide financial management services to individuals across the state.

DADS, on behalf of HHSC, executes a Medicaid provider agreement with each financial management services agency.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Entities are compensated with a flat monthly fee per individual.

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

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

- ☑ **Assist participant in verifying support worker citizenship status**
- ☑ **Collect and process timesheets of support workers**
- ☑ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☑ **Other**

Specify:

Obtain criminal history check on behalf of consumer directed services employer and shares information with the consumer directed services employer so the employer can make a hiring decision.

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:

- [x] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

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

HHSC has delegated to DADS the responsibility of executing Medicaid provider agreements, including day-to-day operations of financial management services and monitoring of financial management services agency. DADS conducts monitoring reviews of financial management services agencies to determine if the financial management services agencies is in compliance with the Medicaid provider agreement and with HCS rules and requirements. These reviews are conducted via desk review or at the location where the financial management services agency is providing financial management services.

Texas monitors 100 percent of the financial management services agency at a minimum every three years. DADS reports the results of the monitoring to HHSC.
DADS assesses a financial management services agency's performance by:
(1) Measuring adherence to rules as described in Title 40 of the Texas Administrative Code, Part 1, Chapter 41;
(2) Matching payroll, optional benefits, and tax deposits to time sheets;
(3) Ensuring that the hours worked and rate of pay are consistent with individual budgets;
(4) Reviewing administrative payments; and
(5) Reviewing the provider agreements.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

- [x] **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:

Local authority staff through targeted case management are responsible for providing each individual or legally authorized representative information sufficient to assure informed decision-making and understanding of the consumer directed services option and of the traditional provider-managed service delivery option. The information includes the responsibilities and choices individuals can make with the election of the consumer

directed services option. Local authority staff review the consumer directed services option at waiver enrollment, at least annually, and upon request.

Information provided orally and in writing to the individual and the legally authorized representative by the local authority staff includes:
1. An overview of the consumer directed services option;
2. Explanation of responsibilities of the individual or individual's legally authorized representative and the financial management services agency in the consumer directed services option;
3. Explanation of benefits and risks of participating in the consumer directed services 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/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
Nursing	☐
Social Work	☐
Behavioral Support	☐
Speech and Language Pathology	☐
Employment Assistance	☐
Financial Management Services	☑
Transition Assistance Services	☐
Dietary Services	☐
Adaptive Aids	☐
Supported Employment	☐
Support Consultation	☑
Dental Treatment	☐
Supported Home Living	☐
Occupational Therapy	☐
Audiology	☐
Day Habilitation	☐
Respite	☐
Prescribed Drugs	☐
Residential Assistance (Host Home/Companion Care, Supervised Living, Residential Support Services)	☐
Cognitive Rehabilitation Therapy	☐
Physical Therapy	☐
Minor Home Modifications	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver;

(d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

An individual or legally authorized representative may voluntarily terminate participation in the consumer directed services option at any time. The local authority service coordinator and HCS provider, if applicable, assists the individual in revising the service plan for the transition of services previously delivered through the consumer directed services option to be delivered by the HCS provider chosen by the individual or legally authorized representative. The HCS provider assists the individual as necessary to ensure continuity of all waiver services through the traditional agency service delivery option (provider-managed service delivery) and maintenance of the individual's health and welfare during the transition from the consumer directed services option.

The financial management services agency closes the employer's payroll and payable accounts and completes all deposits and filings of required reports with governmental agencies on behalf of the individual. The local authority and HCS provider will assist the individual to begin services through the provider option with no gap in coverage. The individual must wait 90 days before returning to the consumer directed services option.

The HCS provider, selected by the individual, works with the service planning team to revise the service plans so that services can be delivered by the provider without delay. The HCS program provider assists the individual as necessary to ensure that there are no gaps in services during the transition from 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.

The local authority service coordinator, the HCS provider, the financial management services agency, or DADS may recommend termination or the consumer directed services option if the individual, legally authorized representative, or designated representative does not implement or successfully complete the following steps and interventions:

1. Address the risk to the individual's health or welfare;
2. Successfully direct the delivery of appropriate program services through the consumer directed services option;
3. Meet employer responsibilities as listed in E-2-a(ii), Participant-Employer Authority, and E-2-b(i), Participant-Budget Authority;
4. Successfully implement corrective action plans; or
5. Appoint a designated representative or access other available help to assist the employer in meeting employer responsibilities.

DADS may require immediate termination from consumer direction in circumstances that jeopardize health and safety, when the designated representative is convicted of a barrable offense, or if another regulatory agency recommends termination.

The local authority service coordinator and HCS provider, if applicable, assist the individual in revising the service plan for the transition of services previously delivered through the consumer directed services option to be delivered by the HCS provider chosen by the individual or legally authorized representative. The local authority service coordinator and the HCS provider assist the individual to ensure continuity of all waiver services through the traditional provider-managed service delivery option and maintenance of the individual's health and welfare during the transition from the consumer directed services option. The financial management services agency closes the employer's payroll and payable accounts and completes all deposits and filing of required reports with governmental agencies on behalf of the individual.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		263
Year 2		280
Year 3		280
Year 4		280
Year 5		280

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- [x] **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

- [x] **Recruit staff**
- [ ] **Refer staff to agency for hiring (co-employer)**
- [ ] **Select staff from worker registry**
- [x] **Hire staff common law employer**
- [x] **Verify staff qualifications**
- [x] **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Funds available in the individual's consumer directed services budget are used for this purpose.

- [x] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. **Participant - Budget Authority** *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**

- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The service plan is developed in the same manner for the individual who elects the consumer directed services option as it is for the individual who elects to have services delivered through the traditional provider-managed option. DADS must authorize the service plan and the estimated cost of waiver services. The consumer directed 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 budget is developed by the individual or legally authorized representative with assistance from the financial management services agency.

The consumer directed budget is allocated to each self-directed service based on the approved service plan. The budget for each service, and any revisions, must be approved by the financial management services agency prior to implementation. The financial management services agency must ensure that projected expenditures are within the authorized budget for each service, are allowable and reasonable, and are projected over the effective period of the plan to ensure that sufficient funds will be available to the end date of the service plan. With approval of the financial management services agency, the individual or legally authorized representative may make revisions to a specific service budget that does not change the amount of funds available for the service based on the approved service plan.

Employer-related costs are paid for through the consumer directed services rates and include costs for equipment, supplies, or activities that will provide direct benefit to the individuals who self-direct services to support specific outcomes related to being an employer including: recruiting expenses, fax machine for sending employee time sheets to the financial management services agency, criminal conviction history checks from the Texas Department of Public Safety, acquiring other background checks of a potential service provider, purchased employee job-specific training, and Hepatitis B vaccination, if elected by an employee. An individual may use up to a maximum of $600 of the consumer directed budget for employer-related support activities.

Support consultation has a specific reimbursement rate and is a component of the individual's service budget. In conjunction with the local authority service coordinator and HCS provider, if applicable, the individual or legally authorized representative determines the level of support consultation necessary for inclusion in each individual's service plan.

Revisions to the budget for a particular service or a request to shift funds from one self-directed waiver service to another, must be justified by the revision of the person-directed plan and individual plan of care and authorized by DADS. With assistance from the financial management services agency, the individual or legally authorized representative revises the consumer directed services budget to reflect a revision in the service plan.

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The individual or legally authorized representative participates with the local authority service coordinator and HCS provider, if applicable, in the development of the individual's service plan. The individual and legally authorized representative are involved in the service planning development process and are apprised of the budget as it is developed. The individual develops the consumer directed services budget based on the finalized service plan and authorized budget. The financial management services agency and the local authority service coordinator inform the individual of the amount authorized for the particular service before the budget is developed.

The individual may request an adjustment to the budget at any time, subject to cost ceilings. When DADS denies an individual's request for an adjustment to the budget or reduces the budget, the individual is entitled to a fair hearing in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, Subchapter A. The specific procedures for a fair hearing are provided in Appendix F, Individual Rights.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

An individual's consumer directed services budget is calculated and monitored based on projected utilization and frequency of the service as determined by the development of the implementation plan. The financial management services agency is required to monitor payroll every pay period (two weeks) and expenditures (as processed for payment) and report over- and under-utilization to the employer and the service coordinator. When an over- or under-utilization is not corrected by the employer, the financial management services agency notifies the individual's local authority service coordinator and the employer. The local authority service coordinator and the employer identify the cause of continuing deviation from projected utilization and develop a plan to correct the deviation or revise the service plan.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

At the time of enrollment, at least annually and upon request, the local authority service coordinator provides the individual's rights and responsibilities, in writing, to the individual or legally authorized representative and obtains the individual's or legally authorized representative's signature acknowledging receipt of the information. These rights include the individual's right to request a fair hearing if the individual's services are denied, suspended, reduced, or terminated.

If services are reduced, denied, or terminated, DADS sends a letter to the individual or legally authorized representative that outlines the fair hearing procedure. This letter informs the individual of the opportunity to request a fair hearing via the official Notice of Denial or Reduction of HCS. The notification explains the person's right of appeal, and the right to have others represent the individual, including legal counsel. The local authority service coordinator or the HCS provider may provide information to individuals concerning available legal services in the community.

An opportunity for a fair hearing under Title 42 of the Code of Federal Regulations Part 431, Subpart E, will be offered to individuals who are not given the choice of home or community-based services as an alternative to institutional care or who are denied the service(s) of their choice. DADS and the HCS provider retain copies of the notice of adverse action taken by the State and the notice to the individual of the opportunity to request a fair hearing. The notice informs an individual or legally authorized representative whether or not the individual is eligible to receive or continue to receive services while the individual's appeal is under consideration and the actions that the individual must take in order for current services to continue. If an individual or legally authorized representative elects to request a fair hearing, DADS and the HCS provider retain a copy of the individual's written request for a hearing in the individual's record. Individuals or legally authorized representatives must request a fair hearing within 12 calendar days of the date of the notice. When the State denies HCS services to an individual who wishes to move from an institutional setting to the community, the individual must request a fair hearing within 90 calendar days of the date of the notice. During the fair hearing process, services continue at the level provided prior to denial and until the fair hearing process is complete.

If an individual requests a fair hearing, a representative of DADS completes Form H4800, Petition for Fair Hearing, and sends it to the HHSC hearing officer. The DADS representative must send Form H4800 to the HHSC hearing officer within five calendar days after the date DADS receives the request for appeal.

Form H4803, Acknowledgement and Notice of Fair Hearing, serves as a notice of the hearing. The HHSC hearing officer sends Form H4803 to the appellant and to DADS to acknowledge the request for a hearing and to set a time, date, and place for the hearing. DADS sends a copy of Form H4800-A, A Petition for Fair Hearing Addendum, along with copies of all relevant documentation to all known parties and required witnesses within five calendar days of receipt of Form H4803.

The HHSC hearing office files the decision on Form H4809, Update after Fair Hearing (Data Entry Form), in the appeal file. DADS will implement the decision of the HHSC hearing officer within 10 calendar days of the date of the decision and send Form H4807 to the HHSC hearing office documenting that the decision has been implemented. DADS maintains a hard copy folder of all appeals the State conducts. Additionally, when an individual requests a fair hearing, DADS uploads the request into the Texas Integrated Eligibility Redesign System, creating an electronic record of the request.

An individual would not be eligible to receive or continue to receive services during an appeal for an adverse action in the following circumstances:
• Situations described in Title 42, Code of Federal Regulations §431.213 which allow an exception to the advance notice and maintenance of benefits requirements
• Denial of waiver enrollment
• Denial of a service not previously authorized on the individual's service plan
• Suspension or termination of services because the individual leaves the state; and
• If the individual does not request a fair hearing for termination or reduction or services in the time frame required in the notice letter for maintenance of benefits.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

HHSC, the single State Medicaid Agency, and DADS, the operating agency, operate the grievance/complaint system.

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

To facilitate an efficient individual response system, DADS has identified the Office of Consumer Rights and Services as its centralized source for the receipt of complaints by individuals, legally authorized representatives, family members, and the general public, as well as concerns and questions regarding the facilities/agencies regulated by DADS, DADS' services, programs, or staff. The DADS Office of Consumer Rights and Services ensures that all contacts are handled in a timely, professional manner and are addressed by the proper authorities. All complaints received are acknowledged. DADS staff advises complainants that the formal filing of a complaint is not required, and is not a substitute for the applicant/individual to request a fair hearing if enrollment or services are denied, reduced, suspended, or terminated. The individual's service coordinator also advises the individual or legally authorized representative that filing a complaint is not a pre-requisite or substitute for requesting a fair hearing.

Grievances or complaints can be submitted by telephone by calling a toll-free line, by e-mail, or by written correspondence. In-office employees answer the toll-free line from 8 a.m. to 5 p.m. Monday through Friday. Voice mail is available 24 hours a day and is monitored from 8 a.m. to 5 p.m. Monday through Friday. Complaints may be anonymous. The identity of all complainants and individuals is protected by law. The DADS Office of Consumer Rights and Services investigates the complaint and attempts resolution within 10 days of the initiation of the investigation, unless the complaint involves abuse, neglect, or exploitation of an individual receiving services.

The HCS provider must ensure that the individual and legally authorized representative are informed of how to report allegations of abuse, neglect, or exploitation to the Department of Family Protective Services.

Individuals are informed in writing by the service coordinator that filing a grievance or making a complaint is not a pre-requisite or substitute for a fair hearing.

The Department of Family and Protective Services notifies DADS Consumer Rights and Services unit of any reports received alleging abuse, neglect, or exploitation. The Consumer Rights and Services department enters the abuse, neglect and exploitation allegation information into the Health and Human Services Enterprise Administration Reporting and Tracking System data base. If an allegation of abuse, neglect, or exploitation is received by DADS, the allegation is reported to the Department of Family and Protective Services for investigation.

The Department of Family and Protective Services provides all of the final investigative reports associated with individuals receiving Home and Community-based Services to DADS Regulatory Services. This information is entered into the Waiver Survey and Certification Tracking database, and DADS Regulatory Services conducts follow-up activities for 100 percent of confirmed abuse, neglect or exploitation cases. The follow-up activities are conducted by risk assessment coordinators and may involve site visits, interviews with individuals served, interviews with provider staff, or persons who have been identified as part of the individual's natural support system. Based on the outcomes of this follow-up activity, DADS Regulatory Services staff will make recommendations to the HCS provider. HCS providers must respond to these recommendations by providing evidence to the DADS that the appropriate remediation has occurred. The resolution of these follow-up recommendations are tracked in the Waiver Survey and Certification Tracking database. Trending of data by HCS provider is performed on a quarterly basis to ensure that follow-up on-site visits or further coordination with the DADS Consumer Rights and Services department occurs in a timely manner. Trending data is also utilized to identify areas of need for statewide training, topics for information letters, and additional policy development.

DADS has procedures to respond to, report, and follow-up on critical incidents involving individuals served in the HCS waiver. Critical incidents are clearly defined in the HCS Client Assignment and Registration system user guide and include medication errors, serious injuries, and the use of emergency restraints. The Client Assignment and Registration system user guide provides instruction on HCS waiver reporting requirements. DADS performs trending of the critical incident data collected in the Client Assignment and Registration system to identify system-wide quality improvement opportunities.

Less serious incidents or concerns which do not meet the definition of abuse, neglect, and exploitation or the definition of critical incidents are reported directly to the DADS Consumer Rights and Services department. Reports come into DADS Consumer Rights and Services from individuals, other community members, service coordinators, and HCS provider staff. Each notification is entered into the Health and Human Services Enterprise Administrative Reporting System database and is assigned to a rights representative for follow-up investigation. The follow-up may consist of telephone interviews, desk review of program records, or on-site follow-up visits, which may include interviews of appropriate individuals, record reviews and observation. The DADS Consumer Rights and Services department has a goal of complaint resolution and closure of the complaint case within 10 days of receipt of the complaint. The individual who filed the complaint receives written notice of the case closure, including the

outcome, unless the individual declined the offer of the notice. When the DADS Consumer Rights and Services department has concerns beyond the scope of the department's work, they refer the case to DADS Regulatory Services for further investigation. When the DADS Regulatory Services reviewers have completed the resolution of the case, the final resolution is shared back to the DADS Consumer Rights and Services department to be entered into the Health and Human Service Enterprise Administrative Reporting System database. The DADS Consumer Rights and Services department tracks complaint data by Medicaid provider agreement and each complaint that has not been closed within the 10 days after receipt receives follow-up. One reason why a case might not be closed within the first 10 days includes a delay in contacting the involved parties due to incorrect contact information. Another is that the triaging of cases, which ensures that the most urgent issues are addressed quickly, may delay resolution of less urgent issues. Once follow-up activities are completed, the complaint case is closed.

Created by Title 4 of the Texas Government Code, Subtitle I, Chapter 531, §531.005, the HHSC Office of the Ombudsman assists the public when the DADS normal complaint process cannot, or does not, satisfactorily resolve an issue. The Office of the Ombudsman includes the following services:
• conducting independent reviews of complaints concerning agency policies or practices;
• ensuring that policies and practices are consistent with the goals of HHSC;
• ensuring that individuals are treated fairly, respectfully, and with dignity; and
• making referrals to other agencies as appropriate

The process to assist with complaints and issues is as follows:
• A member of the public, an individual, or a provider makes first contact with HHSC or with DADS to request assistance with an issue or complaint;
• If not able to resolve the issue or complaint, the Office of the Ombudsman may be contacted;
• The Office of the Ombudsman will provide an impartial review of actions taken by the program or department; and
• The Office of the Ombudsman will seek a resolution.

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

   ◉ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

   ○ **No. This Appendix does not apply** *(do not complete Items b through e)*
   If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All HCS provider personnel, local authority staff, individuals, legally authorized representatives, and financial management services agencies are provided the Texas Department of Family and Protective Services toll-free telephone number in writing and are instructed to report to the Department of Family and Protective Services immediately, but not later than one hour after having knowledge or suspicion that an individual has been or is being abused, neglected, or exploited.

Abuse, neglect, and exploitation data is kept in the Department of Family and Protective Services state-wide reporting system and is electronically sent to DADS.

The HCS provider must report the death of an individual to DADS by the end of the next business day following the death of the individual or the HCS provider's knowledge of the death. If the HCS provider reasonably believes that the individual's legally authorized representative does not know of the individual's death, the HCS provider notifies the individual's legally authorized representative as soon as possible, but not later than 24 hours after the HCS provider learns of the individual's death.

On a monthly basis, HCS providers are required to enter any of the following critical incidents that occurred during the preceding month in the automated Client Assignment and Registration system:

Medication Error – A medication error must be reported when there is a difference between the medication that a physician prescribes and what an individual actually takes whether the individual self-administers medication under supervision of the program provider or has medication administered by the program provider. A medication error occurs in one of three ways:
• Wrong medication - an individual takes medication that is not prescribed for that individual. This includes taking medication after it has been discontinued or taking the incorrect medication because it was inappropriately labeled.
• Wrong dose - an individual takes a dose of medication other than the dose prescribed.
• Omitted dose - an individual does not take the prescribed dose of medication within one hour before or one hour after the prescribed time; an omitted dose does not include an individual's refusal to take medication.

Serious Injury - An injury is considered serious, regardless of the cause or setting in which it occurred, when an individual sustains a(n):
• fracture;
• dislocation of any joint;
• internal injury;
• contusion larger than 2½ inches in diameter;
• concussion;
• second or third degree burn;
• laceration requiring sutures; or
• injury determined serious by a physician, physician assistant, registered nurse, or vocational nurse.

Definitions for Incidents Related to a Behavioral Emergency

1. Mechanical restraint - Any mechanical device, material, or equipment that restricts the ability of an individual to freely move part or all of an individual's body for the purpose of controlling or restricting behavior and that cannot be easily and freely removed by the individual. This includes all restraints, including those in a behavior support plan. This does not include a protective device used for the purpose of safety and positioning.

2. Number of Individuals restrained – A total unduplicated count of individuals who were restrained by physical, mechanical, or psychoactive medication restraint at least once in a calendar month. If an individual has more than one restraint during a calendar month, the individual is reported only one time for that month.

3. Psychoactive medication restraint - A medication used to control behavior or to restrict the individual's freedom of movement and that is not a standard treatment for the individual's medical or psychological condition. This includes all restraints, including those in a behavior support plan.

4. Physical restraint – Any manual method , except for physical guidance or prompting, that restricts the free movement or normal functioning of all or a part of an individual's body; or normal access by an individual to a part of the individual's body. Physical guidance or prompting becomes a restraint if the individual resists the physical guidance or prompting. This includes all restraints, including those in a behavior support plan.

5. Restraint related injury - is a serious injury sustained by any individual or staff that is clearly related to the application of a physical restraint, a mechanical restraint, or a psychoactive medication administered to an individual. Reportable injuries in this category do not include self-injury that occurred prior to the application of restraint. Serious injuries sustained during the application of a restraint that are investigated by DFPS as an allegation of abuse, neglect or exploitation must be included in CARE reporting for this category.

HCS providers are required to compare their use of restraint data with aggregate data provided on the DADS website.

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 of enrollment, as needs of the individual change, and annually, a local authority staff member is required to inform an individual or legally authorized representative orally and in writing of the processes for reporting allegations of abuse, neglect, or exploitation, which includes the toll free number for the Department of Family and Protective Services.

Service coordinators inform all waiver individuals of their rights, including their right to be free of abuse, neglect, and exploitation and provide individuals with information on how to report an allegation of abuse, neglect, or exploitation. Financial management services agencies are required to provide an in-person orientation to individuals who initiate the consumer directed services option. By state rule, financial management services agencies are required to review and leave with the employer and designated representative, if applicable, printed information on how to report allegations of abuse, neglect, and exploitation. The financial management services agency must provide to the employer or designated representative a printed or an electronic copy of the DADS Consumer Directed Services Employer Manual which includes a section of signs of abuse and neglect and how to report.

If an individual elects the consumer directed services option, the financial management services agency is required to provide the individual or the individual's legally authorized representative and, if applicable, the designated representative, with training and written information related to reporting allegations of abuse, neglect, and exploitation during the employer's initial orientation and training.

Evidence supporting compliance with these requirements is reviewed during the DADS annual certification reviews of HCS providers who are serving at least one individual, annual performance contract reviews of local authorities, and triennial contract reviews of financial management services agencies.

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

The Department of Family and Protective Services receives allegations of abuse, neglect, and exploitation of individuals enrolled in the HCS waiver and is statutorily responsible for review, investigation, and response to those reports. Depending on the severity of the allegation, Department of Family and Protective Services investigations must be completed with 14 to 21 days. The Department of Family and Protective Services methods of investigation include interviews with the alleged victim, the alleged perpetrator, and any person who is identified as potentially having relevant information in regard to the investigation, as well as individual service record review and review of other HCS provider records (such as employee time sheets or sign-in sheets for day habilitation programming) which may contain relevant information.

The Department of Family and Protective Services and DADS Regulatory Services communicate during the Department of Family and Protective Services investigation if the severity of the alleged violation warrants a DADS Regulatory Services on-site review simultaneously with the Department of Family and Protective Services investigation. This information is entered into the Waiver Survey and Certification Tracking database, and DADS Regulatory Services conducts follow-up activities for 100 percent of confirmed abuse, neglect, or exploitation cases. The follow-up activities are conducted by risk assessment coordinators and may involve on-site visits, interviews with individuals served, interviews with HCS provider staff, or interviews with persons who have been identified as part of the individual's natural support system. Based on the outcomes of this follow-up activity, DADS Regulatory Services staff will make recommendations to the HCS provider. HCS providers must respond to these recommendations by providing evidence to DADS that the appropriate remediation has occurred. The resolution of these follow-up recommendations are tracked in the Waiver Survey and Certification Tracking database and trending reports are available and utilized to identify opportunities for system improvement. Trending of data by HCS providers is performed on a quarterly basis to ensure that follow-up on-site visits or further coordination with the DADS Consumer Rights and Services department occurs in a timely manner. Trending data is also utilized to

identify areas of need for statewide training, topics for information letters, and additional policy development.

Complaints regarding incidents or concerns that do not meet the definition of abuse, neglect, or exploitation or the definition of critical incidents are reported directly to the DADS Consumer Rights and Services department. DADS Consumer Rights and Services receives such complaints from individuals, members of the public, service coordinators, and HCS provider staff. Each complaint is entered into the Health and Human Services Enterprise Administrative Reporting System database and is assigned to a rights representative for follow-up investigation. The follow-up may consist of telephone interviews, desk review of program records, or on-site follow-up visits, which may include interviews of appropriate persons, record reviews, and observation. The DADS Consumer Rights and Services department has a goal of complaint resolution and closure of the complaint case within 10 days of receipt of the complaint. The person who filed the complaint receives written notice of the case closure, including the outcome, unless the person declined the offer of the notice. When the DADS Consumer Rights and Services department has concerns beyond the scope of the department's work, they refer the case to DADS Regulatory Services for further investigation. When the DADS Regulatory Services reviewers have completed the resolution of the case, the final resolution is shared with the DADS Consumer Rights and Services department to be entered into the Health and Human Service Enterprise Administrative Reporting System database. The DADS Consumer Rights and Services department tracks complaint data by HCS Medicaid provider agreement and each complaint that has not been closed within the 10 days after receipt receives follow-up. One reason why a case might not be closed within the first 10 days includes a delay in contacting the involved parties due to incorrect contact information. Another is that the triaging of cases, which ensures that the most urgent issues are addressed quickly, may delay resolution of less urgent issues. Once follow-up activities are completed, the complaint case is closed.

DADS receives monthly reports of all other critical incidents directly from HCS providers. DADS also receives reports of individual deaths directly from the HCS provider within one business day of the death.

Critical incidents other than abuse, neglect, and exploitation are investigated by DADS Consumer Rights Services and may also be referred to DADS Regulatory Services as a result of a complaint. DADS Consumer Rights and Services and DADS Regulatory Services methods for follow up investigation also include interviews with the individual and all other persons relevant to the allegation or complaint, individual service record review, and HCS provider record review.

In accordance with rules governing the operation of the HCS waiver, an individual's HCS provider must inform the individual and legally authorized representative and the individual's service coordinator of the findings of the investigation by the Department of Family and Protective Services no later than five calendar days from the HCS provider's receipt of the investigation report and the corrective action taken by the HCS provider if the Department of Family and Protective Services confirms that abuse, neglect, or exploitation occurred. The HCS provider must inform the individual and legally authorized representatives of the process to appeal the investigation finding and the process for requesting a copy of the investigative report.

Additionally, DADS Consumer Rights and Services will conduct a desk review of all complaints received, other than those for abuse, neglect, and exploitation. The DADS Consumer Rights and Services department has a goal of complaint resolution and closure of the complaint case within ten days of receipt of the complaint. The most common reason which may hinder the 10 day goal for resolution is an inability to contact and interview a relevant informant in a timely manner due to their unavailability. Within seven days of the complaint, DADS Consumer Rights and Services will document their findings. Any unresolved complaints will be forwarded to the appropriate department for additional follow-up. When a complaint investigation is finalized, the complainant is notified of the findings within five business days if DADS Consumer Rights and Services have the contact information for the complainant.

If the complaint investigation warrants follow up by DADS Regulatory Services, the case is referred for an intermittent review. All critical incidents are reviewed as part of annual certification monitoring by DADS Regulatory Services.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Department of Family and Protective Services notifies the DADS Consumer Rights and Services unit of any reports received alleging abuse, neglect, or exploitation. The DADS Consumer Rights and Services department

enters the abuse, neglect, and exploitation allegation information into the Health and Human Services Enterprise Administration Reporting and Tracking System database. If an allegation of abuse, neglect, or exploitation is received by DADS, the allegation is reported to the Department of Family and Protective Services for investigation.

DADS Regulatory Services reviews all deaths to ensure appropriate follow-up by DADS or by the Department of Family and Protective Services. Follow-up actions are documented in the Waiver Survey and Certification Tracking database. If indicated, DADS may notify law enforcement authorities or the Department of Family and Protective Services of circumstances surrounding a death. Reported deaths are aggregated quarterly by HCS Medicaid provider agreement and included in a quarterly report used to identify Medicaid provider agreements that have a high percentage of confirmed abuse, neglect, exploitation, complaints, or deaths. Additional monitoring by DADS Regulatory Services is conducted on the Medicaid provider agreements which exceed the thresholds for review.

DADS Regulatory Services utilizes reports from the Critical Incident Reporting System to prepare for HCS provider certification monitoring. If during on-site reviews, DADS Regulatory Services determines that HCS providers are not accurately reporting critical incidents, the HCS provider is subject to corrective action by DADS which can include referral to the sanction action review committee or other forms of corrective action.

DADS quarterly and annually aggregates the data and reports to HHSC. HHSC discusses with DADS any significant findings and together with DADS prepares a remediation plan or improvement plan as needed.

Appendix G: Participant Safeguards

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

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

○ **The State does not permit or prohibits the use of restraints**

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

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

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

The Texas Administrative Code allows the use of personal restraints, medications used as restraints, and mechanical restraints. The use of seclusion is prohibited. The use of aversive techniques, except for the use of restraints, is prohibited. The following safeguards apply to all restraints used:

An HCS provider must not use restraint in a manner that:
a)obstructs the individual's airway, including the placement of anything in, on, or over the individual's mouth or nose;
b)impairs the individual's breathing by putting pressure on the individual's torso;
c)interferes with the individual's ability to communicate;
d)places the individual in a prone or supine position;
e)extends muscle groups away from each other;
f)uses hyperextension of joints; or
g)uses pressure points or pain;
2)for disciplinary purposes, that is, as retaliation or retribution;
3)for the convenience of a staff member or service provider or other individuals; or

4)as a substitute for effective treatment or habilitation.

A HCS provider may use restraint in a behavioral emergency; as part of a behavior support plan that addresses inappropriate behavior exhibited voluntarily by an individual; during a medical or dental procedure if necessary to protect the individual or others and follow-up after a medical or dental procedure or following an injury to promote the healing of wounds; to protect the individual from involuntary self-injury; and to provide postural support to the individual or to assist the individual in obtaining and maintaining normative bodily functioning.

Individuals who may require the use of restraint must have a behavior support plan developed by a qualified behavioral support service provider that meets specifications in the Texas Administrative Code and includes identifying triggers and early warning signs of undesired behaviors and individualized restraint prevention strategies developed by a qualified behavioral support provider. The plan must also include assessments of the current level of severity, allow for a decrease of the use of intrusive techniques, revision and right to refuse participating. There is no requirement for a review by a human rights committee, but all behavior support plans must be approved by the individual or legally authorized representative. Approval may be withdrawn at any time. The service planning team authorizes the use of any restraint as part of a behavioral support plan. The service coordinator monitors the individual's health and safety and DADS reviews behavioral support plans and 100 percent of the instances of use of emergency restraint annually.

Written behavior support plans must meet DADS guidelines and based on ongoing data, target the dangerous behavior with individualized objectives, and specify intervention procedures to be followed when the behavior occurs. Specifically, all behavior support plans must contain a baseline of the frequency and severity of the targeted behavior obtained prior to the implementation of the behavior support plan, a functional assessment which describes the hypothesized function of the targeted behavior; a specific objective designed to decrease or eliminate each separately defined behavior, and documentation of approval by members of the service planning team. Behavior support plans for individuals with level of need 9, require a fading plan designed to systematically reduce, and ultimately eliminate, one-to-one staff supervision.

As with any intrusive interventions, the legally authorized representative or any actively involved person is expected to provide input into the development of a behavior support plan. The individual or their legally authorized representative must approve any intrusive techniques, including restraint, prior to their use, with the exception of emergency restraints. The individual or legally authorized representative may also remove their consent at any time. The service coordinator will be made aware of any restrictive interventions utilized. Any person who suspects that an individual's rights may be violated can submit a complaint to DADS Consumer Rights and Services. The contact information for DADS Consumer Rights and Services is given to individuals and their legally authorized representatives annually, posted by the HCS provider at all service sites, and by DADS on the agency's website.

To decrease the frequency of the use of restraint and minimize the risk of harm to an individual, a HCS provider must, with the involvement of a physician, identify the individual's known physical or medical conditions that might constitute a risk to the individual during the use of restraint; the individual's ability to communicate; and other factors that must be taken into account if the use of restraint is considered, including the individual's cognitive functioning level, physical attributes, age, and emotional condition (including whether the individual has a history of having been physically or sexually abused). This is done to decrease the frequency of the use of restraint and to minimize the risk of harm. The HCS provider must document the conditions, factors, and limitations on specific restraint techniques or mechanical restraint devices in the individual's record. The HCS provider must review and update conditions and factors applicable to the use of restraints with a physician, RN, or LVN, at least annually or when a condition or factor changes significantly.

The Texas Administrative Code ensures that all service providers are qualified to deliver services as required by the current needs and characteristics of the individuals to whom they deliver services, including the use of restraint in accordance with §9.179. DADS reviews the training provided by the HCS provider. The training curriculum is reviewed to ensure that all techniques within the training program meet the guidelines specified in rule. DADS allows HCS providers to choose a training program for their agency which adequately trains staff in the correct use of restraint. Examples of

programs utilized by HCS providers are Preventative Management of Aggressive Behaviors ("PMAB"), Non-Violent Crisis Intervention ("NVCI") trademarked by the Crisis Prevention Institute, Inc. and Satori Alternatives to Managing Aggressive Behavior (Crisis Intervention).

If a HCS provider restrains an individual, the HCS provider must:
1)take into account the conditions, factors, and limitations on specific restraint techniques or mechanical restraint devices documented in the individual's record;
2)use the minimal amount of force or pressure that is reasonable and necessary to ensure the safety of the individual and others;
3)safeguard the individual's dignity, privacy, and well-being; and
4)not secure the individual to a stationary object while the individual is in a standing position.

The rule specifies when restraints must be released and that only a restraint hold in which the individual's limbs are held close to the body to limit or prevent movement can be used. A HCS provider must release an individual from restraint:
1)as soon as the individual no longer poses a risk of imminent physical harm to the individual or others;
2)if the individual in restraint experiences a medical emergency, as soon as possible as indicated by the medical emergency; or
3)as soon as an individual in a restraint hold described in subsection (e) of this section who moves toward the floor reaches the floor.

After restraining an individual in a behavioral emergency, a HCS provider must:
1)as soon as possible but no later than one hour after the use of restraint, notify an RN or LVN of the restraint;
2)ensure that medical services are obtained for the individual as necessary;
3)as soon as possible but no later than 24 hours after the use of restraint, notify one of the following persons, if there is such a person, that the individual has been restrained:
a)the individual's legally authorized representative; or
b)a person actively involved with the individual, unless the release of this information would violate other law; and
4)notify the individual's service coordinator by the end of the first business day after the use of restraint so that any necessary changes to the individual's service plan may be appropriately addressed.

Medication may be used as a restraint if prescribed by a physician and specified as an approved intervention within an individual's behavior support plan. If a medication is utilized to control an individual's behavior outside of the specifications within the behavior support plan, it must be reported in the Client Assignment and Registration system as a restraint used for a behavioral emergency. HCS providers must report the use of emergency restraints. Certification principles in the Texas Administrative Code prohibit use of unnecessary restraints during service delivery and specifies the HCS provider must provide adequate information to the consumer advisory committee for quality improvement purposes, including information on incidents of confirmed abuse, neglect, or exploitation; complaints; and unusual incidents. Use of restraint outside of a specified strategy within a behavior support plan is considered an emergency restraint and is an unusual incident. The consumer advisory committee reviews restraint data no less than annually and makes recommendations to the HCS provider. The HCS provider must evaluate its use of restraint and compare program data with aggregate data provided by DADS with critical incident data concerning use of restraints and identify process improvements that will prevent the reoccurrence of restraints and improve service delivery. Information on the use of emergency restraints must be documented in the individual's service record and include the date, time, person performing the restraint, factors precipitating the behaviors which resulted in the use of restraint, the individual's response to the use of restraint, and any negative outcomes experienced by the individual as a result of the application of the restraint, including possible injury.

The HCS provider is required to enter emergency restraints (physical, chemical and mechanical) into the Client Assignment and Registration system monthly. The HCS provider must provide information to the consumer advisory committee for quality improvement purposes, including information regarding the use of restraints. The consumer advisory committee reviews restraint data no less than annually and makes recommendations to the HCS provider. The HCS provider must evaluate its use of restraint and, at a minimum, compare aggregate data provided by DADS with critical incident data concerning use of restraint and identify program process improvements that will prevent the

reoccurrence of restraints and improve service delivery. The use of restraints is reviewed as a result of a certification review annually and as a follow-up to a complaint or an abuse, neglect, or exploitation allegation. During a review of the HCS provider, restraint data is obtained from DADS' Client Assignment and Registration system, records from the HCS provider or interviews from individuals, legally authorized representatives, staff, and other informants.

Complaints concerning unnecessary/unapproved use of restraint can be made to DADS. The HCS provider must also assure that an individual or legally authorized representative is informed orally and in writing of the processes for reporting allegations of abuse, neglect, or exploitation using the toll-free telephone number of the Department of Family and Protective Services.

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:

DADS Regulatory Services monitors improper and unauthorized use of restraints through annual on-site reviews (which can occur both annually or unannounced at any time) and complaint investigations. All reviews are predicated on the use of observations, interviews, and record reviews to identify system or situation issues related to improper, unauthorized, or over use of restraint. DADS Regulatory Services reviews all use of restraint during the annual survey process. Inappropriate use of restraint is cited by the survey team and, based on the pervasive or seriousness of the issue, technical assistance or a corrective action plan is required.

Complaints concerning the use of restraint can be made to DADS or the Department of Family and Protective Services. The HCS provider must assure that an individual or legally authorized representative is informed orally and in writing of the processes for filing complaints about the provision of HCS services including:

• The toll-free telephone number of DADS Consumer Rights and Services to file a complaint; and
• The toll-free telephone number of the Department of Family and Protective Services to file a complaint of abuse, neglect, or exploitation.

DADS requires all critical incident data on emergency restraints (physical, chemical and mechanical) to be entered into to the Client Assignment and Registrations system. Use of emergency restraints must be reported in the Client Assignment and Registration system no later than 30 days past the last day of the previous month. The requirements for documentation within the individual's service record, data collection, and monitoring of restraints are indicated within the individualized behavior support plan which is developed by a qualified behavioral support service provider. Use of emergency restraints must be documented in the individual's service record and include the date, time, person performing the restraint, factors precipitating the behaviors which resulted in the use of restraint, the individual's response to the use of restraint and any negative outcomes experienced by the individual as a result of the application of the restraint.

DADS Regulatory Services runs monthly reports from the incident management system and utilizes the information in reviewing HCS providers for certification. Also, Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D specifies that the HCS provider must provide information to the consumer advisory committee for quality improvement purposes, including information regarding the use of restraints. The consumer advisory committee reviews restraint data no less than annually and makes recommendations to the HCS provider. The HCS provider, at least annually, must evaluate its use of restraints and, at a minimum, compare their data to aggregate data, which is published by DADS on the agency website, for the purpose of making process improvements that will prevent the reoccurrence of restraints and improve service delivery. DADS Regulatory Services reviews whether the prescribed quality improvement activities have occurred and have been incorporated by the HCS provider.
Use of emergency restraints must be reported in the Client Assignment and Registration system no later than 30 days past the last day of the previous month. DADS Regulatory Services reviews all use of restraint during the annual survey process. Inappropriate use of restraint is cited by the survey team and, based on the pervasive or seriousness of the issue, technical assistance or a corrective action plan is required.

The HCS provider, at least annually, must evaluate the use of restraints and compare their data to aggregate data, which is published by DADS on the agency website, for the purpose of making process improvements that will prevent the reoccurrence of restraints and improve service delivery. DADS Regulatory Services reviews whether the prescribed quality improvement activities have occurred and have been incorporated by the HCS provider.

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.

Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D ensures that all service providers are qualified to deliver services as required by the current needs and characteristics of the individuals to whom they deliver services, including the use of restrictive interventions in accordance with §9.179.

The HCS provider must assist the individual, or the legally authorized representative on behalf of the individual, in exercising the same rights and responsibilities exercised by people without disabilities; and must protect and promote the right of the individual, to live in a normative residential living environment, to communicate, associate, and meet privately with individuals of his or her choice, unless this violates the rights of another individual and to participate in social, recreational, and community group activities. If the HCS provider has assessed that an individual's maladaptive behavior or functional assessment indicate that the individual may require support in achieving outcomes in exercising these rights, supports which employ restrictive interventions may be used. These supports, outside of techniques to address serious maladaptive behavior contained within behavior support plans, consist of restrictions which may affect the individual's level of supervision and degree of privacy, freedom of movement, use of personal possessions and money, and inclusion and association in social, recreational, and community activities. The HCS provider must implement a teaching and training philosophy that emphasizes improved and independent functioning and ensure that the rights of the individual or their legally authorized representative are protected.

If the HCS provider has determined that the maladaptive behavior is of such a significant nature that it affects the individual's health, safety, or welfare, or the health, safety, or welfare of others, and that the intervention is so restrictive as to impede the basic rights of the individual, a behavior support plan must be developed by a qualified provider, in conjunction with the individual, legally authorized representative, and others as identified by the individual or legally authorized representative as supporting the individual in the attainment of their goals, to address intrusive or restrictive interventions employed. For example, an individual who has a diagnosis of Prader-Willi and whose overeating places him in immediate danger of physical harm, may have his refrigerator locked, which impedes the basic rights of the individual.

A written behavior support plan must meet DADS guidelines and be based on ongoing data, target the maladaptive behavior with individualized objectives, and specific intervention procedures to be followed when the behavior occurs. The behavior support plan must describe how the behavioral data concerning the behavior is collected and monitored, allow for the decrease in the use of the techniques based on the behavioral data, and allow for revision of the plan when desired behavior is not displayed or the techniques are not effective. All behavior support plans must contain a baseline of the frequency and severity of the targeted maladaptive behavior obtained prior to the implementation of the behavior support plan, a functional assessment which describes the hypothesized function of the maladaptive behavior; a specific objective designed to decrease or eliminate each separately defined maladaptive behavior, and documentation of approval by members of the service planning team. Additionally, behavior support plans for individuals with the highest level of need 9 assignment, require a written fading plan designed to systematically reduce, and ultimately eliminate, one-to-one staff supervision.

The Texas Administrative Code requires on-going approval by the individual or legally authorized representative, and notification to the service coordinator and individual or legally authorized representative if new or existing restrictive interventions are employed or discontinued. On-going approval of a behavior support plan is based upon individualized goals as specified in the behavior support plan and the continued agreement of the individual or legally authorized representative. Routine monitoring of the plan by the qualified behavioral supports service provider must be demonstrated.

Incidents in which the behavior support plan has been implemented must be recorded in the individual's service record. The service coordinator for the individual will also be made aware of any restrictive interventions utilized to support the individuals during the provision of services. If it is determined that an individual's behavior may require the implementation of behavior management techniques involving a restrictive intervention, the HCS provider must obtain an assessment of the individual's needs and current level and severity of the behavior; and ensure that a service provider of behavioral support services develops, with input from the individual, legally authorized representative, HCS provider, and actively involved persons, a behavior support plan that includes the use of techniques appropriate to the level and severity of the behavior; and considers the effects of the techniques on the individual's physical and psychological well-being in developing the plan.

A restrictive intervention is any restriction of individual's rights as described in the Title 40 of the Texas Administrative Code, Chapter 9, Subchapter D. 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. The only intrusive or restrictive intervention which is prohibited is the use of seclusion. Aversive interventions, not including restraints, are not permitted. Prior authorization for the use of restrictive interventions must be documented in the individual's record.

Before implementation of the behavior support plan, the HCS provider must obtain written consent from the individual or legally authorized representative to implement the plan, provide written notification to the individual or legally authorized representative of the right to discontinue implementation of the plan at any time, and notify the individual's service coordinator of the plan. At least annually thereafter, the HCS provider must review the effectiveness of the techniques and determine whether the behavior support plan needs to be continued and notify the service coordinator if the plan needs to be continued. As with any intrusive interventions, the legally authorized representative or any active involved person is expected to provide input into the development of a behavior support plan. Legally authorized representatives must approve any intrusive techniques, including measures which restrict the individual's rights, prior to their use, with the exception of emergency restraints. The legally authorized representative may also remove their consent at any time.

DADS allows HCS providers to choose a training program for their agency which adequately trains staff in the correct use of restraint. Examples of programs utilized by HCS providers are Preventative Management of Aggressive Behaviors ("PMAB"), Non-Violent Crisis Intervention ("NVCI") trademarked by the Crisis Prevention Institute, Inc. and Satori Alternatives to Managing Aggressive Behavior (Crisis Intervention).

DADS reviews HCS providers for compliance with the Title 40 of the Texas Administrative Code, Part

1, Chapter 9, Subchapter D in regard to the development and implementation requirements for restrictive interventions.

Complaints concerning the use of restrictive interventions can be made to DADS or the Department of Family and Protective Services.

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:

DADS monitors improper and unauthorized use of restrictive interventions through on-site reviews and complaint investigations.

DADS monitors improper and unauthorized use of restrictive interventions through on-site reviews (which can occur both annually or unannounced at any time). All reviews are predicated on the use of observations, interviews and record reviews to identify system or situation issues related to improper, unauthorized or over use of restrictive interventions. During a review of the HCS provider, records from the HCS provider and interviews with staff, individuals, individuals' families, and other service providers determine if restrictive interventions are being used without appropriate involvement of the service planning team and behavior support professionals.

DADS follows up with all complaints and investigations and when there are concerns, DADS requires corrective action from HCS providers. If trends are identified, DADS Regulatory Services may conduct an intermittent review of the HCS provider.
Complaints concerning the use of restrictive interventions can be made to DADS or the Department of Family and Protective Services. The HCS provider must assure that an individual or legally authorized representative is informed orally and in writing of the processes for filing complaints about the provision of HCS services including:

• The toll-free telephone number of DADS Consumer Rights and Services to file a complaint; and
• The toll-free telephone number of the Department of Family and Protective Services to file a complaint of abuse, neglect, or exploitation.

DADS Regulatory services analyses monthly reporting from the critical incident reporting system for the purposes of identifying HCS providers who need technical assistance or for who need an intermittent review and to identify statewide training needs. Statewide training is offered to HCS providers through webinars and statewide conference opportunities.

DADS compiles data from the critical incident reporting system and provides the aggregate data on the agency website. The HCS provider must evaluate its use of restraint and, at a minimum, compare aggregate data provided by DADS with critical incident data concerning use of restraint and identify process improvements that will prevent the reoccurrence of restraints and improve service delivery.

Appendix G: Participant Safeguards

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

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

◉ **The State does not permit or prohibits the use of seclusion**

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

The State prohibits the use of seclusion.

At least annual on-site certification reviews conducted by DADS evaluate program provider's compliance with

this prohibition.

Complaints concerning unapproved use of seclusion can be made to the local authority, DADS, or the Department of Family and Protective Services. The service coordinator must assure that an individual or legally authorized representative is informed orally and in writing of the processes for filing complaints about the provision of HCS program services including:
(A) the telephone number of the local authority to file a complaint;
(B) the toll-free telephone number of DADS Consumer Rights and Services to file a complaint; and
(C) the toll-free telephone number of the Department of Family and Protective Services to file a complaint of abuse, neglect, or exploitation.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. **Medication Management and Follow-Up**

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

HCS providers must provide assistance with medication as required by the HCS certification principles located in Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D.

A nurse is responsible for the performance of health care procedures and monitoring the individual's health conditions including: the administration of medication, monitoring the individual's use of medications, and monitoring health data and information. The HCS provider is responsible for ensuring these tasks are performed as required by standards of professional practice and state law for licensed nursing personnel.

Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D directs that nursing services must be provided in accordance with the individual's person-directed plan; individual plan of care; implementation plan; Texas Occupations Code, Chapter 301 (Nursing Practice Act); Title 22 of the Texas Administrative Code, Chapter 217 (relating to Licensure, Peer Assistance, and Practice); Title 22 of the Texas Administrative Code, Part 11, Chapter 224 (relating to Delegation of Nursing Tasks by Registered

Professional Nurses to Unlicensed Personnel for Clients with Acute Conditions or in Acute Care Environments); Title 22 of the Texas Administrative Code, Chapter 225 (relating to RN Delegation to Unlicensed Personnel and Tasks Not Requiring Delegation in Independent Living Environments for Clients with Stable and Predictable Conditions). The Texas Administrative Code does not prescribe a particular time frame for monitoring individuals' use of medications, as the person-directed plan is individualized and the registered nurse performing the assessment determines how frequently medications as well as other health conditions should be monitored.

The implementation plan contains necessary activities for professional and non-professional staff designed to meet the individual's needs and preferences and to ensure health and safety of the individual. The HCS provider must routinely monitor the implementation plan to ensure that the individual's health and safety needs are being met by the HCS provider and to identify potentially harmful practices which may have occurred during service delivery and rectify the situation to meet the health and safety needs of the individual. Follow-up actions may include such things as personnel actions, staff training, communication with the individual's involved family members or friends who provide natural supports, or requesting a service planning team meeting to develop a solution to rectify the situation.

The use of behavior modifying medication may be monitored by a registered nurse or qualified behavioral support professional based upon the nursing or behavioral support portion of the implementation plan developed from the needs identified within the individual's person-centered plan. The registered nurse or behavioral support professional has responsibility for informing the prescribing physician of any clinical concerns regarding the individual's medication regime or presenting conditions related to medication.

DADS Regulatory Services conducts certification reviews annually and reviews the medication error reporting of the HCS provider in the Client Assignment and Registration system as a part of the certification review preparation. During the certification review, DADS assesses the provider's compliance with medication management requirements through record review, on-site observation, interviews with HCS provider staff, and interviews with individuals. Non-compliance with certification principles may require corrective action plans from the HCS provider or may result in sanction against the provider based on the level of severity of the findings. DADS may also refer violations of licensure to the Texas Board of Nursing.

DADS reports performance measure data to HHSC quarterly. These reports include data for on HCS providers requiring sanctions (including corrective action plans) and denial of certification through performance measures A.a.12, C.a.1, and C.a.2.

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.

HCS providers must ensure that nursing is provided in accordance with:

- the individual's service plan;
- Title 3 of the Texas Occupations Code, Subtitle E, Chapter 301;
- Title 22 of the Texas Administrative Code, Part 11, Chapter 217;
- Title 22 of the Texas Administrative Code, Part 11, Chapter 224;
- Title 22 of the Texas Administrative Code, Part 11, Chapter 225; and
- Appendix C of the HCS waiver application approved by CMS and found at www.dads.state.tx.us and consists of performing health care activities and monitoring the individual's health conditions, including:

(A) administering medication;
(B) monitoring the individual's use of medications;
(C) monitoring health risks, data, and information, including ensuring that an unlicensed service provider is performing only those nursing tasks identified from a nursing assessment;
(D) assisting the individual to secure emergency medical services;
(E) making referrals for appropriate medical services;
(F) performing health care procedures ordered or prescribed by a physician or medical practitioner and required by standards of professional practice or law to be performed by a licensed nurse; and
(G) delegating nursing tasks to an unlicensed service provider and supervising the performance of those

tasks in accordance with state law and rules;
(H) teaching an unlicensed service provider about the specific health needs of an individual;
(I) performing an assessment of an individual's health condition

DADS Regulatory Services conducts annual on-site certification reviews of all HCS providers serving at least one individual. Intermittent oversight reviews are also conducted if a pattern of unresolved complaints or critical incidents is detected or if a HCS provider's past performance warrants more frequent review.

DADS may take the following actions based on outcomes of on-site HCS provider reviews:

(1) Require a corrective action plan if the HCS provider is out of compliance with 10 percent or fewer of the certification principles at the end of the review. DADS confirms corrective action during the next annual certification or intermittent oversight review.

(2) If DADS Regulatory Services determines that the HCS provider is out of compliance with between 10 and 20 percent of the certification principles at the end of the review, including any principles found out of compliance in the previous review, DADS Regulatory Services does not certify the HCS provider and applies a Level I sanction against the HCS provider.

Level I Sanctions. Providers must implement corrective actions to address all areas of deficiency within 30 calendar days. DADS conducts follow-up on-site reviews to evaluate whether all areas have been corrected. Based upon the results of the follow-up review, DADS certifies the HCS provider if DADS determines that the HCS provider is in compliance, by the end of the follow-up review exit conference, with the principles found out of compliance; or denies certification of and implements vendor hold against the HCS provider if DADS determines that the HCS provider is not in compliance, by the end of the follow-up review, with the principles found out of compliance.

If DADS implements vendor hold against the HCS provider, DADS conducts a second on-site follow-up review between 30 and 45 calendar days after the effective date of the vendor hold. Based on the results of the review, DADS:
• certifies the HCS provider and removes the vendor hold if DADS determines that the HCS provider is in compliance, by the end of the follow-up review, with the principles found out of compliance; or
• denies certification of the HCS provider and initiates termination of the HCS Medicaid provider agreement if DADS determines that the HCS provider is not in compliance, by the end of the follow-up review.

(3) If DADS Regulatory Services determines that the HCS provider is out of compliance at the end of the review with 20 or more percent of the certification principles, including any principles found out of compliance in the previous review, DADS Regulatory Services does not certify the HCS provider, implements vendor hold, and applies Level II sanctions against the HCS provider.

Level II Sanctions. Providers must implement corrective actions to address all areas of deficiency within 30 calendar days. DADS conducts follow-up on-site reviews to evaluate whether all areas have been corrected. Based upon the results of the follow-up review, DADS certifies the HCS provider and removes the vendor hold if DADS determines that the HCS provider is in compliance, or denies certification of the HCS provider and initiates termination of the HCS Medicaid provider agreement if DADS determines that the HCS provider is not in compliance, by the end of the follow-up review.

If DADS determines that a hazard to the health or safety of one or more individuals exists and the hazard is not eliminated before the end of the review exit conference, DADS denies certification of the HCS provider, initiates termination of the HCS provider's Medicaid provider agreement, implements vendor hold, and, in conjunction with the local authority, coordinates the transfer of the individuals receiving waiver services from the HCS provider to another HCS provider. A hazard to health or safety is any condition that could result in life-threatening harm, serious injury, or death of an individual or other person within 48 hours. If hazards are identified by DADS during a review and the HCS provider corrects the hazards before the end of the review exit conference, the correction will be designated in DADS' report of the review.

If DADS Regulatory Services determines that a HCS provider's failure to comply with one or more of the certification principles is of a serious or pervasive nature, DADS Regulatory Services may, at its discretion, take any action described above against the HCS provider. If DADS Regulatory Services determines that a

HCS provider has falsified documentation used to demonstrate compliance with the certification principles, DADS Regulatory Services may, at its discretion, take any action described above against the HCS provider.

If a HCS provider's certification is withdrawn, DADS immediately notifies the appropriate local authorities. The local authorities notify the affected individuals through the service coordinators and begin transition activities for the affected individuals. If individuals' health or safety is determined by DADS Regulatory Services to be in jeopardy, DADS Regulatory Services works with the appropriate local authorities to find temporary respite for individuals until transition to another chosen HCS provider can occur.

All current HCS provider certification results are available to individuals and their legally authorized representatives as posted on the Quality Reporting System webpage which is accessed through the DADS website. DADS Regulatory Services trends citation data for the purposes of identifying particular HCS providers which need technical assistance or intermittent reviews. DADS Regulatory Services also uses trending data to identify technical assistance and training needs for statewide webinars and on-site statewide training opportunities.

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).

HCS providers must provide assistance with medication as required by the HCS certification principles located in Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D and in accordance with the Texas Board of Nursing rules as defined by Title 22 of the Texas Administrative Code, Part 11, Chapter 225.

The rules also require the HCS provider implement and maintain a plan for initial and periodic training of staff members and service providers that ensures staff members and service providers are qualified to deliver services as required by the current needs and characteristics of the individuals to whom they deliver services.

An RN is responsible for doing the following:

1. performing a nursing assessment for each individual before an unlicensed service provider performs a nursing task for the individual unless a physician has delegated the task as a medical act under Title 3 of the Texas Occupations Code, Subtitle B, Chapter 157, as documented by the physician and as determined necessary by an RN, including if the individual's health needs change;
2. documenting information from performance of a nursing assessment and, if an individual is receiving a service through the consumer directed services option, providing a copy of the documentation to the individual's service coordinator;
3. developing the nursing service portion of an individual's implementation plan, which includes developing a plan and schedule for monitoring and supervising delegated nursing tasks; and
4. making and documenting decisions related to the delegation of a nursing task to an unlicensed service provider and ensuring that an unlicensed service provider has been trained by an RN or an LVN under the direction of an RN regarding the proper administration of medication or has been determined to be competent

by an RN or an LVN under the direction of an RN regarding proper administration of medication, including through a demonstration of proper technique by the unlicensed service provider.

An RN or an LVN under the supervision of an RN reviews the administration of medication to an individual by an unlicensed service provider at least annually and after any significant change in the individual's condition.

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:

Texas Department of Aging and Disability Services (DADS)

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

Providers are required to record any type of medication error, regardless of the severity.

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

A medication error is reported when there is a discrepancy between what a physician prescribes and what an individual takes and the individual self-administers medication under supervision of the HCS provider or has medication administered by the HCS provider. A medication error occurs if the error involves the wrong medication, wrong route, the wrong dose of a medication, the wrong time or an omitted dose of a medication.

On a monthly basis HCS providers are required to report medication errors committed by HCS provider staff or occurring under the supervision of the HCS provider to the Client Assignment Registration system.

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

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

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

On an on-going basis DADS is responsible for monitoring HCS provider compliance with the HCS certification principles located in Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D. At least annually, on-site certification reviews conducted by DADS Regulatory Services include assessing the HCS provider's level of compliance with medication management and monitoring.

DADS maintains a Waiver Survey and Certification database that records the level of compliance of all HCS providers per certification principle violation. The Waiver Survey and Certification database includes level of compliance information regarding medication management and monitoring.

On a monthly basis, HCS providers are required to report any medication errors committed by HCS provider staff or occurring under the supervision of the HCS provider that occurred during the preceding month in the automated Critical Incident Reporting System in the Client Assignment and Registration system. This data is available to DADS staff. DADS Regulatory Services reviews the data from the Critical Incident Reporting System monthly. The data is reviewed for the purposes of identifying trends which indicate a need for an intermittent review of a HCS provider or technical assistance in this area of service provision as well as for the purpose of identifying statewide training needs. Depending on the frequency of occurrence or the severity

of errors, DADS may follow-up with the HCS provider or elect to conduct an on-site intermittent review.

Medication errors are reviewed by DADS as a result of a certification review, annually or intermittently, or as a follow-up to a complaint from DADS Consumer Rights and Services. During a review by DADS of the HCS provider, data is obtained from the Client Assignment and Registration system, the DADS Waiver Survey and Certification database, incident reports, and service records from the HCS provider or interviews with individuals, legally authorized representatives, staff, and other informants.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
G.a.1 Number and percent of individuals who were informed of procedures for filing a complaint. N: Number of individuals who were informed of procedures for filing a complaint. D: Number of individuals reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Client Assignment and Registration system and DADS Regulatory Services reviews

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

		Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.a.2 Number and percent of individuals who were informed of the procedure for reporting allegations of abuse, neglect, and exploitation. N: Number of individuals reporting they received information about reporting abuse, neglect, and exploitation. D: Number of individuals reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Client Assignment and Registration system; DADS Regulatory Services reviews

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G.a.3 Number and percent of complaints resolved by DADS according to policy. N: Number of complaints resolved by DADS according to policy. D: Number of complaints received by DADS Consumer Rights and Services.

Data Source (Select one):

Other
If 'Other' is selected, specify:
DADS Consumer Rights and Services database

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

Data Aggregation and Analysis:

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

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

Performance Measure:
G.a.4 Number and percent of individuals who are free from confirmed abuse, neglect, or exploitation. N: Number of individuals who are free from confirmed abuse, neglect, or exploitation. D: Number of individuals listed as a victim in a report of abuse, neglect, or exploitation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DADS Waiver Survey and Certification database; Abuse, Neglect, and Exploitation Database

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

Data Aggregation and Analysis:

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

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

Performance Measure:
G.a.5 Number and percent of individuals free from an allegation of abuse, neglect, or exploitation. N: Number of individuals without an allegation of abuse, neglect, or exploitation. D: Number of enrolled individuals.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Survey and Certification database; Abuse, Neglect, and Exploitation Database; Quality Assurance and Improvement Data Mart

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.a.6 Number and percent of the individual case records that reflect the individual has a current backup plan. N: Number of individual case records that reflect the individual has a current backup plan. D: Number of individual case records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Survey and Certification Data Base

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

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Texas Department of Family and Protective Services, is statutorily responsible for investigating allegations of abuse, neglect, and exploitation of individuals enrolled in HCS. The Department of Family and Protective Services forwards DADS and the HCS provider a report of each of its investigations along with its determination that the allegation was confirmed or not confirmed or that results of the investigation were inconclusive.

In accordance with state law, DADS maintains an Employee Misconduct Registry that includes the names of persons who are unemployable because of certain confirmations of abuse, neglect, or exploitation regarding an individual receiving services from any of the following entities:
• licensed intermediate care facilities;
• nursing facilities;
• assisted living facilities;
• adult foster care facilities;
• adult day care facilities;
• home and community support services agencies, which include hospice and home health agencies; and
• persons exempt from licensing under Title 2 of the Health and Safety Code, Subtitle G, Chapter 142, Subchapter A, Section §142.003, which includes HCS providers.

In addition, in accordance with federal law, DADS maintains a Nurse Aide Registry that includes names of certified nurse aides who are unemployable because of certain confirmations of abuse, neglect, or exploitation regarding a resident of a licensed nursing facility. HCS providers and local authorities must consult these registries prior to offering employment to a non-licensed service provider and refrain from employing that person if the person is listed as unemployable in either registry.

State law prohibits HCS providers and local authorities from employing a person whose criminal background indicates the person has been convicted of certain offenses. HCS providers and local authorities are required to complete pre-employment criminal background checks for each non-licensed applicant that will provide services or service coordination to an individual enrolled in the HCS waiver and refrain from employing the applicant if the person has been convicted of an offense listed in state law.

The Quality Assurance and Improvement unit of DADS will continue its National Core Indicators survey project with the individuals who participate in home and community-based service programs operated by DADS. As a part of the National Core Indicators survey, individuals who receive services in the HCS waiver may respond to questions regarding health, welfare, and rights. Some of the topics in the survey tool include safety from abuse and neglect, the ability to secure needed health services, medication management, protection of and respect for individual rights, and support to maintain health habits. Discovery findings from the National Core Indicators survey project will be routinely evaluated to assess the status of remediation and improvement activities. In addition, DADS will use findings to update the HCS quality management strategy as necessary. Reports on each of the following assurances will be provided annually to the State. Findings from the National Core Indicators survey will be provided to HHSC each year the survey is administered.

b. Methods for Remediation/Fixing Individual Problems

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

DADS Regulatory Services conducts on-site reviews of all HCS providers following the enrollment of the first individual to the HCS provider and then at least annually. As stated in Appendix C, service summary: provider specifications, the HCS agency provider must ensure that service providers complete initial and periodic training, including how to recognizes and report possible abuse, neglect, and exploitation violations, in accordance with Title 40 of the Texas Administrative Code, Part 1, Chapter 9, Subchapter D, §9.177.

If DADS Regulatory Services determines that the HCS provider is out of compliance with 10 percent or fewer of the certification principles, the HCS provider must submit a corrective action plan to DADS Regulatory Services within 14 calendar days for approval. If the plan is approved, the HCS provider is certified. If the corrective action plan is not submitted or is not approved, a termination of the HCS provider's Medicaid provider agreement is initiated, a vendor hold is placed against the HCS provider, and the local authority informs the individuals served by the HCS provider of the proposed Medicaid provider agreement termination and coordinates transfer to another HCS provider if requested by the individuals. If these conditions are not met, DADS Regulatory Services does not certify the HCS provider and initiates termination of the HCS provider's Medicaid provider agreement.

If DADS Regulatory Services determines that the HCS provider is out of compliance with between 10 and 20 percent of the certification principles, DADS Regulatory Services does not certify the HCS provider and applies a Level I sanction against the HCS provider. Under a Level I sanction, the HCS provider must submit a corrective action plan and DADS Regulatory Services conducts an on-site follow-up review within 30 to 45 calendar days after the review. Based on the results of the follow-up review, DADS Regulatory Services certifies the HCS provider or denies certification of and implements vendor hold against the HCS provider.

If DADS Regulatory Services implements a vendor hold against the HCS provider, DADS Regulatory Services conducts a second on-site follow-up review between 30 and 45 calendar days after the effective date of the vendor hold. Based on the results of the review, DADS Regulatory Services may certify the HCS provider and remove the vendor hold or may deny certification of the HCS provider and initiate termination of the Medicaid provider agreement.

If DADS Regulatory Services determines that the HCS provider is out of compliance with 20 or more percent of the certification principles, DADS Regulatory Services does not certify the HCS provider, implements vendor hold, and applies Level II sanctions against the HCS provider. Under Level II sanctions the HCS provider must submit a corrective action plan and DADS Regulatory Services conducts an on-site follow-up review within 30 to 45 calendar days after the required correction date. Based on the results of the follow-up review, DADS Regulatory Services may certify the HCS provider and remove the vendor hold if DADS Regulatory Services determines that the HCS provider is in compliance, or may deny certification of the HCS provider and initiate termination of the HCS provider's Medicaid provider agreement if DADS Regulatory Services determines that the HCS provider is not in compliance by the end of the follow-up review.

If DADS Regulatory Services determines that a HCS provider's failure to comply with one or more of the certification principles is of a serious or pervasive nature, DADS Regulatory Services may, at its discretion, take any action described above against the HCS provider. If DADS Regulatory Services determines that a

HCS provider has falsified documentation used to demonstrate compliance with the certification principles, DADS Regulatory Services may, at its discretion, take any action described above against the HCS provider.

At least annually, DADS Regulatory Services also conducts unannounced visits of each residence in which host home/companion care, residential support, or supervised living is provided to verify that the residence provides an environment that is healthy, safe, and comfortable for the individuals who live there and that the residence complies with the DADS Regulatory Services residential checklist.

DADS ensures oversight of local authorities and remediation through an annual on-site review of service coordination for waiver participants. The on-site review includes review of the qualifications and training requirements for service coordinators, the provision of service coordination service, record review of each sample individual's record, and meetings with assigned service coordinators and individuals or their legally authorized representatives, at the discretion of the review team members. Technical assistance is provided during the review and a formal debriefing is held prior to the determination of final findings. The local authority is then given up to one hour following the formal debriefing to provide additional information that may alter or clear findings. At the conclusion of the review, a final report of the review is provided to the local authority.

A local authority may request reconsideration of finding(s) of the review within 10 business days of receipt of the review report, based on the evidence originally submitted at the time of the on-site review.

Barring a successful request for reconsideration of findings, if any item is cited as "Not Met," a corrective action plan will be required for all items of non-compliance. The corrective action plan is due within 30 days after the date of the exit conference. Failure to submit a corrective action plan or failure to correct an item of non-compliance will result in a remedy or sanction.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

HHSC and DADS have articulated the vision and infrastructure for the quality improvement strategy for the waivers in the Quality Oversight Plan, which was approved by both agencies' commissioners in 2010. The Quality Oversight Plan includes all waivers operated by DADS. Central to this plan is the Quality Review Team, which consists of representatives from several agencies within the Texas Health and Human Services enterprise. In addition to directing the improvement activities for each waiver operated by DADS, the Quality Review Team oversees implementation of the Quality Oversight Plan and related processes. This includes making recommendations for new or revised quality measures, identifying and facilitating access to new data sources, identifying new intra and inter-agency processes impacting any and all phases of the quality program, approving and monitoring all active quality improvement projects, and other actions needed to assure continued improvement of Texas' Home and Community-Based Services waiver programs. Additionally, the Quality Review Team will review the Quality Oversight Plan at least every three years. Revisions to the plan will be approved by HHSC leadership.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The Quality Review Team meets quarterly and reviews comprehensive quality reports from each waiver at least annually. These reports are generated primarily from the DADS Center for Policy and Innovation Quality Assurance and Improvement Data Mart that includes data on the waivers' quality improvement strategy measures. These reports also include remediation activities and outcomes. HHSC and DADS staff present the reports and recommendations to the Quality Review Team. Priorities are established by the Quality Review Team. Improvement plans are developed as issues are identified and the Quality Review Team reviews; modifies, if needed; and approves all improvement plans. All active improvement plans for all waivers are monitored at each quality review team meeting, to include updates on data to determine whether or not improvement activities have had the intended effect. The DADS Quality Assurance and Improvement Data Mart compiles data currently collected in multiple automated systems. The Data Mart produces standardized reports and provides capability for ad-hoc reporting. The areas covered by the reports include: individual demographics; service utilization; enrollments; levels of care; service plans; consumer-direction; critical incidents; provider compliance and oversight; transfers; and discharges. This system has the capability to provide management reports at the individual level or any level of aggregation needed.

To facilitate communication with external stakeholders, the agency has implemented Texas Quality Matters, which is a web-based medium that provides external stakeholders with an increased ability to access quality reporting information. Texas Quality Matters provides the State with the ability to conduct online surveys related to quality improvement. Stakeholders have the opportunity to provide testimony on policies and rules governing the delivery of services in the HCS waiver in writing and at meetings of the Medical Care Advisory Committee, the DADS Advisory Council, and the HHSC Advisory Council. DADS posts announcements for all stakeholder meetings on the DADS website at least 30 days prior to the meeting.

The Promoting Independence Advisory Committee is comprised of member representatives from all departments of the State Medicaid Agency and external stakeholders. The Promoting Independence Advisory Committee studies and makes recommendations to the State regarding appropriate care settings for persons with disabilities.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

At least every three years, DADS and HHSC staff will evaluate the processes and indicators of the Quality Oversight Plan. State staff will examine issues such as whether or not the indicators are providing substantive information about each sub-assurance and whether the Quality Review Team composition is inclusive of key agency stakeholders. If areas for improvement exist, staff will make recommendations for changes to the Quality Review Team and the Quality Review Team will approve or revise staff's recommended changes.

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).

HCS providers and financial management services agencies are not required to be independently audited. DADS uses a fiscal monitoring process, billing and payment reviews, to ensure that HCS providers and financial management services agencies are complying with waiver requirements. DADS conducts fiscal monitoring of HCS providers on-site at least every four years and typically reviews a three month sample of the HCS provider's records, but may lengthen that sample period, if deemed necessary. Fiscal monitoring of financial management services agencies is conducted every three years. The methods used in the monitoring process include:

- Review of the HCS provider's/financial management services agency's existing billing system and internal controls;
- Comparison of the HCS provider's/financial management services agency's service delivery records with its billing records to verify that payments DADS made to the HCS provider or financial management services agency were appropriate and for services provided in compliance with the Medicaid provider agreement and with the rules and regulations for those services;
- Individual's service plans and records; and
- Comparison of service delivery and other supporting documentation with individual service plans.

As initial results warrant, DADS may broaden the scope of the review to include inspection of the service settings, observation of service provision, examination of personnel qualifications, and interviews with individuals, or the individuals' families, or service providers.

DADS may perform desk and on-site compliance reviews associated with claims the HCS provider/financial management services agency submits under a Medicaid provider agreement. DADS recovers improper payments, without extrapolation, when DADS verifies that the HCS provider/financial management services agency has been overpaid because of improper billing or accounting practices or failure to comply with the terms of the Medicaid provider agreement.

The HCS provider must provide the detailed information DADS requests that supports the claims information the HCS provider reported. If the HCS provider fails to provide the requested information, DADS may take adverse action

against the Medicaid provider agreement. DADS may withhold the HCS provider's payments and apply them to the billing and payment review exception for any payments the HCS provider owes DADS and may require corrective action for any billing and payment finding.

HCS Providers are subject to intermittent audits following complaints concerning fiscal compliance. HCS providers submit annual cost reports to HHSC, which are subject to audit by the Texas State Auditor's Office.

HCS providers and financial management services agencies are not required to conduct independent financial audits.

The Texas State Auditor's Office is responsible for the annual statewide financial and compliance audit performed by KPMG, LLC. The Office of the Inspector General is responsible for performing audits of Medicaid provider agreements between DADS and providers.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*
   i. **Sub-Assurances:**

      a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
I.a.1 Number and percent of provider claims that are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. N: Number of provider claims that are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. D: Number of paid claims.

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

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

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
HCS providers and financial management services agencies enter billing claims into the Client Assignment and Registration system, which assigns the correct reimbursement rate associated with the billing code entered by a HCS provider/financial management services agency. The Client Assignment and Registration system automatically rejects any claim that is entered with an unauthorized billing code or for a service not included in an individual's authorized individual plan of care. A report on this assurance is prepared annually and reviewed by the Quality Review Team.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When DADS detects provider non-compliance with HCS billing guidelines, DADS requires the HCS provider or financial management services agency to implement corrective action. Following billing and payment reviews and financial management services agency monitoring reviews, all HCS providers and financial management services agencies receive a written review report that details the specific areas of non-compliance found during the review and includes instruction regarding the HCS provider's or financial management services agency's responsibility with regard to the areas of deficiency. The program provider or CDSA must take action according to instructions within 15 days of the notification. DADS then conducts follow-up activities in accordance with HCS review procedures and financial management services agency monitoring review procedures to ensure corrective action has been implemented. DADS recoups funds when claims for services to individuals were found in error.

Annual monitoring by HHSC includes reviewing data from the quarterly quality measures and annual CMS-372 reports and implementing the Quality Review Team processes, the key formal mechanism for monitoring DADS' performance. The Quality Review Team meets quarterly and reviews comprehensive quality reports from each waiver at least annually. These reports include data on all of the waiver's quality improvement strategy measures. These reports also include remediation activities and outcomes. Improvement plans are developed as issues are identified by DADS or HHSC, and the Quality Review Team reviews, modifying if needed, and approves all improvement plans. All active improvement plans for all waivers are monitored at each quality review team meeting.

ii. Remediation Data Aggregation

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

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

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

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

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

HHSC, the State Medicaid Agency, determines payment rates every two years. Payment rates are determined for each service, and the rates for services are prospective and uniform statewide. HHSC determines payment rates after analysis of financial and statistical information, and the effect of the payment rates on achievement of program objectives, including economic conditions and budgetary considerations. Information about adopted payment rates is available on the HHSC Rate Analysis webpage.

All providers are required to submit annual cost reports to HHSC Rate Analysis Department. Providers are responsible for eliminating all unallowable expenses from the cost report prior to submission of the cost report. The annual cost report contains information on direct service costs, including direct service wages, benefits, contract services and staffing information; facility costs; operations costs; and administrations costs of the providers. The HHSC Office of Inspector General conducts reviews of all cost reports and a sample of cost reports is reviewed on-site. The HHSC Office of Inspector General removes any unallowable costs and corrects any errors detected on the cost report in the course of the review or on-site audit. Some cost reports are returned for correction and the revised cost reports are reviewed to determine if appropriate changes are made. Audited cost reports are used in the determination of statewide prospective rates.

Costs reported on the cost reports are projected to the applicable rate period. HHSC determines reasonable methods for projecting each provider's costs to allow for significant changes in cost-related conditions anticipated as occurring between the historical cost reporting period and the prospective rate period.

HHSC uses the projected costs from cost reports to rebase modeled rates for the following services: day habilitation,

respite, supported employment, host home/companion care, supervised living, residential support services, social work; and supported home living. The initial model-based rates for these services were determined using cost, financial, statistical and operational information collected during site visits performed by an independent consultant. The data was collected from cost reports and the service providers' accounting systems. Additionally, the state fiscal year (SFY) 1996 state wage data, the SFY 1994 cost data and the SFY 1995 data from service providers was reviewed and analyzed. The base model rate year was calendar year 1997. Data from SFY 1994-1996 were used to develop the current rate structure; rates are rebased every biennium from the most recent projected cost report data, within available appropriations. Current rates are based on cost report data from providers' fiscal years ending in 2010.

Nursing, speech and language pathology, audiology, occupational therapy, physical therapy, dietary, and behavioral support services are provided under more than one Home and Community-based 1915(c) waiver. The rates for these services are determined by combining the allowable costs per unit of service for the providers with Medicaid provider agreements in all the waivers offering these services into an array. The array is weighted by the number of units of service and the median cost per unit of service is calculated.

Prescribed drugs are paid at cost.

When historical costs are unavailable, such as in the case of changes in program requirements, payment rates may be based on a pro forma approach. This approach involves using historical costs of delivering similar services, where appropriate data are available, and determining the types and costs of products and services necessary to deliver services meeting federal and state requirements. HHSC models rates as specified below.

The reimbursement for transition assistance services is modeled using this pro forma approach.

Minor home modifications, adaptive aids, and dental treatment services are paid at cost. Providers are given additional payments for the cost of acquiring minor home modifications, adaptive aids, and dental treatment services for individuals; these payments are called requisition fees. The rates for the requisition fees are determined by modeling the estimated time required for staff to conduct the assessment of the need for the service, purchase the item, and complete any necessary follow-up.

In setting the rates for financial management services provided under the consumer directed services option, the reimbursement rate to the financial management services provider is a flat monthly fee, determined by modeling the estimated cost to carry out the financial management responsibilities of the financial management services provider. The payment rate available for the individual's budget for the self-directed service is modeled based on the payment rate to the traditional agency less an adjustment for the traditional agency's indirect costs.

The rate for support consultation is determined by modeling the estimated salary for a person with similar skills and training requirements. This rate is updated periodically for inflation. The modeled inputs for the support consultation rate are evaluated based on the most recently audited cost reports every two years.

HCS providers have the option of participating in the attendant compensation rate enhancement for the following services: day habilitation, respite, supported employment, supervised living/residential support services, and supported home living. HHSC adopted rules in Title 1 of the Texas Administrative Code, Part 15, Chapter 355, Subchapter A to establish procedures for providers to obtain additional funds for increased attendant wages, benefits/insurance, and mileage reimbursement. As per these rules, providers who choose to participate in the attendant compensation rate enhancement and receive additional funds must demonstrate compliance with enhanced spending requirements. For providers who choose not to participate in the enhancement program, the attendant compensation rate component will remain constant over time, except for adjustments necessitated by increases in the federal minimum wage.

Participation in the attendant compensation rate enhancement is voluntary. Providers may choose to participate in the attendant compensation rate enhancement by submitting to HHSC a signed Enrollment Contract Amendment choosing to enroll and indicating the level of enhanced add-on rate they desire to receive. Requested add-on rate levels are granted beginning with the lowest level and granting successive levels until requested enhancements are granted within available funds.

Enrollment in the attendant compensation rate enhancement is held in July, prior to the rate year. Funding for the enhancement add-on rate levels is limited by appropriations.

Providers are notified of the open enrollment period for the attendant compensation rate enhancement program through certified letters mailed to all providers listed as active at the time of mailing. New providers are notified of the program and enrollment requirements as HHSC is notified of the contract award. A webinar to review the program and respond to questions is held during the open enrollment period. Changes to the rule related to the program at Title 1 of the Texas Administrative Code, Part 15, Chapter 355, §355.112 are published in the Texas Register for public comment.

Providers participating in the attendant compensation rate enhancement agree to spend approximately 90 percent of their total attendant revenues, including their enhanced add-on rate revenues, on attendant compensation. Attendant compensation includes salaries, payroll taxes, benefits, and mileage reimbursement. Participating providers must submit reports to HHSC documenting their spending on attendant compensation.

Determination of each provider's compliance with the attendant compensation spending requirement will be made on an annual basis from the cost reports submitted to HHSC. Individuals failing to meet their spending requirement for the reporting period will have their enhanced add-on revenues associated with the unmet spending requirements recouped. At no time will a participating provider's attendant care rate after their spending recoupment be less than the rate paid to providers not participating in receiving the enhanced add-on rates. The federal portion of any recouped funds is returned to the federal government.

HHSC holds a public hearing before it approves rates. The purpose of the hearing is to give interested parties an opportunity to comment on the proposed rates. Notice of the hearing is provided to the public via the Texas Register and the HHSC website. The notice of the public hearing includes information about the proposed rate changes and identifies the name, address, and telephone number of the staff member to contact for the materials pertinent to the proposed rates. At least ten working days before the public hearing takes place, material pertinent to the proposed statewide uniform rates is made available to the public. The public may present comments at the hearing or submit written comments regarding the proposed rates.

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:

HCS providers and financial management services agencies submit billing claims directly to the State.

HCS providers and financial management services agencies enter individual service usage information (billing claims) into the State's electronic billing system. HCS providers and financial management services agencies submit appropriate receipts for adaptive aids, minor home modifications, and dental treatment that are authorized for payment by DADS. Following authorization, the HCS providers and financial management services agencies submit electronic claims for the adaptive aids, minor home modifications, or dental treatment.

Service usage information is entered into the State's electronic billing system and all claims are paid without being routed through the State's claims payment system (MMIS) at the current time. The State's electronic billing system authorizes payments to providers for claims under the waiver. The system then generates a file that interfaces with the State Comptroller's office, which makes all payments to providers. The State's electronic billing system sends a paid claims file to the MMIS and these records can be accessed from that system.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

HCS providers and financial management services agencies may enter electronic billing claims weekly. A claim includes the total units of each service delivered to an individual, the date of delivery, and the amount due the HCS provider or financial management services agency. The State's electronic billing system verifies the following before a billing claim is approved:
• The individual meets level of care and financial eligibility requirements on the date of service;
• The services billed are included on the individual's current, approved service plan;
• The amount of units and unit costs do not exceed the most current, approved service plan; and
• The billing claim is complete, accurate, and is received by DADS no later than 12 months after the last day of the month in which the service was provided.

HCS providers and financial management services agencies submit appropriate receipts for adaptive aids, minor home modifications, and dental treatment that are authorized for payment by DADS staff. Following authorization, the HCS providers and financial management services agencies submit electronic claims for the adaptive aids, minor home modifications, or dental treatment.

The State uses a fiscal monitoring process to ensure that reimbursement to HCS providers and financial management services agencies are for services actually provided in compliance with waiver requirements. The methods used in the fiscal monitoring process and outcomes of the process are described in Appendix I-1.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

○ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

○ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

◉ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Although the current system is not an approved MMIS, it meets the MMIS functional criteria for claims adjudication. Paid claims data is sent to the Texas Medicaid and Healthcare Partnership for each adjudication cycle.

A process is run weekly which compares received claims to the criteria for approval of claims and produces a list of adjudicated/approved claims to be processed for payment. Rate tables and service authorizations support the computation of the amount to pay and approved-to-pay claims are exported weekly to the HCS Provider Payment System. The HCS Provider Payment System computes the federal and general revenue funding split for each approved-to-pay claim, determines the accounting coding block, and builds interface transactions to the agency's accounts payable system, the Health and Human Services Accounting System. The Health and Human Services Accounting System prepares a warrant request that is sent to the Comptroller of Public Accounts who, in turn, produces a warrant that is sent to the HCS provider or financial management services agency. The data used for the claims and expenditures on the CMS 64 is this adjudicated claim information contained in the Health and Human Services Accounting System. The State, the HCS provider, the financial management services agency, and the individual employer in the consumer directed services option maintain supporting documentation to provide an audit trail.

The State retains copies of Medicaid provider agreements between the State and each HCS provider and financial management services agency, along with documentation of each HCS provider's and financial management services agency's compliance with state standards for participation.

The State maintains the following documentation related to each individual:
- Approved service plans;
- Documentation of the individual's financial eligibility and level of care eligibility;
- A record for each individual that documents the content of service plans and details of all services approved or rejected for payment including the number of service units delivered, the date of service delivery, the amount claimed for reimbursement, copies of receipts for adaptive aids, minor home modifications and dental services, and the amount approved for reimbursement; and
- Records of discharges of individuals from waiver services.

HCS providers, financial management services agencies, and individual employers must maintain separate service information for each individual receiving services from the provider. At a minimum, service documentation information includes the following: results of individual assessments, evaluations, and accompanying recommendations that identify specific needs to be addressed by the services included on the individual's service plan; service plans and revisions to plans for each individual; person-directed plan for each individual; copies of billings and vouchers submitted for reimbursement; service delivery logs indicating date and type of service provided and name of service provider; narrative documentation of outcomes of each service delivery event; verification by DADS of the date of the individual's eligibility for enrollment and of provider eligibility for payment and, when applicable, records of individual's discharge from waiver services; when applicable, documentation verifying the individual's eligibility for employment assistance or supported employment; when applicable, receipts for the provision of adaptive aids, minor home modifications, and dental treatment and documentation that the provision of dental treatment, adaptive aids, or minor home modifications

is authorized by the recipient's service planning team; and evidence that all service providers meet the minimum provider qualifications at the time services were delivered.

○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☑ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to

CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ○ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ◉ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Local community centers, established in accordance with Chapter 534 of the Texas Health and Safety Code, and a local Council of Government, established in accordance with Chapter 391 of the Texas Local Government Code, have been designated by the State as local authorities.

Local authorities have Medicaid provider agreements with the State as HCS providers, and therefore must provide all HCS services. Local authorities may also have Medicaid provider agreements to provide financial management services and support consultation under the consumer directed services option, but may not provide any other services to the same individual.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- ◉ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of**

the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

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:

Funds to operate this waiver are appropriated by the Texas Legislature to the State.

There are no Inter-Governmental Transfers (IGTs) or Certified Public Expenditures (CPEs). There are no local sources of funds included in the State's non-federal share. The non-federal share is exclusively from the legislative appropriations of state general revenue to the State. The non-federal matching funds are appropriated to the State as a specific line item for the provision of the HCS waiver. The HCS appropriation remains in the State Comptroller's account designated for the HCS waiver. Once a claim has been approved via the Client Assignment and Registration system, which is not an approved MMIS but does meet the MMIS functional criteria for claims adjudication, federal funds are drawn and combined with the state appropriations to make payments to the provider.

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**
  Check each that applies:
  - [ ] **Appropriation of Local Government Revenues.**

    Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

    [ ]

  - [ ] **Other Local Government Level Source(s) of Funds.**

    Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

    [ ]

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**
  Check each that applies:
  - [ ] **Health care-related taxes or fees**
  - [ ] **Provider-related donations**
  - [ ] **Federal funds**

  For each source of funds indicated above, describe the source of the funds in detail:

  [ ]

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- (●) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Payment of the cost for room and board is the responsibility of the individual except when room and board is provided under the waiver as part of out-of-home respite.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the

Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	40834.82	7786.54	48621.36	114092.34	2837.42	116929.76	68308.40
2	40910.00	8175.87	49085.87	116374.19	2979.29	119353.48	70267.61
3	41788.70	8584.66	50373.36	118701.67	3128.25	121829.92	71456.56
4	42688.79	9013.89	51702.68	121075.70	3284.66	124360.36	72657.68
5	43609.74	9464.58	53074.32	123497.21	3448.89	126946.10	73871.78

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)		
		Level of Care:		
		ICF/IID		
Year 1	21927		21927	
Year 2	21945		21945	
Year 3	21945		21945	
Year 4	21945		21945	
Year 5	21945		21945	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay for an individual is calculated based on historical data in the Client Assignment and Registration system regarding the length of time all individuals remain in the waiver. When new capacity is added, a phase-in schedule is developed to account for timing of adding the new capacity. The data from the Client Assignment and Registration system and the phase-in schedule is aggregated and an average length of stay is calculated by averaging out the total time divided by the number of unduplicated individuals.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The Factor D estimates are based on claims payment data from the CMS 372 report for state fiscal year 2011 and current rates (effective September 2011). For services where a unit rate is established, no inflation was assumed through Waiver Year 2 (state fiscal year 15) and assumed a 2 percent annual inflator for rates for Waiver Years 3 through 5. For those services not involving unit rates (Adaptive Aids, Dental, and Minor Home Modifications) we assumed an annual inflation rate of 2 percent over the cost per service derived from the CMS 372 for state fiscal year 2011. For prescribed drugs, we assumed an annual rate of 5 percent over the cost of service derived from the CMS 372 for state fiscal year 2011.

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' derivation assumes an annual inflation rate of 5 percent over the factor D' cost from the CMS 372 for state fiscal year 2011.

Medicare Part D went into effect in 2006. Since that time, Medicare Part D is paying for all drug costs for the dual eligible population, rather than Medicaid. Since the CMS data for 2011 was used as the basis for the Part D estimates-- which is five years after Medicare Part D was implemented-- no adjustment to the D' costs is necessary, because no drugs for the dual eligible population were billed to Medicaid in 2011.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The factor G derivation assumes an annual inflation rate of 2 percent over the actual G cost for state fiscal year 2011.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The factor G' derivation assumes an annual inflation rate of 5 percent over the Actual G' cost for state fiscal year 2011.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Day Habilitation	
Respite	
Supported Employment	
Adaptive Aids	
Audiology	
Occupational Therapy	
Physical Therapy	
Prescribed Drugs	
Speech and Language Pathology	
Financial Management Services	
Support Consultation	
Behavioral Support	
Cognitive Rehabilitation Therapy	
Dental Treatment	
Dietary Services	
Employment Assistance	
Minor Home Modifications	
Nursing	

Waiver Services	
Residential Assistance (Host Home/Companion Care, Supervised Living, Residential Support Services)	
Social Work	
Supported Home Living	
Transition Assistance Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**88594770.19**
Day Habilitation, Pervasive Plus	per day	84	171.00	149.32	**2144832.48**	
Day Habilitation, Extensive	per day	3080	184.00	33.73	**19115465.60**	
Day Habilitation, Limited	per day	7354	189.00	27.96	**38861771.76**	
Day Habilitation, Intermittent	per day	4185	172.00	25.18	**18125067.60**	
Day Habilitation, Pervasive	per day	1235	185.00	45.29	**10347632.75**	
Respite Total:						**4990893.40**
Provider-managed	per hour	1353	172.00	19.57	**4554252.12**	
CDS	per hour	191	128.00	17.86	**436641.28**	
Supported Employment Total:						**704486.40**
Provider-managed	per hour	501	40.00	33.78	**676951.20**	
CDS	per hour	21	40.00	32.78	**27535.20**	
Adaptive Aids Total:						**3018183.91**
Adaptive Aids	per item	4607	7.00	93.59	**3018183.91**	
				GRAND TOTAL:		**895385128.40**
				Total Estimated Unduplicated Participants:		**21927**
				Factor D (Divide total by number of participants):		**40834.82**
				Average Length of Stay on the Waiver:		356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Audiology Total:						**1476.44**
Audiology	per hour	28	1.00	52.73	**1476.44**	
Occupational Therapy Total:						**221403.25**
Occupational Therapy	per hour	607	5.00	72.95	**221403.25**	
Physical Therapy Total:						**524665.68**
Physical Therapy	per hour	616	11.00	77.43	**524665.68**	
Prescribed Drugs Total:						**42826115.64**
Prescribed Drugs	per prescription	8599	28.00	177.87	**42826115.64**	
Speech and Language Pathology Total:						**1188598.20**
Speech and Language Pathology	per hour	779	20.00	76.29	**1188598.20**	
Financial Management Services Total:						**385427.10**
Financial Management Services	per month	249	10.00	154.79	**385427.10**	
Support Consultation Total:						**737.76**
Support Consultation	per hour	6	8.00	15.37	**737.76**	
Behavioral Support Total:						**2211808.83**
Behavioral Support	per hour	3973	7.00	79.53	**2211808.83**	
Cognitive Rehabilitation Therapy Total:						**453606.00**
Provider-managed	per hour	11	437.00	80.00	**384560.00**	
CDS	per hour	2	437.00	79.00	**69046.00**	
Dental Treatment Total:						**7268136.96**
Dental Treatment	per visit	12964	2.00	280.32	**7268136.96**	
Dietary Services Total:						**142570.80**
Dietary Services	per hour	1290	2.00	55.26	**142570.80**	
Employment Assistance Total:						**369855.36**
Provider-managed	per hour	501	21.00	33.78	**355399.38**	

GRAND TOTAL:	**895385128.40**
Total Estimated Unduplicated Participants:	**21927**
Factor D (Divide total by number of participants):	**40834.82**
Average Length of Stay on the Waiver:	356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CDS	per hour	21	21.00	32.78	14455.98	
Minor Home Modifications Total:						1125918.72
Minor Home Modifications	per item	256	1.00	4398.12	1125918.72	
Nursing Total:						8518370.74
Provider-managed	per hour	21097	11.00	36.29	8421711.43	
CDS	per hour	249	11.00	35.29	96659.31	
Residential Assistance (Host Home/Companion Care, Supervised Living, Residential Support Services) Total:						677467139.48
Host Home/Companion Care, Pervasive Plus	per day	16	265.00	147.84	626841.60	
Supervised Living, Pervasive Plus	per day	7	176.00	255.65	314960.80	
Residential Support, Limited	per day	2054	318.00	141.49	92417306.28	
Supervised Living, Intermittent	per day	1068	314.00	133.15	44652118.80	
Host Home/Companion Care, Extensive	per day	2022	353.00	94.07	67143967.62	
Supervised Living, Limited	per day	1623	324.00	141.49	74402799.48	
Residential Support, Pervasive	per day	581	312.00	173.99	31539515.28	
Host Home/Companion Care, Limited	per day	4859	354.00	76.14	130967348.04	
Residential Support, Pervasive Plus	per day	69	271.00	255.65	4780399.35	
Host Home/Companion Care, Intermittent	per day	3128	353.00	72.56	80119591.04	
Supervised Living, Extensive	per day	420	324.00	153.65	20908692.00	
Residential Support, Extensive	per day	1323	320.00	153.65	65049264.00	
Residential Support, Intermittent	per day	513	275.00	133.15	18784136.25	
Host Home /Companion Care, Pervasive	per day	922	352.00	119.18	38679153.92	
Supervised Living, Pervasive	per day	126	323.00	173.99	7081045.02	
				GRAND TOTAL:		895385128.40
				Total Estimated Unduplicated Participants:		21927
				Factor D (Divide total by number of participants):		40834.82
				Average Length of Stay on the Waiver:		356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Social Work Total:						**2646.16**
Social Work	per hour	11	4.00	60.14	**2646.16**	
Supported Home Living Total:						**54791214.03**
Provider-managed	per hour	3998	540.00	23.09	**49849462.80**	
CDS	per hour	247	909.00	22.01	**4941751.23**	
Transition Assistance Services Total:						**577103.35**
Transition Assistance Services	per Item	235	1.00	2451.61	**576128.35**	
Transition Assistance Services- Minor Home Modifications	per Item	0	0.00	0.01	**0.00**	
Transition Assistance Services- Assessments for Minor Home Modifications	per Item	13	1.00	75.00	**975.00**	
				GRAND TOTAL:		**895385128.40**
				Total Estimated Unduplicated Participants:		**21927**
				Factor D (Divide total by number of participants):		**40834.82**
				Average Length of Stay on the Waiver:		356

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**88594770.19**
Day Habilitation, Pervasive Plus	per day	84	171.00	149.32	**2144832.48**	
Day Habilitation, Extensive	per day	3080	184.00	33.73	**19115465.60**	
Day Habilitation, Limited	per day	7354	189.00	27.96	**38861771.76**	
Day Habilitation, Intermittent	per day	4185	172.00	25.18	**18125067.60**	
Day Habilitation, Pervasive					**10347632.75**	
				GRAND TOTAL:		**897765393.00**
				Total Estimated Unduplicated Participants:		**21945**
				Factor D (Divide total by number of participants):		**40910.00**
				Average Length of Stay on the Waiver:		356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	per day	1235	185.00	45.29		
Respite Total:						**4990893.40**
Provider-managed	per hour	1353	172.00	19.57	**4554252.12**	
CDS	per hour	191	128.00	17.86	**436641.28**	
Supported Employment Total:						**704486.40**
Provider-managed	per hour	501	40.00	33.78	**676951.20**	
CDS	per hour	21	40.00	32.78	**27535.20**	
Adaptive Aids Total:						**3078489.54**
Adaptive Aids	per item	4607	7.00	95.46	**3078489.54**	
Audiology Total:						**1476.44**
Audiology	per hour	28	1.00	52.73	**1476.44**	
Occupational Therapy Total:						**221403.25**
Occupational Therapy	per hour	607	5.00	72.95	**221403.25**	
Physical Therapy Total:						**524665.68**
Physical Therapy	per hour	616	11.00	77.43	**524665.68**	
Prescribed Drugs Total:						**44966578.72**
Prescribed Drugs	per prescription	8599	28.00	186.76	**44966578.72**	
Speech and Language Pathology Total:						**1188598.20**
Speech and Language Pathology	per hour	779	20.00	76.29	**1188598.20**	
Financial Management Services Total:						**385427.10**
Financial Management Services	per month	249	10.00	154.79	**385427.10**	
Support Consultation Total:						**737.76**
Support Consultation	per hour	6	8.00	15.37	**737.76**	
Behavioral Support Total:						**2211808.83**
Behavioral Support	per hour	3973	7.00	79.53	**2211808.83**	

GRAND TOTAL:	**897765393.00**
Total Estimated Unduplicated Participants:	**21945**
Factor D (Divide total by number of participants):	**40910.00**
Average Length of Stay on the Waiver:	356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Cognitive Rehabilitation Therapy Total:						**453606.00**
Provider-managed	per hour	11	437.00	80.00	**384560.00**	
CDS	per hour	2	437.00	79.00	**69046.00**	
Dental Treatment Total:						**7413593.04**
Dental Treatment	per visit	12964	2.00	285.93	**7413593.04**	
Dietary Services Total:						**142570.80**
Dietary Services	per hour	1290	2.00	55.26	**142570.80**	
Employment Assistance Total:						**369855.36**
Provider-managed	per hour	501	21.00	33.78	**355399.38**	
CDS	per hour	21	21.00	32.78	**14455.98**	
Minor Home Modifications Total:						**1148436.48**
Minor Home Modifications	per item	256	1.00	4486.08	**1148436.48**	
Nursing Total:						**8518370.74**
Provider-managed	per hour	21097	11.00	36.29	**8421711.43**	
CDS	per hour	249	11.00	35.29	**96659.31**	
Residential Assistance (Host Home/Companion Care, Supervised Living, Residential Support Services) Total:						**677467139.48**
Host Home/Companion Care, Pervasive Plus	per day	16	265.00	147.84	**626841.60**	
Supervised Living, Pervasive Plus	per day	7	176.00	255.65	**314960.80**	
Residential Support, Limited	per day	2054	318.00	141.49	**92417306.28**	
Supervised Living, Intermittent	per day	1068	314.00	133.15	**44652118.80**	
Host Home/Companion Care, Extensive	per day	2022	353.00	94.07	**67143967.62**	
Supervised Living, Limited	per day	1623	324.00	141.49	**74402799.48**	
Residential Support, Pervasive	per day	581	312.00	173.99	**31539515.28**	

GRAND TOTAL:	**897765393.00**
Total Estimated Unduplicated Participants:	**21945**
Factor D (Divide total by number of participants):	**40910.00**
Average Length of Stay on the Waiver:	356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Host Home/Companion Care, Limited	per day	4859	354.00	76.14	130967348.04	
Residential Support, Pervasive Plus	per day	69	271.00	255.65	4780399.35	
Host Home/Companion Care, Intermittent	per day	3128	353.00	72.56	80119591.04	
Supervised Living, Extensive	per day	420	324.00	153.65	20908692.00	
Residential Support, Extensive	per day	1323	320.00	153.65	65049264.00	
Residential Support, Intermittent	per day	513	275.00	133.15	18784136.25	
Host Home /Companion Care, Pervasive	per day	922	352.00	119.18	38679153.92	
Supervised Living, Pervasive	per day	126	323.00	173.99	7081045.02	
Social Work Total:						**2646.16**
Social Work	per hour	11	4.00	60.14	2646.16	
Supported Home Living Total:						**54791214.03**
Provider-managed	per hour	3998	540.00	23.09	49849462.80	
CDS	per hour	247	909.00	22.01	4941751.23	
Transition Assistance Services Total:						**588625.40**
Transition Assistance Services	per Item	235	1.00	2500.64	587650.40	
Transition Assistance Services- Minor Home Modifications	per Item	0	0.00	0.01	0.00	
Transition Assistance Services- Assessments for Minor Home Modifications	per Item	13	1.00	75.00	975.00	
				GRAND TOTAL:		**897765393.00**
				Total Estimated Unduplicated Participants:		**21945**
				Factor D (Divide total by number of participants):		**40910.00**
				Average Length of Stay on the Waiver:		356

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**90363590.56**
Day Habilitation, Pervasive Plus	per day	84	171.00	152.31	**2187780.84**	
Day Habilitation, Extensive	per day	3080	184.00	34.40	**19495168.00**	
Day Habilitation, Limited	per day	7354	189.00	28.52	**39640119.12**	
Day Habilitation, Intermittent	per day	4185	172.00	25.68	**18484977.60**	
Day Habilitation, Pervasive	per day	1235	185.00	46.20	**10555545.00**	
Respite Total:						**5090453.92**
Provider-managed	per hour	1353	172.00	19.96	**4645011.36**	
CDS	per hour	191	128.00	18.22	**445442.56**	
Supported Employment Total:						**718668.00**
Provider-managed	per hour	501	40.00	34.46	**690578.40**	
CDS	per hour	21	40.00	33.44	**28089.60**	
Adaptive Aids Total:						**3140085.13**
Adaptive Aids	per item	4607	7.00	97.37	**3140085.13**	
Audiology Total:						**1505.84**
Audiology	per hour	28	1.00	53.78	**1505.84**	
Occupational Therapy Total:						**225834.35**
Occupational Therapy	per hour	607	5.00	74.41	**225834.35**	
Physical Therapy Total:						**535168.48**
Physical Therapy	per hour	616	11.00	78.98	**535168.48**	
Prescribed Drugs Total:						**47215389.20**
Prescribed Drugs	per prescription	8599	28.00	196.10	**47215389.20**	
Speech and Language Pathology Total:						**1212435.60**
Speech and Language Pathology	per hour	779	20.00	77.82	**1212435.60**	

GRAND TOTAL:	**917053059.99**
Total Estimated Unduplicated Participants:	**21945**
Factor D (Divide total by number of participants):	**41788.70**
Average Length of Stay on the Waiver:	356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Financial Management Services Total:						**393146.10**
Financial Management Services	per month	249	10.00	157.89	**393146.10**	
Support Consultation Total:						**752.64**
Support Consultation	per hour	6	8.00	15.68	**752.64**	
Behavioral Support Total:						**2256028.32**
Behavioral Support	per hour	3973	7.00	81.12	**2256028.32**	
Cognitive Rehabilitation Therapy Total:						**462678.12**
Provider-managed	per hour	11	437.00	81.60	**392251.20**	
CDS	per hour	2	437.00	80.58	**70426.92**	
Dental Treatment Total:						**7561901.20**
Dental Treatment	per visit	12964	2.00	291.65	**7561901.20**	
Dietary Services Total:						**145434.60**
Dietary Services	per hour	1290	2.00	56.37	**145434.60**	
Employment Assistance Total:						**377300.70**
Provider-managed	per hour	501	21.00	34.46	**362553.66**	
CDS	per hour	21	21.00	33.44	**14747.04**	
Minor Home Modifications Total:						**1171404.80**
Minor Home Modifications	per item	256	1.00	4575.80	**1171404.80**	
Nursing Total:						**8689779.12**
Provider-managed	per hour	21097	11.00	37.02	**8591120.34**	
CDS	per hour	249	11.00	36.02	**98658.78**	
Residential Assistance (Host Home/Companion Care, Supervised Living, Residential Support Services) Total:						**691005299.75**
Host Home/Companion Care, Pervasive Plus	per day	16	265.00	150.80	**639392.00**	
Supervised Living, Pervasive Plus					**321256.32**	
				GRAND TOTAL:		**917053059.99**
				Total Estimated Unduplicated Participants:		**21945**
				Factor D (Divide total by number of participants):		**41788.70**
				Average Length of Stay on the Waiver:		356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	per day	7	176.00	260.76		
Residential Support, Limited	per day	2054	318.00	144.32	**94265783.04**	
Supervised Living, Intermittent	per day	1068	314.00	135.81	**45544155.12**	
Host Home/Companion Care, Extensive	per day	2022	353.00	95.95	**68485847.70**	
Supervised Living, Limited	per day	1623	324.00	144.32	**75890960.64**	
Residential Support, Pervasive	per day	581	312.00	177.47	**32170341.84**	
Host Home/Companion Care, Limited	per day	4859	354.00	77.66	**133581878.76**	
Residential Support, Pervasive Plus	per day	69	271.00	260.76	**4875951.24**	
Host Home/Companion Care, Intermittent	per day	3128	353.00	74.01	**81720657.84**	
Supervised Living, Extensive	per day	420	324.00	156.72	**21326457.60**	
Residential Support, Extensive	per day	1323	320.00	156.72	**66348979.20**	
Residential Support, Intermittent	per day	513	275.00	135.81	**19159395.75**	
Host Home /Companion Care, Pervasive	per day	922	352.00	121.56	**39451568.64**	
Supervised Living, Pervasive	per day	126	323.00	177.47	**7222674.06**	
Social Work Total:						**2698.96**
Social Work	per hour	11	4.00	61.34	**2698.96**	
Supported Home Living Total:						**55883107.35**
Provider-managed	per hour	3998	540.00	23.55	**50842566.00**	
CDS	per hour	247	909.00	22.45	**5040541.35**	
Transition Assistance Services Total:						**600397.25**
Transition Assistance Services	per Item	235	1.00	2550.65	**599402.75**	
Transition Assistance Services- Minor Home Modifications	per Item	0	0.00	0.01	**0.00**	
Transition Assistance Services- Assessments for Minor Home Modifications	per Item	13	1.00	76.50	**994.50**	

GRAND TOTAL:	**917053059.99**
Total Estimated Unduplicated Participants:	**21945**
Factor D (Divide total by number of participants):	**41788.70**
Average Length of Stay on the Waiver:	356

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**92167989.18**
Day Habilitation, Pervasive Plus	per day	84	171.00	155.36	**2231591.04**	
Day Habilitation, Extensive	per day	3080	184.00	35.09	**19886204.80**	
Day Habilitation, Limited	per day	7354	189.00	29.09	**40432365.54**	
Day Habilitation, Intermittent	per day	4185	172.00	26.19	**18852085.80**	
Day Habilitation, Pervasive	per day	1235	185.00	47.12	**10765742.00**	
Respite Total:						**5192341.60**
Provider-managed	per hour	1353	172.00	20.36	**4738097.76**	
CDS	per hour	191	128.00	18.58	**454243.84**	
Supported Employment Total:						**733058.40**
Provider-managed	per hour	501	40.00	35.15	**704406.00**	
CDS	per hour	21	40.00	34.11	**28652.40**	
Adaptive Aids Total:						**3202970.68**
Adaptive Aids	per item	4607	7.00	99.32	**3202970.68**	
Audiology Total:						**1536.08**
Audiology	per hour	28	1.00	54.86	**1536.08**	
Occupational Therapy Total:						**230356.50**
Occupational Therapy	per hour	607	5.00	75.90	**230356.50**	
Physical Therapy Total:						
				GRAND TOTAL:		**936805488.13**
				Total Estimated Unduplicated Participants:		**21945**
				Factor D (Divide total by number of participants):		**42688.79**
				Average Length of Stay on the Waiver:		356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						545874.56
Physical Therapy	per hour	616	11.00	80.56	545874.56	
Prescribed Drugs Total:						49577362.52
Prescribed Drugs	per prescription	8599	28.00	205.91	49577362.52	
Speech and Language Pathology Total:						1236740.40
Speech and Language Pathology	per hour	779	20.00	79.38	1236740.40	
Financial Management Services Total:						401014.50
Financial Management Services	per month	249	10.00	161.05	401014.50	
Support Consultation Total:						767.52
Support Consultation	per hour	6	8.00	15.99	767.52	
Behavioral Support Total:						2301082.14
Behavioral Support	per hour	3973	7.00	82.74	2301082.14	
Cognitive Rehabilitation Therapy Total:						471920.67
Provider-managed	per hour	11	437.00	83.23	400086.61	
CDS	per hour	2	437.00	82.19	71834.06	
Dental Treatment Total:						7713061.44
Dental Treatment	per visit	12964	2.00	297.48	7713061.44	
Dietary Services Total:						148350.00
Dietary Services	per hour	1290	2.00	57.50	148350.00	
Employment Assistance Total:						384855.66
Provider-managed	per hour	501	21.00	35.15	369813.15	
CDS	per hour	21	21.00	34.11	15042.51	
Minor Home Modifications Total:						1194833.92
Minor Home Modifications	per item	256	1.00	4667.32	1194833.92	
Nursing Total:						8863535.56

GRAND TOTAL:	936805488.13
Total Estimated Unduplicated Participants:	21945
Factor D (Divide total by number of participants):	42688.79
Average Length of Stay on the Waiver:	356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Provider-managed	per hour	21097	11.00	37.76	**8762849.92**	
CDS	per hour	249	11.00	36.76	**100685.64**	
Residential Assistance (Host Home/Companion Care, Supervised Living, Residential Support Services) Total:						**704823844.13**
Host Home/Companion Care, Pervasive Plus	per day	16	265.00	153.82	**652196.80**	
Supervised Living, Pervasive Plus	per day	7	176.00	265.98	**327687.36**	
Residential Support, Limited	per day	2054	318.00	147.21	**96153450.12**	
Supervised Living, Intermittent	per day	1068	314.00	138.53	**46456312.56**	
Host Home/Companion Care, Extensive	per day	2022	353.00	97.87	**69856278.42**	
Supervised Living, Limited	per day	1623	324.00	147.21	**77410672.92**	
Residential Support, Pervasive	per day	581	312.00	181.02	**32813857.44**	
Host Home/Companion Care, Limited	per day	4859	354.00	79.21	**136248012.06**	
Residential Support, Pervasive Plus	per day	69	271.00	265.98	**4973560.02**	
Host Home/Companion Care, Intermittent	per day	3128	353.00	75.49	**83354850.16**	
Supervised Living, Extensive	per day	420	324.00	159.85	**21752388.00**	
Residential Support, Extensive	per day	1323	320.00	159.85	**67674096.00**	
Residential Support, Intermittent	per day	513	275.00	138.53	**19543119.75**	
Host Home /Companion Care, Pervasive	per day	922	352.00	123.99	**40240210.56**	
Supervised Living, Pervasive	per day	126	323.00	181.02	**7367151.96**	
Social Work Total:						**2753.08**
Social Work	per hour	11	4.00	62.57	**2753.08**	
Supported Home Living Total:						**56998835.10**
Provider-managed	per hour	3998	540.00	24.02	**51857258.40**	

GRAND TOTAL:	**936805488.13**
Total Estimated Unduplicated Participants:	**21945**
Factor D (Divide total by number of participants):	**42688.79**
Average Length of Stay on the Waiver:	356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CDS	per hour	247	909.00	22.90	**5141576.70**	
Transition Assistance Services Total:						**612404.49**
Transition Assistance Services	per Item	235	1.00	2601.66	**611390.10**	
Transition Assistance Services- Minor Home Modifications	per Item	0	0.00	0.01	**0.00**	
Transition Assistance Services- Assessments for Minor Home Modifications	per Item	13	1.00	78.03	**1014.39**	
				GRAND TOTAL:		**936805488.13**
				Total Estimated Unduplicated Participants:		**21945**
				Factor D (Divide total by number of participants):		**42688.79**
				Average Length of Stay on the Waiver:		356

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**94004583.60**
Day Habilitation, Pervasive Plus	per day	84	171.00	158.47	**2276263.08**	
Day Habilitation, Extensive	per day	3080	184.00	35.79	**20282908.80**	
Day Habilitation, Limited	per day	7354	189.00	29.67	**41238511.02**	
Day Habilitation, Intermittent	per day	4185	172.00	26.71	**19226392.20**	
Day Habilitation, Pervasive	per day	1235	185.00	48.06	**10980508.50**	
Respite Total:						**5296800.92**
Provider-managed	per hour	1353	172.00	20.77	**4833511.32**	
CDS	per hour	191	128.00	18.95	**463289.60**	
Supported Employment Total:						**747657.60**
				GRAND TOTAL:		**957015814.95**
				Total Estimated Unduplicated Participants:		**21945**
				Factor D (Divide total by number of participants):		**43609.74**
				Average Length of Stay on the Waiver:		356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Provider-managed	per hour	501	40.00	35.85	**718434.00**	
CDS	per hour	21	40.00	34.79	**29223.60**	
Adaptive Aids Total:						**3267146.19**
Adaptive Aids	per item	4607	7.00	101.31	**3267146.19**	
Audiology Total:						**1566.88**
Audiology	per hour	28	1.00	55.96	**1566.88**	
Occupational Therapy Total:						**234969.70**
Occupational Therapy	per hour	607	5.00	77.42	**234969.70**	
Physical Therapy Total:						**556783.92**
Physical Therapy	per hour	616	11.00	82.17	**556783.92**	
Prescribed Drugs Total:						**52057314.12**
Prescribed Drugs	per prescription	8599	28.00	216.21	**52057314.12**	
Speech and Language Pathology Total:						**1261512.60**
Speech and Language Pathology	per hour	779	20.00	80.97	**1261512.60**	
Financial Management Services Total:						**409032.30**
Financial Management Services	per month	249	10.00	164.27	**409032.30**	
Support Consultation Total:						**782.88**
Support Consultation	per hour	6	8.00	16.31	**782.88**	
Behavioral Support Total:						**2346970.29**
Behavioral Support	per hour	3973	7.00	84.39	**2346970.29**	
Cognitive Rehabilitation Therapy Total:						**481333.65**
Provider-managed	per hour	11	437.00	84.89	**408066.23**	
CDS	per hour	2	437.00	83.83	**73267.42**	
Dental Treatment Total:						**7867333.04**
Dental Treatment	per visit	12964	2.00	303.43	**7867333.04**	

GRAND TOTAL:	**957015814.95**
Total Estimated Unduplicated Participants:	**21945**
Factor D (Divide total by number of participants):	**43609.74**
Average Length of Stay on the Waiver:	356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Dietary Services Total:						**151317.00**
Dietary Services	per hour	1290	2.00	58.65	**151317.00**	
Employment Assistance Total:						**392520.24**
Provider-managed	per hour	501	21.00	35.85	**377177.85**	
CDS	per hour	21	21.00	34.79	**15342.39**	
Minor Home Modifications Total:						**1218731.52**
Minor Home Modifications	per item	256	1.00	4760.67	**1218731.52**	
Nursing Total:						**9041988.12**
Provider-managed	per hour	21097	11.00	38.52	**8939220.84**	
CDS	per hour	249	11.00	37.52	**102767.28**	
Residential Assistance (Host Home/Companion Care, Supervised Living, Residential Support Services) Total:						**718911613.20**
Host Home/Companion Care, Pervasive Plus	per day	16	265.00	156.90	**665256.00**	
Supervised Living, Pervasive Plus	per day	7	176.00	271.30	**334241.60**	
Residential Support, Limited	per day	2054	318.00	150.15	**98073775.80**	
Supervised Living, Intermittent	per day	1068	314.00	141.30	**47385237.60**	
Host Home/Companion Care, Extensive	per day	2022	353.00	99.83	**71255259.78**	
Supervised Living, Limited	per day	1623	324.00	150.15	**78956677.80**	
Residential Support, Pervasive	per day	581	312.00	184.64	**33470062.08**	
Host Home/Companion Care, Limited	per day	4859	354.00	80.79	**138965747.94**	
Residential Support, Pervasive Plus	per day	69	271.00	271.30	**5073038.70**	
Host Home/Companion Care, Intermittent	per day	3128	353.00	77.00	**85022168.00**	
Supervised Living, Extensive	per day	420	324.00	163.05	**22187844.00**	
					69028848.00	

GRAND TOTAL:	**957015814.95**
Total Estimated Unduplicated Participants:	**21945**
Factor D (Divide total by number of participants):	**43609.74**
Average Length of Stay on the Waiver:	356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Support, Extensive	per day	1323	320.00	163.05		
Residential Support, Intermittent	per day	513	275.00	141.30	**19933897.50**	
Host Home /Companion Care, Pervasive	per day	922	352.00	126.47	**41045079.68**	
Supervised Living, Pervasive	per day	126	323.00	184.64	**7514478.72**	
Social Work Total:						**2808.08**
Social Work	per hour	11	4.00	63.82	**2808.08**	
Supported Home Living Total:						**58138397.28**
Provider-managed	per hour	3998	540.00	24.50	**52893540.00**	
CDS	per hour	247	909.00	23.36	**5244857.28**	
Transition Assistance Services Total:						**624651.82**
Transition Assistance Services	per Item	235	1.00	2653.69	**623617.15**	
Transition Assistance Services- Minor Home Modifications	per Item	0	0.00	0.01	**0.00**	
Transition Assistance Services- Assessments for Minor Home Modifications	per Item	13	1.00	79.59	**1034.67**	

GRAND TOTAL:	**957015814.95**
Total Estimated Unduplicated Participants:	**21945**
Factor D (Divide total by number of participants):	**43609.74**
Average Length of Stay on the Waiver:	356