FORM C
Contract Amendment Request
FYs 2016 and 2017 Performance Contract

LIDDA NAME: **All LIDDAs**

COMPONENT CODE: _____ DATE: **September 1, 2016**

Indicate contract elements proposed for amendment: (check all that apply)

☑ Other (please specify) ☐ Report III (submit via SFTP)

Amendment Packet #2

The Department of Aging and Disability Services ("DADS") and the Local Intellectual and Developmental Disability Authority ("LIDDA"), parties to a Performance Contract (the "Contract"), desire to amend the Contract. DADS and the LIDDA, collectively, the "parties," each a "party."

The parties therefore agree as follows:

A. Amendments to Certain Attachments to the Performance Contract

The Performance Contract Attachments identified in this section are revised as follows:

1. **Amendment to Attachment C (relating to FY 17 Allocation Schedule).** Attachment C to the Performance Contract is hereby deleted in its entirety and replaced with new Attachment C.
2. **Amendment to Attachment D (relating to FY 17 Required Local Match Schedule).** Attachment D to the Performance Contract is hereby deleted in its entirety and replaced with new Attachment D.
3. **Amendment to Attachment E (relating to Description of Consumers)**. Attachment E to the Performance Contract is hereby deleted in its entirety and replaced with new Attachment E.
4. **Amendment to Attachment F (relating to Description of IDD Services).** Attachment F to the Performance Contract is hereby deleted in its entirety and replaced with new Attachment F.
5. **Amendment to Attachment G (relating to PASSR Requirements and Enhanced Community Coordination).** Attachment G to the Performance Contract is hereby deleted in its entirety and replaced with new Attachment G.
6. **Amendment to Attachment K (relating to Medicaid Program Enrollment Requirements).** Attachment K to the Performance Contract is hereby deleted in its entirety and replaced with new Attachment K.
7. **Amendment to Attachment N (relating to LIDDA IDD Submission Calendar).** Attachment N to the Performance Contract is hereby deleted in its entirety and replaced with new Attachment N.

8. **Amendment to Attachment Q (relating to Community First Choice: Assessments, Service planning, and Service Coordination)**. Attachment Q to the Performance Contract is hereby deleted in its entirety and replaced with new Attachment Q.
9. **Amendment to Attachment T (relating to Relevant Rules Grid for Providers of LIDDAs).** Attachment T to the Performance Contract is hereby deleted in its entirety and replaced with new Attachment T.
10. **Amendment to Attachment Y (relating to Crisis Respite).** Attachment Y to the Performance Contract is hereby deleted in its entirety and replaced with new Attachment Y.
11. **Amendment to Attachment Z (relating to Crisis Intervention Specialist).** Attachment Z to the Performance Contract is hereby deleted in its entirety and replaced with new Attachment Z.

The new Attachments referenced in this Section A are hereby incorporated by reference into the Performance Contract.

B. Amendments to the FY 2016-2017 Performance Contract

The Performance Contract is amended as follows:

1. **Amendment to Article II, section C (relating to IDD Services).** Section C.5 of the Performance Contract is hereby amended by replacing "37 TAC Chapter 87, Subchapter B, Special Needs Offender Programs, §87.79, (relating to Discharge of Non-sentenced Offenders with Mental Illness or Mental Retardation)" with "37 TAC Chapter 390, Subchapter B, Rules for State-operated Programs and Facilities Treatment, §380.8779, (relating to Discharge of Non-sentenced Offenders with Mental Illness or Intellectual Disability);"

2. **Amendment to Article II, section D (relating to IDD Services).** Section D of the Performance Contract is hereby amended by inserting after section D.42 the following new section D.43 as follows:

   "43. Ensure designated staff receive training as may be required at any time by DADS for the duration of this Contract. DADS will notify the LIDDA of any required training when it becomes available;"

   All sections after the insertion of new section D.43 are hereby renumbered as sections D.44 through D.51.

C. Miscellaneous.

1. **Terms remain in effect.** The parties agree that the terms of the Contract shall remain in effect and continue to govern, except to the extent modified in this Amendment.

2. **Incorporation of Amendment**. By signing this Amendment the parties expressly understand and agree this Amendment is hereby made a part of the Contract as though it were set out word for word in the Contract.

3. **Effective date of the Amendment.** The Amendment is effective on September 1, 2016.

4. **Amendment Execution.** This Amendment may be executed in counterparts, each of which will be deemed an original, and both of which taken together will constitute one and the same document.

DADS and LIDDA represent that each party has caused this Amendment to be signed and delivered by its respective authorized representative.

_____	_____	_____	_____
Signature of Authorized Representative of LIDDA	Date Signed	**Approved by:** Assistant Commissioner Access & Intake Department of Aging and Disability Services	Date Signed

Mail two (2) original signed Amendment Request forms to:

DADS
Access and Intake, LIDDA Section
Attn: Performance Contract Manager
Mail Code W354
P.O. Box 149030
Austin, TX 78714-9030

Overnight Delivery:
Mail Code W354
701 W. 51st Street
Austin, TX 78751

DADS FYs 2016 and 2017 Performance Contract with a Local Intellectual and Developmental Disability Authority (LIDDA) Amendment Packet #2

EXPLANATION OF CHANGES

Contract Document

- *Updated citation in Article II.C.5 regarding consumers referred by the Texas Juvenile Justice Department*
- *Added provision to Article II.D.43 requiring designated staff to receive training as may be required by DADS for the duration of the contract*

Allocation Schedule…… ..... Attachment C

The allocation schedule lists allocations for all for FY 2017.

Required Local Match Schedule….……Attachment D

The local match schedule lists required local match dollar amounts for FY 2017.

Description of Consumers……. ..... Attachment E

The first portion of Section A was revised to add reference to 40 TAC, Chapter 5, Subchapter D (Diagnostic Assessment) and the definition of LIDDA Priority Population revised to be consistent with the rule.

Description of IDD Services……..... Attachment F

On page F-6, the CARE and Grid Codes for Service Coordination have been expanded to address Enhanced Community Coordination for individuals diverting or transitioning from an NF or an SSLC

Requirements Related to Individuals with IDD Residing in or Transferring from Nursing Facilities…….. Attachment G

- *Revised section I.B.1 to add the requirements from Information Letter No. 16-19.*
- *Revised sections I.D.1.b. and I.D.5.a. to require community living options information (CLO) be provided initially and at least semi-annually thereafter. Please note that Amendment Pkt #1 changed CLO from semi-annually to annually. Amendment Pkt #2 changes it back to semi-annually.*
- *Revised section II.B.1. "Use of Designated Funds for Enhanced Community Coordination," by removing bullet 1.a. Crisis respite services. A separate funding source now addresses this item.*
- *Revised section III.C. "Transition to Community Medicaid Program from NF," subsection 2, to clarify the purpose of monitoring and service coordination visits.*
- *Revised section IV.B. "Transition to HCS from SSLC," to add new bullet, 1.d., regarding a pre-move site review required in 40 TAC, §2.277 using DADS Form 8630.*
- *Revised section IV.C. "Transition from SSLC to a setting other than HCS," to add new bullet, 1.c., regarding a pre-move site review required in 40 TAC, §2.277 using DADS Form 8630.*

Medicaid Program Enrollment Requirements.....……...Attachment K

- *Revised section II.M.4. to state that if the LIDDA operates an HCS or TxHmL program and the enrollment is at or above capacity, the LIDDA must redact its provider name from the list of providers given to the consumer or LAR.*
- *Revised section II.N. to require the LIDDA to complete DADS Form 1052 if the HCS or TxHmL program operated by the LIDDA is selected by a consumer or the LAR to be the consumer's program provider. This form must be completed regardless of whether the LIDDA's HCS or TxHmL program enrollment is at or above capacity. The remaining language in section N. is deleted.*

IDD Submission Calendar…….……Attachment N

Revised to add Transition Support Team invoice and report dates and correct date errors.

Community First Choice…… .....Attachment Q

The language in the attachment was extensively revised to reflect the current practice for initial and reassessment eligibility activities and service planning activities.

Relevant Rules Grid for Providers of LIDDAs …… ..... Attachment T

The types of service coordination listed at the bottom of page T-1 and T-2 were revised to be consistent with types of service coordination listed in Attachment F, page F-2.

Crisis Respite……. …… ..... Attachment Y

- *Language in Section B was revised to state that the section is applicable only if the LIDDA does not have an approved crisis plan by August 31, 2016.*
- *Language in Section C related to notification by DADS of the LIDDA's fiscal year 2017 allocation was deleted.*
- *New Section E. "Communication to Stakeholders" was added to require the LIDDA to communicate to stakeholders its provision of crisis respite within its funded allocation.*

Crisis Intervention Specialist……..... Attachment Z

- *Language in Subsections A. B. and C. under Section III related to the lead crisis intervention specialist, additional staff and qualifications was revised.*
- *New Section III.F. "Communication to Stakeholders" was added to require the LIDDA to communicate to stakeholders about the creation of the crisis intervention specialist and the general duties of the position.*

Attachment C
Allocation Schedule
FY 2017 Summary - Amendment #2

Comp #	Community Center	General Revenue	Permanency Planning	CLOIP	Enhanced Community Coordination*	Transition Support Teams*	IDD Crisis Intervention Specialists 1 FTE=$132,216	IDD Crisis Respite Services	Nursing Facility PASRR Service Coordination	Total FY 2017 Allocation
010	Betty Hardwick Center	632,566	23,348	382,042	$ 8,970.25		$ 132,216	$ 30,599.31	$83,066	$ 1,292,808
020	Texas Panhandle Centers	3,211,415	12,971	-	$ 45,540.23		$ 132,216	$ 69,961.10	$132,775	$ 3,604,878
030	Austin Travis County Integral Care	2,655,100	34,589	322,348	$ 37,651.28	$ 178,787.67	$ 264,432	$ 193,309.54	$293,675	$ 3,979,892
040	Central Counties Center for MHMR	1,230,422	17,295		$ 17,448.29		$ 132,216	$ 82,471.50	$184,447	$ 1,664,300
051	Alamo Local Authority for IDD	3,411,959	66,584	208,531	$ 48,384.10		$ 198,324	$ 316,619.85	$442,802	$ 4,693,204
060	Center for Life Resources	481,759	6,918		$ 6,831.70		$ 132,216	$ 16,977.57	$77,834	$ 722,536
070	Central Plains Center	482,088	865		$ 6,836.36		$ 132,216	$ 16,095.69	$56,904	$ 695,005
090	El Paso MHMR	1,682,830	10,377	103,470	$ 23,863.77	$ 85,640.37	$ 396,648	$ 146,745.13	$11,773	$ 2,461,347
100	Gulf Coast Center	1,793,256	23,348		$ 25,429.69		$ 132,216	$ 113,234.24	$77,834	$ 2,165,318
110	Gulf Bend MHMR Center	335,940	5,188		$ 4,763.88		$ 132,216	$ 30,371.66	$153,705	$ 662,185
130	Tropical Texas Behavioral Health	2,286,852	16,430	59,694	$ 32,429.25		$ 264,432	$ 229,479.44	$122,964	$ 3,012,281
140	Spindletop Center	3,238,517	16,430	-	$ 45,924.56		$ 132,216	$ 73,986.35	$156,322	$ 3,663,396
150	Lubbock Regional MHMR Center	982,249	19,889	206,939	$ 13,929.02	$ 98,202.99	$ 132,216	$ 56,029.01	$99,418	$ 1,608,872
160	MHMR Services for the Concho Valley	516,941	17,295	211,715	$ 7,330.60		$ 132,216	$ 21,621.54	$47,093	$ 954,212
170	Permian Basin Community Centers	901,880	10,377	-	$ 12,789.32		$ 132,216	$ 56,782.45	$56,904	$ 1,170,949
180	MHMR of Nueces County	501,687	12,971	269,817	$ 7,114.29	$ 115,668.11	$ 132,216	$ 59,686.94	$68,677	$ 1,167,837
190	Andrews Center	1,222,625	19,024	-	$ 17,337.72		$ 132,216	$ 70,200.48	$165,479	$ 1,626,882
200	MHMR of Tarrant County	6,124,140	63,990	-	$ 86,844.82	$ 188,286.24	$ 264,432	$ 328,787.69	$568,383	$ 7,624,864
220	Heart of Texas Region MHMR Center	1,256,867	21,618	327,123	$ 17,823.30		$ 198,324	$ 60,895.02	$267,513	$ 2,150,163
230	Helen Farabee Centers	1,089,519	20,754		$ 15,450.18		$ 132,216	$ 52,682.92	$179,868	$ 1,490,490
240	Community Healthcore	1,230,104	26,807		$ 17,443.78		$ 264,432	$ 78,730.04	$457,192	$ 2,074,709
250	MHMR Authority of Brazos Valley	817,193	15,565	279,368	$ 11,588.40		$ 198,324	$ 58,599.36	$113,807	$ 1,494,445
260	Burke Center	789,977	18,159	308,817	$ 11,202.46		$ 198,324	$ 66,397.44	$281,902	$ 1,674,779
280	MHMR Authority of Harris County	8,681,794	133,167		$ 123,114.25		$ 396,648	$ 751,369.33	$390,477	$ 10,476,570
290	MHMR of Texoma	727,894	5,188	-	$ 10,322.07		$ 132,216	$ 33,834.13	$108,575	$ 1,018,029
300	Metrocare SERVICES	7,063,374	48,425	-	$ 100,163.86	$ 413,800.76	$ 396,648	$ 508,213.83	$369,547	$ 8,900,172
350	Pecan Valley Centers	630,283	19,024	-	$ 8,937.88		$ 132,216	$ 74,137.40	$168,095	$ 1,032,693
380	Tri-County Services	1,637,009	19,889	-	$ 23,214.00		$ 132,216	$ 119,592.28	$156,322	$ 2,088,242
400	Denton County MHMR Center	1,291,487	14,700	492,674	$ 18,314.24		$ 264,432	$ 134,932.88	$108,575	$ 2,325,115
410	LifePath Systems	1,167,464	15,565		$ 16,555.50		$ 264,432	$ 162,922.04	$73,255	$ 1,700,194
430	Texana Center	2,428,001	45,831	382,042	$ 34,430.85	$ 305,486.38	$ 198,324	$ 155,612.12	$134,738	$ 3,684,465
440	Anderson-Cherokee Community Enrichment Services	996,545	4,324	-	$ 14,131.74		$ 132,216	$ 19,071.16	$90,261	$ 1,256,549
450	West Texas Centers	970,844	12,106	-	$ 13,767.28		$ 198,324	$ 37,274.81	$87,645	$ 1,319,961
460	Bluebonnet Trails Community Centers	2,550,222	18,159		$ 36,164.03		$ 198,324	$ 156,653.30	$232,193	$ 3,191,715
470	Hill Country MHDD Centers	1,787,386	16,430		$ 25,346.45	$ 146,155.47	$ 198,324	$ 111,807.58	$182,484	$ 2,467,934
475	Coastal Plains Community Center	1,259,876	3,459		$ 17,865.97		$ 132,216	$ 38,650.95	$16,352	$ 1,468,420
480	Lakes Regional MHMR Center	1,965,829	21,618		$ 27,876.91		$ 132,216	$ 27,807.08	$217,804	$ 2,393,151
485	Border Region MHMR Community Center	1,455,300	4,324		$ 20,637.23		$ 198,324	$ 62,113.51	$26,163	$ 1,766,862
490	Camino Real Community Services	1,416,321	1,729		$ 20,084.48		$ 132,216	$ 37,755.37	$77,834	$ 1,685,940
	Community Services TOTAL	**$ 72,905,515**	**$ 864,730**	**$ 3,554,580**	**$ 1,033,854.00**	**$ 1,532,028**	**$ 7,337,988**	**$ 4,662,012**	**$ 6,540,657.00**	**$ 98,431,364**

*Amendment #2 allocations for Enhanced Community Coordination and Transition Support Teams is provided for the period covering 9/1/16-12/31/16 only.

Attachment D
FY 2017 Local Authorities Required Local Match
Amendment #2

Component #	Local Intellectual and Developmental Disability Authorities	Allocations Requiring Local Match	Required Match %	Required Local Match $ Amount
010	Betty Hardwick Center	632,566	9.0%	56,931
020	Texas Panhandle Centers	3,211,415	10.0%	321,142
030	Austin Travis County Integral Care	2,655,100	12.0%	318,612
040	Central Counties Center for MHMR	1,230,422	9.0%	110,738
051	Alamo Local Authority for IDD	3,411,959	9.0%	307,076
060	Center for Life Resources	481,759	9.0%	43,358
070	Central Plains Center	482,088	8.0%	38,567
090	El Paso MHMR	1,682,830	7.0%	117,798
100	Gulf Coast Center	1,793,256	10.0%	179,326
110	Gulf Bend MHMR Center	335,940	10.0%	33,594
130	Tropical Texas Behavioral Health	2,286,852	5.0%	114,343
140	Spindletop Center	3,238,517	9.0%	291,467
150	Lubbock Regional MHMR Center	982,249	8.0%	78,580
160	MHMR Services for the Concho Valley	516,941	9.0%	46,525
170	Permian Basin Community Centers	901,880	15.0%	135,282
180	MHMR of Nueces County	501,687	9.0%	45,152
190	Andrews Center	1,222,625	9.0%	110,036
200	MHMR of Tarrant County	6,124,140	10.0%	612,414
220	Heart of Texas Region MHMR Center	1,256,867	8.0%	100,549
230	Helen Farabee Centers	1,089,519	9.0%	98,057
240	Community Healthcore	1,230,104	9.0%	110,709
250	MHMR Authority of Brazos Valley	817,193	8.0%	65,375
260	Burke Center	789,977	8.0%	63,198
280	MHMR Authority of Harris County	8,681,794	12.0%	1,041,815
290	MHMR of Texoma	727,894	9.0%	65,510
300	Metrocare SERVICES	7,063,374	11.0%	776,971
350	Pecan Valley Centers	630,283	9.0%	56,725
380	Tri-County Services	1,637,009	11.0%	180,071
400	Denton County MHMR Center	1,291,487	10.0%	129,149
410	LifePath Systems	1,167,464	13.0%	151,770
430	Texana Center	2,428,001	11.0%	267,080
440	Anderson-Cherokee Community Enrichment Services	996,545	7.0%	69,758
450	West Texas Centers	970,844	9.0%	87,376
460	Bluebonnet Trails Community Centers	2,550,222	8.0%	204,018
470	Hill Country MHDD Centers	1,787,386	9.0%	160,865
475	Coastal Plains Community Center	1,259,876	8.0%	100,790
480	Lakes Regional MHMR Center	1,965,829	8.0%	157,266
485	Border Region MHMR Community Center	1,455,300	6.0%	87,318
490	Camino Real Community Services	1,416,321	8.0%	113,306
	Local Authority Total	**$ 72,905,515.00**		**$ 7,048,618**

ATTACHMENT E
Description of Consumers

A. LIDDA Priority Population

In accordance with the definition of "LIDDA priority population" found in 40 TAC, Chapter 5, Subchapter D (Diagnostic Assessment), the LIDDA priority population is a group comprised of persons who meet one or more of the following descriptions:

- A person with an intellectual disability, as defined by Texas Health and Safety Code §591.003;
- A person with autism spectrum disorder, as defined in the Diagnostic and Statistical Manual of Mental Disorders;
- A person with a related condition, listed in http://www.dads.state.tx.us/providers/guidelines/ICD-9-CM_Diagnostic_Codes.pdf, who is eligible for, and enrolling in services in the ICF/IID Program, Home and Community-based Services (HCS) Program, or Texas Home Living (TxHmL) Program;
- A nursing facility resident who is eligible for specialized services for intellectual disability or a related condition pursuant to Section 1919(e)(7) of the Social Security Act;
- A child who is eligible for Early Childhood Intervention services through the Health and Human Services Commission; and
- A person diagnosed by an authorized provider as having a pervasive developmental disorder through a diagnostic assessment completed before November 15, 2015.

The determination of eligibility for the priority population must be made through the use of assessments and evaluations performed by qualified professionals. Individuals who are members of the priority population are eligible to receive IDD services identified in Attachment F, as appropriate for the individual's level of need, eligibility for a particular service, and the availability of that service.

Since resources are insufficient to meet the service needs of every consumer in the priority population, services should be provided to meet the most intense needs first. Intense needs are determined as follows:

- an individual is in danger or at risk of losing his or her support system, especially the living arrangement or supports needed to maintain self;
- an individual is at risk of abuse or neglect;
- an individual's basic health and safety needs not being met through current supports;
- an individual is at risk for functional loss without intervention or preventive or maintenance services; or
- an individual demonstrates repeated criminal behavior.

B. Miscellaneous

An LIDDA may serve consumers who have resided in a state supported living center on a regular admission status, but who may not be in the priority population.

ATTACHMENT F
Description of IDD Services

* Indicates that the LIDDA must establish a reasonable standard charge for this service. For those services that have multiple grid codes (as listed on the last page of this attachment), the LIDDA must establish a standard charge for each service grid code.

SERVICE CATEGORY	DESCRIPTION -- Additional requirements are contained in the Service Definition Manual, available at www.dads.state.tx.us	Required by Law / Optional
Screening (a service that is an authority function that may be subcontracted)	Gathering information to determine a need for services. This service is performed face-to-face or by telephone contact with persons. Screening includes the process of documenting consumers' initial and updated preferences for services and the LIDDA's biennial contact of consumers on the HCS Interest List. The service does not include providing information and referrals.	Optional
Eligibility Determination (a service that is an authority function that may be subcontracted)	An interview and assessment or an endorsement conducted in accordance with Texas Health and Safety Code, §593.005, and 40 TAC Chapter 5, Subchapter D to determine if an individual has an intellectual disability or is a member of the IDD priority population.	Required This meets the requirements of §534.053(a)(3).
* Service Coordination (a service that is an authority function that may NOT be subcontracted)	Assistance in accessing medical, social, educational, and other appropriate services and supports that will help a consumer achieve a quality of life and community participation acceptable to the consumer as described in the plan of services and supports. Service coordination functions are: ▪ assessment — identifying the consumer's needs and the services and supports that address those needs as they relate to the nature of the consumer's presenting problem and disability; ▪ service planning and coordination — identifying, arranging, advocating, collaborating with other agencies, and linking for the delivery of outcome-focused services and supports that address the consumer's needs and desires; ▪ monitoring — ensuring the consumer receives needed services, evaluating the effectiveness and adequacy of services, and determining if identified outcomes are meeting the consumer's needs and desires; and ▪ crisis prevention and management — linking and assisting the consumer to secure services and supports that will prevent or manage a crisis. The plan of services and supports is based on a person-directed process that is consistent with the DADS *Person Directed Planning Guidelines* and describes: ▪ the consumer's desired outcomes; and ▪ the services and supports, including service coordination services, to be provided to the consumer, with specifics concerning frequency and duration.	Required This meets the requirements of §534.053(a)(4),(5).

SERVICE CATEGORY	DESCRIPTION -- Additional requirements are contained in the Service Definition Manual, available at www.dads.state.tx.us	Required by Law / Optional
	This service category includes the following:	
	A. Basic Service Coordination: Service Coordination performed in accordance with 40 TAC Chapter 2, Subchapter L.	
	B. Continuity of Services: Activities performed in accordance with: ▪ 40 TAC Chapter 2, Subchapter F, for a consumer residing in an SSLC whose movement to the community is being planned or for a consumer who formerly resided in a state facility and is on community-placement status, or ▪ Article II. B. 4. of this Contract for a consumer enrolled in the ICF/IID program to maintain the consumer's placement or to develop another placement for the consumer.	
	C. Service Authorization and Monitoring: Services provided to a consumer who is assessed as having a single need (provision of this service counts toward Total Served if the consumer is receiving no other general revenue-funded IDD service).	
	D. Service Coordination – HCS or TxHmL Program Service Coordination for consumers enrolled in the Home and Community-based Services (HCS) Program or Texas Home Living (TxHmL) Program in accordance with 40 TAC Chapter 9, Subchapter D or Subchapter N.	
* IDD Community Services (provider services that may be subcontracted)	Services provided to assist a consumer to participate in age-appropriate community activities and services. The type, frequency, and duration of services are specified in the consumer's plan of services and supports. This service category includes:	
	A. Community Support: Individualized activities that are consistent with the consumer's plan of services and supports and provided in the consumer's home and at community locations (e.g., libraries and stores). Supports include: ▪ habilitation and support activities that foster improvement of, or facilitate, a consumer's ability to perform functional living skills and other daily living activities; ▪ activities for the consumer's family that help preserve the family unit and prevent or limit out-of-home placement of the consumer; ▪ transportation for a consumer between home and the consumer's community employment site or day habilitation site; and ▪ transportation to facilitate the consumer's employment opportunities and participation in community activities.	Optional

SERVICE CATEGORY	DESCRIPTION -- Additional requirements are contained in the Service Definition Manual, available at www.dads.state.tx.us	Required by Law / Optional
	B. Respite: Planned or emergency short-term relief services provided to the consumer's unpaid caregiver when the caregiver is temporarily unavailable to provide supports due to non-routine circumstances. This service provides a consumer with personal assistance in daily living activities (e.g., grooming, eating, bathing, dressing and personal hygiene) and functional living tasks. The service includes assistance with: planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulating and mobility; reinforcement of behavioral support or specialized therapies activities; assistance with medications and the performance of tasks delegated by an RN in accordance with state law; and supervision of the consumer's safety and security. The service also includes habilitation activities, use of natural supports and typical community services available to all people, social interaction and participation in leisure activities, and assistance in developing socially valued behaviors and daily living and functional living skills.	Required This meets the requirements of §534.053(a)(4).
	C. Employment Assistance: Assistance to a consumer in locating paid, individualized, competitive employment in the community, including: ▪ helping the consumer identify employment preferences, job skills, work requirements and conditions; and ▪ identifying prospective employers offering employment compatible with the consumer's identified preferences, skills, and work requirements and conditions.	Optional
	D. Supported Employment: Supported employment is provided to a consumer who has paid, individualized, competitive employment in the community (i.e., a setting that includes non-disabled workers) to help the consumer sustain that employment. It includes individualized support services consistent with the consumer's plan of services and supports as well as supervision and training.	Optional
	E. Behavioral Support: Specialized interventions by professionals with required credentials to assist a consumer to increase adaptive behaviors and to replace or modify maladaptive behavior that prevent or interfere with the consumer's inclusion in home and family life or community life. Support includes: ▪ assessing and analyzing assessment findings so that an appropriate behavior support plan may be designed; ▪ developing an individualized behavior support plan consistent with the outcomes identified in the consumer's plan of services and supports; ▪ training and consulting with family members or other providers and, as appropriate, the consumer; ▪ and monitoring and evaluating the success of the behavioral support plan and modifying the plan as necessary.	Optional
	F. Nursing: Treatment and monitoring of health care procedures prescribed by physician or medical practitioner or required by standards of professional practice or state law to be performed by licensed nursing personnel.	Optional

SERVICE CATEGORY	DESCRIPTION -- Additional requirements are contained in the Service Definition Manual, available at www.dads.state.tx.us	Required by Law / Optional
	G. Specialized Therapies: Specialized therapies are: ▪ assessment and treatment by licensed or certified professionals for: • social work services; • counseling services; • occupational therapy; • physical therapy; • speech and language therapy; • audiology services; • dietary services; and • behavioral health services, other than those provided by a local mental health authority pursuant to its contract with the Department of State Health Services (DSHS); and ▪ training and consulting with family members or other providers.	Optional
	H. Vocational Training: Day Training Services provided to a consumer in an industrial enclave, a work crew, a sheltered workshop, or an affirmative industry, to enable the consumer to obtain employment. Contract funds are not used for the cost of production.	Optional
	I. Day Habilitation: Assistance with acquiring, retaining, or improving self help, socialization, and adaptive skills necessary to live successfully in the community and to participate in home and community life. Individualized activities are consistent with achieving the outcomes identified in the consumer's plan of services and supports and activities are designed to reinforce therapeutic outcomes targeted by other service components, school or other support providers. Day habilitation is normally furnished in a group setting other than the consumer's residence for up to six (6) hours a day, five (5) days per week on a regularly scheduled basis. The service includes personal assistance for consumers who cannot manage their personal care needs during the day habilitation activity as well as assistance with medications and the performance of tasks delegated by a RN in accordance with state law.	Optional
Crisis Intervention Specialist	**J. Lead Crisis Intervention Specialist:** a full-time employee or contract employee who oversees all activities required by Attachment Z and who is not assigned responsibilities, duties, or tasks other than those described in section III.E. of Attachment Z.	Required by contract
	K. Additional Staff: staff who support the Lead Crisis Intervention Specialist in accordance with Attachment Z and who is prohibited from providing service coordination.	

SERVICE CATEGORY	DESCRIPTION -- Additional requirements are contained in the Service Definition Manual, available at www.dads.state.tx.us	Required by Law / Optional
Crisis Respite	**L. Crisis Respite – Out-of-Home:** Therapeutic support provided in a safe environment with staff on-site providing 24-hour supervision to an individual who is demonstrating a crisis that cannot be stabilized in a less intensive setting. Out of home respite is provided in a setting for which the state provides oversight (for example, an ICF, a HCS group home, a DSHS-authorized crisis respite facility or crisis residential facility).	Required by contract
	M. Crisis Respite – In-Home: Therapeutic support provided to an individual, who is demonstrating a crisis, in the individual's home when it is deemed clinically appropriate for the individual to remain in his/her natural environment and it is anticipated the crisis can be stabilized within a 72-hour period.	
Residential Services (provider services that may be subcontracted)	Twenty-four hour services provided to a consumer who does not live independently or with his or her natural family. These services are provided by employees or contractors of the LIDDA who regularly stay overnight in the consumer's home. This service category includes:	Optional
	A. Family Living: Residential Services provided to no more than three consumers living in a single residence that is not a Contracted Specialized Residence.	
	B. Residential Living: Residential Services provided to more than three consumers living in a single residence that is not a Contracted Specialized Residence.	
	C. Contracted Specialized Residences: Residential Services provided to a consumer in a general hospital, a substance abuse program, an autism program, or an AIDS hospice.	

Service Category	CARE Code	Grid Code	Name of Service	Report III-IDD Crosswalk
Screening	NA	311	Screening	A.1.1
Eligibility Determination	R005	321	Eligibility Determination (DID / endorsement)	A.1.1
NA	NA	323	ICAP without DID	A.1.1
Service Coordination and Enhanced Community Coordination (ECC)	R014 RONF RONR	351	Basic Service Coordination (SC)	A.1.1
	R019	341	SC – Continuity of Services	A.1.1
	R017	355	SC - Service Authorization and Monitoring	A.1.1
	R014 R01A	351	SC - HCS or TxHmL Program R014 is used to represent the service delivery and R01A is used to identify the service coordinator. Both codes are necessary.	A.1.1
	RONF R019 R014 R01A	347	ECC – Pre-Move Site Review (diverting or transitioning from an NF or SSLC as required by Attachment G) Note: A service coordinator may use this grid code if the service coordinator meets the qualifications and experience of an enhanced community coordinator and maintains a caseload of no more than 30 individuals.	A.1.1
	RONF R019 R014 R01A	348	ECC – Post-Move Monitoring Review (diverting or transitioning from an NF or SSLC as required by Attachment G) Note: A service coordinator may use this grid code if the service coordinator meets the qualifications and experience of an enhanced community coordinator and maintains a caseload of no more than 30 individuals.	A.1.1
	RONF RONR	366	SC – Community Living Options (CLO)	A.1.1
	RONF	370	SC – Any NF SPT exclusive of the Initial or Quarterly SPT	A.1.1
	RONF	371	SC – Initial/Renewal	A.1.1
	RONF	372	SC – Quarterly Service Planning Meeting	A.1.1
	RONF R019 R014 R01A	373	ECC – Transition Planning for individual who is diverting or transitioning from an NF or SSLC Note: A service coordinator may use this grid code if the service coordinator meets the qualifications and experience of an enhanced community coordinator and maintains a caseload of no more than 30 individuals.	A.1.1
	RONF R019 R014 R01A	374	ECC – Other ECC activities not otherwise identified above for an individual who is diverting or transitioning from an NF or SSLC, Note: A service coordinator may use this grid code if the service coordinator meets the qualifications and experience of an enhanced community coordinator and maintains a caseload of no more than 30 individuals.	A.1.1

IDD Community Services	R021	3101	Community Support	A.4.2
	R022	3122 hourly, 3132 daily	Out-of-Home Respite	A.4.2
	R023	3123 hourly, 3133 daily	In-Home Respite	A.4.2
	R041	3401	Employment Assistance	A.4.2
	R042	3402	Supported Employment	A.4.2
	R043	3403	Vocational Training	A.4.2
	R053	3104	Day Habilitation	A.4.2
	R055	3206	Behavioral Support	A.4.2
	R054	3209	Nursing	A.4.2
	RO54	3201 speech / language 3202 PT 3203 OT 3211 behavioral health services 3210 social work, counseling, audiology, and dietary	Specialized Therapies	A.4.2
Crisis Respite	NA	3112	Crisis Respite Out-of-Home	A.4.2
	NA	3113	Crisis Respite In-Home	A.4.2
Crisis Intervention Specialist	NA	3207	Lead Crisis Intervention Specialist	A.4.2
	NA	3208	Crisis Intervention Specialist (Additional Staff)	A.4.2
Residential Services	R031	3301	Residential - Family Living	A.4.2
	R032	3304	Residential Living	A.4.2
	R033	3303	Contracted Specialized Residences	A.4.2
NA	NA	360	Benefits Eligibility Determination	A.1.1
NA	NA	345	Permanency Planning Review	A.1.1
NA	NA	365	Community Living Options Information Process (CLOIP)	A.4.2
NA	NA	311	PASRR Level II Evaluation	A.1.1.

ATTACHMENT G
PASRR Requirements and Enhanced Community Coordination

I. Requirements for a LIDDA relating to Individuals Residing in a Nursing Facility

A. Definition of terms used in Section I of this Attachment G:

1. "Individual" means an individual 21 years of age or older with an intellectual disability, related condition, or both, who is a Medicaid recipient.

2. "Individual in a nursing facility" means an individual who is admitted to and residing in a nursing facility and has been referred for a stay greater than 30 consecutive days.

B. Pre Admission Screening and Resident Review (PASRR)

The LIDDA must:

1. Comply with all PASRR requirements set forth in the LIDDA's Medicaid Provider Agreement for the Provision of Intellectual Disability Service Coordination and PASRR and 40 Texas Administrative Code (TAC), Chapter 17. If, during a PASRR Evaluation, the LIDDA suspects an individual of having ID or DD but is unable to confirm the individual has a diagnosis of ID or DD due to lack of records or access to family history, the LIDDA must ensure compliance with the requirements in Section I.B.1.a-c of this Attachment G.

   a. The LIDDA staff conducting the PE must:
      i. complete a "referral" in Section F1000 of the PE:
         I) in Section F1000A, mark 19 for "Other";
         II) in Section F1000B, enter a statement that the individual is being referred for a Determination of Intellectual Disability (DID);
         III) enter the phone number of the LIDDA staff completing the PE in F1000C;
         IV) in Section F1000D, enter the "date of referral" for the DID; and
         V) mark the PE negative to indicate the individual does not have ID or DD (i.e., in Sections B0100 and B0200, enter "No"); and
      ii. not send the individual or LAR a notice of denial of eligibility for specialized services and an opportunity for a fair hearing.

   b. The LIDDA must:
      i. within 45 calendar days after the "date of referral" entered in Section F1000D, ensure a DID is conducted on the individual in accordance with DADS rules governing diagnostic assessment (40 TAC, Chapter 5, Subchapter D); and

ii. within 30 calendar days after the DID is conducted, submit a copy of the written DID report to the DADS PASRR unit via the Secure File Transfer Protocol (SFTP) file folder named "PASRR Reporting."

c. The LIDDA must:
   i. If the DID report indicates the individual does not have ID or DD, then the LIDDA must:
      I) enter a note on the previously completed negative PE by clicking on the "add note" button on the yellow Form Action bar of the PE and state that the individual does not have ID or DD per the result of the DID; and
      II) send the individual or LAR a notice of denial of eligibility for specialized services and an opportunity for a fair hearing.
   ii. If the DID report indicates the individual has ID or DD, then, within seven calendar days after the DID report is completed, the LIDDA must complete a new PE for the individual and mark it positive to indicate the individual has ID or DD.

2. Within five working days after the initial interdisciplinary team (IDT) meeting, document the following information in the Long Term Services (LTS) online portal:
   a. Confirm if representatives of the LIDDA attended the IDT meeting, either in person or by telephone; and
   b. Either agree or disagree that the specialized services listed in the LTS online portal for an individual were those that were agreed upon during the individual's IDT meeting.

C. Nursing Facility Diversion

1. The LIDDA must designate a staff member as the Diversion Coordinator who:
   a. is at least credentialed as a qualified intellectual disabilities professional (QIDP); and
   b. has experience in coordinating or providing services to individuals with IDD, including those with complex medical needs, in the community.

2. The LIDDA must ensure that the Diversion Coordinator performs the following duties:
   a. Identify available community living options, services, and supports to assist individuals to successfully live in the community;
   b. Provide information and assistance to service coordinators and other LIDDA staff who are facilitating diversion for individuals at risk of admission to a nursing facility and for individuals transitioning to the community from a nursing facility;
   c. Coordinate educational activities for service coordinators and other LIDDA staff about available community services and about strategies to avoid nursing facility placement;

d. Within 45-75 calendar days after an individual is admitted into a nursing facility, review the individual's admission to ensure that community living options, services and supports that could provide an alternative to nursing facility placement have been explored and if not, refer the individual to his or her service coordinator for that purpose;
e. On a quarterly basis, as indicated in the PASRR Reporting Manual, report to DADS the number of individuals admitted to nursing facilities, diverted from nursing facilities, and residing in a nursing facility for more than 90 days; and
f. On a quarterly basis, as indicated in the PASRR Reporting Manual, provide DADS with information about barriers individuals have experienced in moving from a nursing facility to the community.

3. When conducting a PASRR Evaluation (PE), the LIDDA must inform the individual referred for admission to a nursing facility, their family, and the legally authorized representative (LAR) of the community options, services, and supports for which the individual may be eligible. The LIDDA, under the direction of the Diversion Coordinator, must identify, arrange, and coordinate access to these services in order to avoid admission to a nursing facility, wherever possible and consistent with an individual's informed choice.

4. The LIDDA's initiation of enrollment in HCS as a diversion from admission to a nursing facility must occur before the individual's admission to a nursing facility when, consistent with the PE, community living options, services, and/or supports provide an appropriate alternate placement to avoid admission to a nursing facility, consistent with the individual's choice.

5. The LIDDA must ensure no individual in a nursing facility will be served in another nursing facility or in a residential setting that serves more than four individuals, and that no individual who has transitioned from a nursing facility will be served in a residential setting that serves more than six individuals, unless the Diversion Coordinator:
   a. In consultation with the individual's service planning team (SPT), attempted and was unable to address barriers to placement in a more integrated setting; and
   b. Verified that the individual, family, and/or LAR made an informed decision regarding alternate living options.

D. Service Coordination

1. The LIDDA must assign a service coordinator to an individual in a nursing facility within 30 calendar days after completion of the individual's PE.
   a. If the individual refuses service coordination, the service coordinator must use Form 1044 (Refusal of Service Coordination for Individuals Residing in Nursing Facilities) to document the refusal, obtain necessary signatures

and maintain documentation copy of the completed form in the individual's record.

b. For an individual who refuses service coordination, the LIDDA must ensure the individual receives information about the range of community living options (CLO) using DADS developed materials during the individual's initial meeting with a service coordinator and at least annually thereafter, documenting the discussion on DADS Form 1039 (Community Living Options);

2. The LIDDA must ensure the assigned service coordinator for an individual in a nursing facility:
   a. Meets face-to-face with the individual on a monthly basis, or more frequently, if needed;
   b. Within 30 calendar days after the completion of the PE, facilitates the development of the individual's ISP on Form 1041 (Individual Service Plan/Transition Plan – NF) with the individual's service planning team (SPT), including documenting SPT discussions;
   c. Facilitates revisions to the individual's ISP on Form 1041 (Individual Service Plan/Transition Plan – NF), as needed, including documenting SPT discussions;
   d. Facilitates coordination between an individual's ISP and the nursing facility's plan of care;
   e. Facilitates the coordination of the individual's specialized services; and
   f. Monitors the delivery of all services and supports provided to the individual.

3. The LIDDA must ensure the assigned service coordinator for an individual in a nursing facility convenes the individual's SPT at least quarterly, or more frequently if requested by the individual or LAR, or if there is a change in service needs. Quarterly SPT meetings must take place every three months in accordance with the instructions for Form 1041 (Individual Service Plan/Transition Plan – NF).

4. The assigned service coordinator must complete the *PASRR Specialized Services Form* for every SPT meeting (initial, quarterly, and any updates). The LIDDA must submit the information on the completed form via the Long-Term Care Portal.

5. The LIDDA must ensure the assigned service coordinator for an individual in a nursing facility:
   a. Provides information and discusses with the individual and LAR about the range of community living options (CLO) using DADS developed materials during the individuals initial meeting with the service coordinator and at least semi-annually thereafter, documenting the discussion on DADS Form 1039 (Community Living Options);

b. Facilitates visits to community programs, when appropriate, and addresses concerns about community living with the SPT; and
c. Offers the individual and LAR opportunities for educational and informational activities described in Section I.F.2. of this attachment.

6. The LIDDA must ensure the assigned service coordinator completes Section 9 (Transition Plan to the Community) Phase I of the individual service plan (DADS Form 1041) for an individual in a nursing facility:
   a. whose MDS 3.0 indicates the individual is interested in speaking with someone about transitioning to the community;
   b. whose PASRR evaluation reflects that the individual's needs can be met in an appropriate community setting; or
   c. who expresses an interest in transitioning to the community.

E. Service Planning Team

1. For an individual in a nursing facility for whom the LIDDA provides service coordination, the LIDDA must ensure the individual's SPT includes the following persons:
   a. the individual being served;
   b. his or her LAR, if any;
   c. the service coordinator;
   d a nursing facility staff familiar with the individual's needs;
   e. persons providing specialized services for the individual;
   f. DADS contracted relocation specialist, if the individual desires to move to the community;
   g. a representative from the community Medicaid program provider, if one has been selected; and
   h. other participants such as:
      i. a concerned person whose inclusion is requested by the individual or the LAR; and
      ii. at the discretion of the LIDDA, other persons who are directly involved in the delivery of services to individuals with IDD.

2. The SPT must ensure an individual in a nursing facility, regardless of whether he or she has an LAR, participates in the SPT to the fullest extent possible and will receive the support necessary to do so, including, but not limited to, communication supports.

3. The LIDDA must ensure the SPT:
   a. develops an ISP using Form 1041 (Individual Service Plan/Transition Plan – NF) that:
      i. Is individualized and developed through a person-centered process;
      ii. Identifies the individual's:
         I) strengths;

II) preferences;
III) psychiatric, behavioral, nutritional management, and support needs; and
IV) desired outcomes;

iii. Identifies the specific specialized services to be provided to the individual, including the amount, intensity, and frequency of each specialized service; and

iv. Identifies the services and supports that are needed to meet the individual's needs, achieve the desired outcomes, and maximize the person's ability to live successfully in the most integrated setting possible;

b. is responsible for planning, ensuring the implementation of, and monitoring all specialized services identified in the ISP, and transition planning in coordination with the nursing facility's care planning team;

c. ensures the individual's ISP, including specialized services, is integrated into the nursing facility's plan of care and that specialized services are planned, provided, and monitored in a consistent manner, and integrated with the services provided by the nursing facility; and

d. assesses the adequacy of the services and supports that the individual is receiving; and

e. monitors the individual's ISP to make timely additional referrals, service changes, and amendments to the plan as needed.

F. Administrative Requirements

1. Upon notice from and in a format approved by DADS, the LIDDA must provide data and other information related to the services and requirements described in this Attachment G.

2. At least semi-annually, the LIDDA must provide or arrange for the provision of educational or informational activities addressing community living options for individuals in nursing facilities in the LIDDAs local service area and their families. These activities may include family-to-family and peer-to-peer programs, providing information about the benefits of community living options, facilitating visits in such settings, and offering opportunities to meet with other individuals who are living, working, and receiving services in integrated settings, with their families, and with community providers.
   a. These educational or informational activities must be provided by persons who are knowledgeable about community services and supports.
   b. These activities must not be provided by nursing facility staff or others with a contractual relationship with nursing facilities.

c. The LIDDA must maintain documentation related to an offer of and attendance at educational or informational activities in the record for each individual in a nursing facility.
d. The LIDDA must maintain evidence of the content of and attendance at each semi-annual educational or informational activity.

3. The LIDDA must maintain a list of all individuals in a nursing facility who express an interest in transitioning to the community to any employee, contractor, or provider of specialized services. For each individual on the list, the LIDDA must notify the service coordinator to discuss community living options.

4. For an individual in a nursing facility, the LIDDA must request reimbursement for the delivery of specialized services provided by the LIDDA in accordance with DADS instructions on DADS Form 1048 (Summary Sheet for Services to Individuals with IDD in a Nursing Facility).

5. For an individual in a nursing facility receiving service coordination who is <u>not</u> transitioning to the community, the LIDDA must fund service coordination using the Nursing Facility PASRR Service Coordination allocation set forth in Attachment C (Allocation Schedule).

6. For an individual in a nursing facility receiving service coordination who is transitioning to the community, the LIDDA must fund service coordination through Targeted Case Management.

II. Enhanced Community Coordination.

A. Qualifications and Duties of Enhanced Community Coordinator

For all individuals diverting or transitioning from a nursing facility (NF) or state supported living center (SSLC) as required in Sections III and IV of this Attachment G, the LIDDA shall ensure:

1. the individual is assigned an enhanced community coordinator who:
   a. meets the qualifications of a service coordinator in accordance with 40 TAC, §2.559 (Minimum Qualifications); and
   b. has extensive experience in providing service coordination to individuals with IDD, including those who have complex medical needs; and

2. the assigned enhanced community coordinator:
   a. complies with the rules governing service coordination for an individual with an intellectual disability (40 TAC, Chapter 2, Local Authority Responsibilities, Subchapter L, Service Coordination for Individuals with an Intellectual Disability);

b. provides intensive and flexible support to achieve success in a community setting, including arranging for support needed to prevent and manage a crisis, such as a Transition Support Team or crisis respite;
c. provides pre- and post-transition services;
d. monitors the individual as required by Sections III and IV of this Attachment G for one year after transition or diversion; and
e. maintains a case load of no more than 30 individuals regardless of whether the community coordinator provides service coordination to other individuals who are not covered under the provisions of this Attachment G.

B. Use of Designated Funds for Enhanced Community Coordination.

The LIDDA shall utilize designated funds, as submitted and approved by DADS, to enhance an individual's natural supports and promote successful community living, such as:

1. One-time emergency assistance:
   a. Rental or utility assistance;
   b. Food or nutritional supplements;
   c. Clothing; and
   d. Medication;

2. Items to address an individual's special needs, including minor home modifications not funded by other sources;

3. Transportation to and from trial visits with community providers; and

4. Educational tuition assistance, such as vocational programs through community colleges so an individual can develop job skills.

C. Reporting

The LIDDA shall submit quarterly reporting to the Performance Contracts mailbox by the 15th of the month that follows the previous fiscal quarter using a format prescribed by DADS. A quarterly report must contain:

1. A narrative of the results of the provision of enhanced community coordination, including positive and negative outcomes and barriers encountered during the provision of enhanced community coordination;

2. A list of the names of individuals receiving enhanced community coordination at any time during the quarter being reported and the date they began receiving enhanced community coordination; and

3. An expenditure report including but not limited to salaries, employee benefits, training, travel and other operating expenses.

D. Payments

1. Contingent on the Centers for Medicare and Medicaid approving Money Follows the Person funding, DADS will pay LIDDA an amount not to exceed the allocation provided to the LIDDA to provide enhanced community coordination as stated in this Attachment G. Funds will be paid in compliance with the OMB Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (UGG), which may be found online at: http://www.ecfr.gov/cgi-bin/text-idx?node=2:1.1.2.2.1&rgn=div5.

2. Under these requirements, the LIDDA may request payment be provided in advance or may submit requests for reimbursement of costs.
   a. Under 2 CFR §200.305, Reimbursement is the preferred method when the requirements in paragraph (b) cannot be met, when the federal awarding agency sets a specific condition per §200.207 (Specific conditions), or when a non-federal entity requests payment by reimbursement. Requests for advance payment are subject to the financial management standards test and requirements established by UGG. An advance payment request must:
      i. be limited to cash needed to meet the immediate needs of the grant project;
      ii. minimize time between advances and payments for grants activities; and
      iii. be deposited in a separate interest bearing account and interest earned on grant funds must be returned to the federal government.
   b. If the LIDDA requests reimbursement for costs, the LIDDA must submit an invoice, no later than the 15th day of the month that follows the month of service delivery, on a template provided by DADS and include supporting documentation as described by DADS.

III. Enhanced Community Coordination for Individuals Diverting or Transitioning from an NF.

A. HCS as a diversion from NF admission

For an individual enrolling in HCS as a diversion from NF admission, the LIDDA shall ensure the assigned enhanced community coordinator:

1. before the individual enrolls in HCS:
   a. develops, and revises as necessary, using DADS Form 1050 (Diversion Plan) with an individual's service planning team (SPT), as defined in rules governing the HCS program in 40 TAC, §9.153 (Definitions);
   b. using all available assessments, develops, and revises as necessary, with the individual's SPT an HCS Person-Directed Plan (PDP) Form 8665

(Person-Directed Plan), that identifies the individual's strengths and preferences, and medical, nursing, nutritional management, clinical, and support needs; and

c. conducts a pre-move site review using DADS Form 1042 (Pre-Move Site Review), to determine whether supports are in place and any areas of concern are being addressed.

2. for one year after an individual has diverted to the HCS waiver program:
   a. conducts service planning team meetings at least quarterly, or more frequently if there is a change in an individual's needs or if requested by the individual or LAR;
   b. revises the HCS PDP, as necessary, and coordinates the individual's services and supports;
   c. conducts at least monthly face-to-face visits with an individual, or more frequently if determined by the SPT based on risk factors, and monitors the delivery of all services and supports;
   d. conducts onsite visits of community service delivery sites to determine whether supports continue to be in place and any areas of concern are being addressed using DADS Form 1043 (Post-Move Monitoring);
   e. inquires about any recent hospitalizations, emergency department contacts, increased physician visits, or other crises, including medical crises, and if the individual experiences such, convenes the SPT to identify all necessary revisions to the individual's HCS PDP to address additional need for services;
   f. ensures an individual receives timely assessments of behavioral, medical, nursing, specialized therapies and nutritional management needs, as necessary and as indicated on the HCS PDP;
   g. records health care status sufficient to readily identify when changes in the individual's status occurs;
   h. conducts service planning, ensures implementation of services, and monitors all services identified on the HCS PDP, including:
      i. reviewing the HCS program provider's implementation plans and provider records, as well as visiting service delivery sites, as needed to determine the individual's needs are being met; and
      ii. monitoring critical incidents involving the individual and convening the service planning team to provide needed prevention or intervention services for an individual; and
   i. monitors an individual while on suspension from the HCS waiver program at least monthly and provide reports to DADS upon request.

B. Transition to HCS from NF

1. For an individual 21 years of age or older who is transitioning to HCS from an NF, the LIDDA shall, before the individual transitions from the NF, ensure the assigned enhanced community coordinator:

a. develops, implements, monitors, and revises as necessary, Section 9 (Transition Plan to the Community) Phases II and III of the individual service plan, DADS Form 1041 (Individual Service Plan/Transition Plan - NF) with an individual's SPT, as defined in rules governing the HCS program in 40 TAC, §9.153 (Definitions);
b. provides increased coordination and interaction with an NF's care planning team and the assigned relocation specialist;
c. facilitates trial visits to providers in the community for the individual, including overnight visits where feasible, as requested by the individual or LAR;
d. using all available assessments, develops, and revises as necessary, with the individual's SPT an HCS Person-Directed Plan (PDP) Form 8665 (Person-Directed Plan), that identifies the individual's strengths and preferences, and medical, nursing, nutritional management, clinical, and support needs; and
e. conducts a pre-move site review using DADS Form 1042 (Pre-Move Site Review), to determine whether supports are in place and any areas of concern are being addressed and ensure all essential supports identified on the transition plan are in place before the individual transitions.

2. For an individual of any age who transitioned to HCS from an NF, the LIDDA shall, for at least one year after the individual has transitioned, ensure the assigned enhanced community coordinator:
   a. for an individual under the age of 21 years, communicate with an appropriate staff of the entity that was responsible for transitioning the individual from the nursing facility (for FYs 2016 and 2017, the entity is EveryChild, Inc.) to gather all necessary information and documents to ensure a successful transition for the individual;
   b. conducts service planning team meetings at least quarterly, or more frequently if there is a change in an individual's needs or if requested by the individual or LAR;
   c. revises the service plan, as necessary, on the HCS PDP and coordinates the individual's services and supports;
   d. conducts at least monthly face-to-face visits with an individual, or more frequently if determined by the SPT based on risk factors, and monitors the delivery of all services and supports;
   e. conducts onsite visits of community service delivery sites to determine whether supports continue to be in place and any areas of concern are being addressed using DADS Form 1043 (Post-Move Monitoring);
   f. Inquires about any recent hospitalizations, emergency department contacts, increased physician visits, or other crises, including medical crises, and if the individual experiences such, convenes the SPT to identify all necessary revisions to the individual's HCS PDP to address additional need for services;

g. ensures an individual receives timely assessments of behavioral, medical, nursing, specialized therapies and nutritional management needs, as necessary and as indicated on the HCS PDP;
h. records health care status sufficient to readily identify when changes in the individual's status occurs;
i. conducts service planning, ensures implementation of services, and monitors all services identified on the HCS PDP, including:
   i. reviewing the HCS program provider's implementation plans and provider records, as well as visiting service delivery sites, as needed to determine the individual's needs are being met; and
   ii. monitoring critical incidents involving the individual and convening the service planning team to provide needed prevention or intervention services for an individual; and
j. monitors an individual while on suspension from the HCS waiver program at least monthly and provide reports to DADS upon request.

C. Transition to a Community Medicaid Program from NF

For an individual 21 years of age or older who is transitioning from an NF to a community Medicaid program (i.e., a community ICF/IID or a Medicaid waiver program other than HCS), the LIDDA shall ensure the assigned enhanced community coordinator:

1. before the individual transitions from the NF:
   a. develops, implements, monitors, and revises as necessary, Section 9 (Transition Plan to the Community) Phases II and III of the individual service plan, DADS Form 1041 (Individual Service Plan/Transition Plan - NF) with an individual's SPT;
   b. provides increased coordination and interaction with an NF's care planning team and, if the individual is transitioning to a Medicaid waiver program other than HCS, the assigned relocation specialist;
   c. facilitates trial visits to providers in the community that offer residential services (for example, an ICF/IID, a Star+Plus waiver assisted living facility) for the individual, including overnight visits where feasible, as requested by the individual or LAR;
   d. provides all available assessments to the selected community Medicaid program provider; and
   e. conducts a pre-move site review using DADS Form 1042 (Pre-Move Site Review), to determine whether supports are in place and any areas of concern are being addressed and ensure all essential supports identified on the transition plan are in place before the individual transitions.

2. for at least one year after the individual has transitioned to a community Medicaid program conducts the following activities to determine whether necessary services and supports are being provided and areas of concern

are being addressed and to assess the individual's adjustment to community life and the individual's (and LAR's) satisfaction with community life:

a. post-move monitoring using DADS Form 1043 (Post-Move Monitoring); and
b. face-to-face service coordination contacts monthly during the first six months following the individual's move from the NF, and quarterly during the second six months following the individual's move.

IV. Enhanced Community Coordination for Individuals Diverting or Transitioning from a State Supported Living Center

A. HCS as a Diversion from SSLC Admission

For an individual enrolling in HCS as a diversion from SSLC admission, the LIDDA shall ensure the assigned enhanced community coordinator:

1. before the individual enrolls in HCS:
   a. develops, and revises as necessary, using DADS Form 1050 (Diversion Plan) with an individual's service planning team (SPT);
   b. using all available assessments develop the HCS PDP; and
   c. conducts a pre-move site review using DADS Form 1042 (Pre-Move Site Review), to determine whether supports are in place and any areas of concern are being addressed.

2. for one year after an individual has diverted to the HCS waiver program:
   a. conducts service planning team meetings at least quarterly, or more frequently if there is a change in the individual's needs or if requested by the individual or LAR;
   b. conducts at least monthly face-to-face visits with the individual and monitors the delivery of all services and supports by:
      i. conducts post-move monitoring using DADS Form 1043 (Post-Move Site Review) to determine whether supports are in place and any areas of concern are being addressed;
      ii. ensuring the individual receives timely assessments of behavioral, medical, nursing, specialized therapies and nutritional management needs, as necessary and as indicated on the HCS PDP;
      iii. reviewing the HCS program provider's implementation plans and provider records, as well as visiting service delivery sites, as needed to determine the individual's needs are being met;
      iv. monitoring critical incidents involving the individual and convening the service planning team to provide needed prevention or intervention services for an individual; and
      v. monitoring an individual while on suspension from the HCS waiver program at least monthly and provide reports to DADS upon request.

B. Transition to HCS from SSLC

For an individual transitioning to HCS from an SSLC, the LIDDA shall ensure the assigned enhanced community coordinator:

1. before the individual transitions from the SSLC:
   a. participates in developing the CLDP with SSLC staff as required by 40 TAC, §2.278 (Community Living/Discharge Plan by Alternate Living Arrangements);
   b. uses all available assessments to develop the HCS PDP;
   c. participates in the pre-move site review conducted by SSLC staff to determine whether supports are in place and any areas of concern are being addressed; and
   d. complies with the requirements contained in 40 TAC, §2.277(b)-(d) (relating to Arrangements for the Move to an Alternate Living Arrangement of an Individual Residing in a State MR Facility) using DADS Form 8630 (Continuity of Care);

2. for one year after the individual has transitioned to HCS:
   a. conducts at least monthly face-to-face visits with an individual for one-year;
   b. complies with the monitoring activities and agreement portions set forth in the CLDP;
   c. conducts periodic monitoring (i.e., every 90 days) and, using a DADS-prescribed format, develops written reports of monitoring that addresses specific findings for any significant monitoring activity, including:
      i. psychiatric or medical hospitalization;
      ii. any visits to an emergency room within the period being reported;
      iii. death;
      iv. arrest or incarceration;
      v. any contacts with law enforcement within the period being reported;
      vi. unable to locate or left program;
      vii. HCS program provider issue – change of homes;
      viii. HCS program provider issue – closure;
      ix. HCS program provider issue – confirmed abuse, neglect or exploitation;
      x. HCS program provider issue – change of program provider; and
      xi. return to the SSLC; and
   d. submits the written reports required in 2.c. above to the SSLC admission placement coordinator (APC), DADS, and the HCS program provider.

C. Transition from SSLC to a setting other than HCS

For an individual transitioning from an SSLC to setting other than HCS (such as a community ICF/IID or family's home), the LIDDA shall ensure the assigned enhanced community coordinator:

1. before the individual transitions from the SSLC:
   a. participates in developing the CLDP with SSLC staff as required by 40 TAC, §2.278 (Community Living/Discharge Plan by Alternate Living Arrangements); and
   b. participates in the pre-move site review conducted by SSLC staff to determine whether supports are in place and any areas of concern are being addressed; and
   c. complies with the requirements contained in 40 TAC, §2.277(b)-(d) (relating to Arrangements for the Move to an Alternate Living Arrangement of an Individual Residing in a State MR Facility) using DADS Form 8630 (Continuity of Care); and

2. for one year after the individual has transitioned from an SSLC:
   a. complies with the monitoring activities and agreement portions set forth in the CLDP; and
   b. conducts periodic monitoring (i.e., every 90 calendar days) and, using a DADS-prescribed format, develops written reports of monitoring that addresses specific findings for any significant monitoring activity, including:
      i. psychiatric or medical hospitalization;
      ii. any visits to an emergency room within the period being reported;
      iii. death;
      iv. arrest or incarceration;
      v. any contacts with law enforcement within the period being reported;
      vi. unable to locate, left community program, moved out-of-state;
      vii. move to another residence;
      viii. community program provider issue – closure;
      ix. community program provider issue – confirmed abuse, neglect or exploitation;
      x. community program provider issue – change of program provider; and
      xi. return to the SSLC; and
   c. submits written reports required in Section C. 2.b. of this Attachment G to the SSLC admission placement coordinator (APC) and DADS.

ATTACHMENT K
Medicaid Program Enrollment Requirements

ENROLLMENT INTO THE HCS PROGRAM AND TXHML PROGRAM

I. THE LIDDA SHALL:
   A. Designate staff to complete enrollments for the following waiver programs:
      1. Home and Community-based Services (HCS) Program; and
      2. Texas Home Living (TxHmL) Program.

   B. Require all designated staff to complete the online DADS enrollment training before performing enrollment activities and at least annually thereafter for as long as the staff performs enrollment activities for the LIDDA. The training can be found at:
      http://www.dads.state.tx.us/providers/LIDDA/training/index.html

   C. Ensure designated enrollment staff do not perform functions for the LIDDA's provider operations.

II. THE LIDDA SHALL:
   A. Complete the enrollment process for each authorized consumer into the HCS Program and TxHmL Program in accordance with DADS rules and within the timeframes below (the enrollment process is complete when the consumer status in CARE screen C61 is "active" or "denied"). The LIDDA may request an extension of the timeframes and DADS will grant an extension for good cause:
      1. for a consumer residing in a nursing facility — 90 calendar days after the LIDDA was notified of the program vacancy;
      2. for a consumer residing in a community ICF/IID or being discharged from a state mental health facility — 90 calendar days after the LIDDA was notified of the program vacancy; and
      3. for a consumer residing in his or her own or family's home — 75 calendar days after the LIDDA was notified of the program vacancy.

   B. Access the Service Authorization System Online (SASO) to determine if the consumer is currently enrolled in a DADS program or a Medicaid waiver program. The LIDDA shall review the DADS Mutually Exclusive Services chart (http://www.dads.state.tx.us/handbooks/appendix/12.htm) to determine if a service the consumer is receiving is mutually exclusive to the program that the LIDDA is offering. If the consumer is enrolled in a Medicaid waiver program or a service that is mutually exclusive to the program that the LIDDA is offering, the LIDDA shall:
      1. contact the consumer's case manager or service coordinator for the service or program the consumer is currently enrolled in to coordinate an explanation to the consumer and LAR about the similarities and differences between the service the consumer is receiving and the program that the LIDDA is offering

using the program comparison information found at: http://www.dads.state.tx.us/providers/waiver_comparisons/index.html; and

2. following the explanation as described above, inform the consumer or LAR of the requirement to choose either the program the consumer is currently enrolled in or the program that the LIDDA is offering.

C. Use Form 8665 (Person Directed Plan), as well as the form's instructions and the information contained in the discovery tool and discovery guide in the HCS Handbook appendices, when conducting person-directed planning for a consumer enrolling in the HCS or TxHmL Program.

D. Enter the consumer's enrollment information into the CARE Automated Enrollment and Billing System screens L01, L23 (if applicable), L02, L03, L09, and L05.

E. Review each consumer enrolling in HCS to determine if the consumer is eligible for inclusion in the Money Follows the Person (MFP) Demonstration Project as follows.

1. A consumer is eligible for inclusion in the MFP Demonstration Project if the consumer meets all of the following criteria:
   a. the consumer must reside continuously in an institutional setting (i.e., ICF/IID, nursing facility, hospital, or state hospital) for at least 90 days prior to the HCS enrollment date *and be enrolled in HCS from a nursing facility, a large ICF/IID (14 beds or more), or a medium ICF/IID (9-13 beds)*;
   b. the consumer's 90-day stay in the institutional setting as required by a. above excludes any days funded by Medicare;
   c. the consumer must be Medicaid eligible under Title XIX of the Social Security Act; and
   d. the consumer must transition from the nursing facility or ICF/IID into a qualifying residence, which is the consumer's own home or family home, a foster companion care home, a three-person group home, or a four-person group home.

2. A consumer is eligible for inclusion in the MFP Demonstration Project if:
   a. the consumer is a resident of a medium ICF/IID (9-13 beds) or large ICF/IID (14 beds or more);
   b. the facility owner has an approved plan to participate in the MFP Demonstration Voluntary Closure Pilot; and
   c. the consumer meets the eligibility criteria described in E.1.a.-E.1.d. above.

3. A consumer is eligible for inclusion in the MFP Demonstration Project if the consumer is under 22 years of age and:
   a. is a resident of a small ICF/IID (1-8 beds);
   b. meets the eligibility criteria described in E.1.a.-E.1.c. above except the ICF/IID may be a small facility; and

c. transitions from the small ICF/IID into the consumer's own home or family home or a foster companion care home.

4. If the consumer is eligible for the MFP Demonstration Project, the LIDDA will provide the consumer or LAR with a brief explanation of the project using the information on Form 1580 (Texas Money Follows the Person Demonstration Project Informed Consent for Participation) and invite the consumer and LAR to participate in the project by signing the form. If the consumer or LAR agrees, the LIDDA will follow the instructions on the form, including completion of the "For Official Use Only" section of the form. The LIDDA must complete the form as soon as possible and fax it to DADS immediately after completion, but no later than two weeks before the consumer is discharged from the facility. NOTE: The LIDDA is not required to comply with this provision for a resident of a state supported living center (SSLC) who is eligible for the MFP Demonstration Project. SSLC staff are responsible for the explanation and completion and faxing of Form 1580 (Texas Money Follows the Person Demonstration Project Informed Consent for Participation).

5. If the consumer or LAR signs the form, the LIDDA must enter "Y" on the CARE screen L01 for the question MFP DEMO Y_ N_.

6. On a case-by-case basis, DADS may determine a consumer eligible for the MFP Demonstration Project and direct the LIDDA to comply with II.E.4. and 5. for that consumer or LAR.

F. If the consumer being offered a program vacancy in HCS or TxHmL is enrolled in STAR+PLUS Waiver program (SPW):

1. inform the consumer that disenrollment in SPW is required in order to enroll in HCS or TxHmL;

2. ensure the consumer's Individual Plan of Care (IPC) begins on the first day of a month;

3. ensure the consumer's enrollment data has been entered into CARE within seven (7) days prior to the end of the month before the consumer's scheduled enrollment date; and

4. if the LIDDA anticipates the consumer's HCS or TxHmL enrollment will not be completed within the timeframes listed in II.A. of this attachment, request that DADS approve an extension using Form 1045 (Request for HCS/TxHmL Enrollment Extension) or an Excel spreadsheet developed by DADS, to the time allowed for the enrollment.

G. Comply with the instructions in this section when offering an HCS or TxHmL Program vacancy:

1. For a consumer whose enrollment process is not complete within the timeframes listed in II.A. of this attachment, the LIDDA must have, within the same timeframes*:*
   a. submitted to DADS a Verification of Freedom of Choice form with the consumer's or LAR's signature and date declining the HCS or TxHmL Program, as appropriate;
   b. submitted to DADS documentation that the LIDDA sent a letter of withdrawal in accordance with DADS rules; or
   c. submitted a request to extend to the time allowed for the enrollment using Form 1045 (Request for HCS/TxHmL Enrollment Extension) or an Excel spreadsheet developed by DADS. NOTE: A Request for extension received by DADS after the 15th day of the last month of a quarter will not be approved for that quarter.

2. If the LIDDA that is authorized to offer an HCS or TxHmL program vacancy to a consumer (the authorized LIDDA) anticipates the consumer's HCS or TxHmL enrollment will not be completed by the required date, the LIDDA must request that DADS grant an extension (using Form 1045, Request for HCS/TxHmL Enrollment Extension, or an Excel spreadsheet developed by DADS) to the time allowed for the enrollment and provide a reason for the delay.

   For HCS only: If the reason for the delay is related to determination of Medicaid eligibility, the LIDDA must proceed with enrollment activities and data entry of all the enrollment screens in CARE, as required by II.D. above, prior to submitting a request for extension.

   For TxHmL only: If the reason for the delay is related to determination of Medicaid eligibility, the LIDDA must proceed with enrollment activities and data entry of all the enrollment screens in CARE, as required by II.D. above, prior to submitting a request for extension *unless the LIDDA determines the individual is likely to be denied Medicaid. In which case, the LIDDA must provide a reason for such determination.*

3. For all HCS slots and those TxHmL slots that are *not* refinance slots: If the authorized LIDDA attempts to contact the consumer or LAR and learns that the consumer or LAR has relocated to another local authority's local service area, the authorized LIDDA must determine the consumer's designated LIDDA using the "Guidelines for Determining and Changing Designated LIDDA" (see Attachment O). If the authorized LIDDA is the designated LIDDA, then the authorized LIDDA will continue with all enrollment activities. If the authorized LIDDA determines that another LIDDA is the designated LIDDA, then the authorized LIDDA must forward to the designated LIDDA a copy of the authorization letter, the Provider Choice form, and a copy of any extensions already obtained. The authorized LIDDA must notify the appropriate staff at DADS LIDDA section of the transfer. Once the designated LIDDA receives the information from the authorized LIDDA, then the

designated LIDDA becomes the authorized LIDDA and is responsible for meeting required timeframes for enrollment or requesting an extension.

For refinance TxHmL slots only: If the authorized LIDDA attempts to contact the consumer or LAR and learns that the consumer or LAR has relocated to another local authority's local service area, the authorized LIDDA must contact DADS for further instructions.

4. For all HCS slots and those TxHmL slots that are *not* refinance slots: If the authorized LIDDA contacts the consumer or LAR and begins the enrollment process and the applicant or LAR selects a provider in a different local authority's local service area, then the authorized LIDDA must conduct all pre-enrollment activities, such as explanation of services, obtaining signature on Verification of Freedom of Choice, conducting diagnostic activities and ID/RC, Medicaid eligibility information, initial person-directed plan (PDP), and proposed IPC. The authorized LIDDA must:
   a. request an extension on the enrollment if the enrollment will not be competed in the originally assigned or extended timeframe;
   b. transfer the consumer to the local authority in which the selected provider operates;
   c. provide the initial PDP to the provider and complete the IPC negotiations with the provider; and
   d. send hard copies of all enrollment documents, including the provider choice form and any enrollment extensions already obtained, to the receiving LIDDA.

   Once the receiving LIDDA receives the information from the authorized LIDDA, then the receiving LIDDA is responsible for meeting required timeframes for enrollment.

   For HCS only: The receiving LIDDA must complete the data entry of all enrollment screens in a timely manner and request an extension if enrollment is not expected to be approved by the required timeframe.

   For TxHmL only: The receiving LIDDA must complete the data entry of all enrollment screens in a timely manner and request an extension if enrollment is not expected to be approved by the required timeframe. An exception to the requirement to complete data entry of all enrollment screens prior to requesting an extension is when *the LIDDA determines the individual is likely to be denied Medicaid. In which case, the LIDDA must provide a reason for such determination on Form 1045 (Request for HCS/TxHmL Enrollment Extension).*

H. If the consumer being offered a program vacancy is currently receiving general revenue-funded services from the LIDDA, inform the consumer and LAR that if the consumer or LAR declines the offer of waiver services identified by DADS (i.e., HCS or TxHmL) the LIDDA will terminate the general revenue services in accordance with rules governing the HCS or TxHmL Program.

I. Prior to enrollment, ensure the consumer and LAR are provided information about the Medicaid Estate Recovery Program as described in Attachment R (Medicaid Estate Recovery Program).

J. Prior to enrollment, determine whether the consumer is a Medicare beneficiary. If the consumer is a Medicare beneficiary, the LIDDA must comply with the following:
   1. The LIDDA must verify that the consumer:
      a. is enrolled in a Medicare-sponsored prescription drug plan, which can be a stand-alone drugs-only insurance plan or a Medicare Advantage Prescription Drug (MA-PD) plan; and
      b. has been deemed eligible for extra help and if not, assist the consumer in applying for extra help using the SSA-1020 form found at www.socialsecurity.gov.

   2. If the consumer is not already enrolled in a drug plan, the LIDDA shall explain to the consumer and LAR that the consumer must enroll in a drug plan in order to receive prescription medications and that upon enrollment in the waiver program he or she will be auto-enrolled in a drug plan, which may or may not be the drug plan that is most beneficial. The LIDDA shall:
      a. encourage the consumer to enroll in a drug plan before enrollment if possible; and
      b. offer assistance, and provide assistance if requested, to the consumer and LAR with evaluating the drug plans to identify the plan that is most beneficial to the consumer.

   3. The LIDDA shall explain to the consumer and LAR that:
      a. the consumer will get his or her prescription medications through a drug plan. Note: as a Medicaid wrap-around service, Medicaid will pay for a limited list of drugs that Medicare will not pay for, including benzodiazepines, barbiturates, and prescribed over-the-counter drugs;
      b. the consumer will be automatically deemed eligible for the extra help, which will assist with his or her drug costs;
      c. the consumer is not responsible for any cost sharing for his or her prescription medications;
      d. the consumer will pay little or no premiums and no deductible;
      e. the consumer will be responsible for paying for any prescription medications that are not covered by his or her drug plan or the Medicaid wrap-around service (as noted in a. above);
      f. if the consumer is enrolling in TxHmL, the LIDDA service coordinator can assist him or her with changing drug plans and filing an exception, appeal, or grievance with the drug plan; and
      g. if the consumer is enrolling in HCS, the program provider can assist him or her with changing drug plans and filing an exception, appeal, or grievance with the drug plan.

4. Note: The information contained in 1.-3. above pertains to a consumer with Medicare *and* Medicaid (referred to as “full-dual eligible”). A consumer with only Medicaid is not affected by the Medicare Prescription Drug Program and will continue to receive his or her drugs through Medicaid.

K. Explain to the consumer or LAR he or she must document the following on the *Verification of Freedom of Choice* form:
   1. that he or she chooses the TxHmL or HCS Program rather than the ICF/IID Program or other services (or program); or

   2. that he or she declines the TxHmL or HCS Program and chooses instead the ICF/IID Program or “Other”. If the consumer or LAR chooses "Other," then the LIDDA must ensure the reason for declining is explicitly stated.

L. For a consumer who has declined to participate in the HCS or TxHmL Program:
   1. submit to DADS a copy of the completed *Verification of Freedom of Choice* form; and

   2. enter the decline status code in CARE if the consumer's name is on the HCS or TxHmL Interest List;

M. For a consumer who has chosen to participate in the HCS or TxHmL Program:
   1. submit to DADS a copy of the completed *Verification of Freedom of Choice* form;

   2. explain to the consumer or LAR that he or she may choose any contracted HCS or TxHmL Program provider, as appropriate to the program being offered, in the LSA that has not reached its service capacity as identified in CARE;

   3. be objective in assisting a consumer or LAR in selecting an HCS or TxHmL Program provider, and not influence the consumer’s or LAR’s decision;

   4. provide the consumer or LAR with a current list (i.e., dated within seven (7) days) from CARE (XPTR HC062096 for HCS and HC062097 for TxHmL) of all contracted TxHmL or HCS Program providers, as appropriate to the program being offered, in the LIDDA’s LSA. The list will also include local “applicant contact” information, if available, for use by the consumer or LAR. If the LIDDA operates an HCS or TxHmL program and the program’s enrollment is at or above capacity (identified in CARE Screen 370 as “CAP”), the LIDDA must redact its provider name from the list of providers given to the consumer or LAR; and

   5. document the selection of the program provider on the *Documentation of Provider Choice* form and submit a copy of the form.

N. If the HCS or TxHmL program operated by the LIDDA is selected by the consumer or the LAR to be the consumer's program provider, the LIDDA must complete DADS Form 1052 (Public Provider Choice Request) and submit to DADS in accordance with the form's instructions.

O. Not allow any of the LIDDA's staff from its provider operations to initiate contact with the consumer or LAR prior to the completion of the *Documentation of Provider Choice* form.

P. For a consumer who is being enrolled in the TxHmL Program, ensure the LIDDA service coordinator facilitates the completion of Form 8586 (TxHmL Program Service Coordination Notification).

Q. Maintain the following completed forms in the consumer's record:
   1. Verification *of Freedom of Choice* form;

   2. Documentation *of Provider Choice* form; and

   3. *Texas Home Living Program Service Coordination Notification* (Form 8586), if applicable.

ENROLLMENT INTO THE ICF/IID PROGRAM

THE LA SHALL:

A. Complete enrollment of a consumer into the ICF/IID Program in accordance with DADS rules;

B. Prior to enrollment, ensure the consumer and LAR are provided information about the Medicaid Estate Recovery Program as described in Attachment R (Medicaid Estate Recovery Program); and

C. Prior to enrollment, determine whether the consumer is a Medicare beneficiary. If the consumer is a Medicare beneficiary, the LIDDA must do the following:
   1. The LIDDA must verify that the consumer:
      a. is enrolled in a Medicare-sponsored prescription drug plan, which can be a stand alone drugs-only insurance plan or a Medicare Advantage Prescription Drug (MA-PD) plan; and
      b. has been deemed eligible for extra help and if not, assist the consumer in applying for extra help using the SSA-1020 form found at www.socialsecurity.gov.

   2. If the consumer is not already enrolled in a drug plan, the LIDDA shall explain to the consumer and LAR that the consumer must enroll in a drug plan in order to receive prescription medications and that upon enrollment in the

ICF/IID Program he or she will be auto-enrolled in a drug plan, which may or may not be the drug plan that is most beneficial. The LIDDA shall:

a. encourage the consumer to enroll in a drug plan before enrollment if possible; and
b. offer assistance, and provide assistance if requested, to the consumer and LAR with evaluating the drug plans to identify the plan that is most beneficial to the consumer.

3. The LIDDA shall explain to the consumer and LAR that:
   a. the consumer will get his or her prescription medications through a drug plan. Note: as a Medicaid wrap-around service, Medicaid will pay for a limited list of drugs that Medicare will not pay for, including benzodiazepines, barbiturates, and prescribed over-the-counter drugs;
   b. the consumer will be automatically deemed eligible for the extra help, which will assist with his or her drug costs;
   c. the consumer will not have any cost-sharing responsibilities such as premiums, deductibles, co-payments, or co-insurance for drugs covered by the plan; and
   d. the ICF/IID Program provider can assist the consumer or LAR with changing drug plans and filing an exception, appeal, or grievance with the drug plan.

4. Note that the information contained in 1.-3. above pertains to a consumer with Medicare *and* Medicaid. A consumer with Medicaid only is not affected by the Medicare Prescription Drug Program and will continue to receive his or her drugs through Medicaid.

ATTACHMENT N
IDD Submission Calendar

For tracking of receipt purposes, electronic mail submissions must be sent to DADS at performance.contracts@dads.state.tx.us and hard copy contract submissions must be sent to the Contract Manager. When a LIDDA submits an electronic or facsimile submission, the LIDDA must maintain original submission for their records. Performance Contracts Unit will forward electronic mail and hard copy submissions to the appropriate department. Encounter Data must be submitted using the secure file transfer protocol and CARE submissions must be submitted using CARE.

Submission Type:
"HC" – Hard Copy Submission to Contract Manager
"E" – Electronic Submission to DADS
"CARE" – Submission Using CARE
"SFTP" – File Transfer Protocol
"F" – Facsimile
"MBOW" – Intellectual & Developmental Disabilities and Behavioral Health Outpatient Data Warehouse

September 2015

Type	Document	Due Date
HC	Form D – Certification Regarding Lobbying with FYs 16 and 17 Performance Contract	9/01/15
E	Form S – Contact List with FYs 16 and 17 Performance Contract	9/01/15

October 2015

Type	Document	Due Date
SFTP	Monthly Encounter Data for September 2015	10/16/15 by 4 a.m.
CARE	Monthly IDD - Critical Incident Data for September 2015	10/30/15

November 2015

Type	Document	Due Date
HC/E/F	HCS/TxHmL Enrollment Extension (Form 1045) Request Cut-Off Date for 1st Quarter	11/16/15
SFTP	Monthly Encounter Data for October 2015	11/16/15 by 4 a.m.
CARE	Monthly IDD - Critical Incident Data for October 2015	11/30/15

December 2015

Type	Document	Due Date
SFTP	Monthly Encounter Data for November 2015	12/16/15 by 4 a.m.
SFTP	FY 2016 Q1 IDD Financial Reporting	12/16/15
CARE	Monthly IDD - Critical Incident Data for November 2015	12/31/15

January 2016

Type	Document	Due Date
SFTP	Monthly Encounter Data for December 2015	1/15/16 by 4 a.m.
HC/E	FY 2016 Q1 Financial Statements and Certification Form G	1/15/16
CARE	Monthly IDD - Critical Incident Data for December 2015	1/29/16

February 2016

Type	Document	Due Date
HC	Financial and Compliance Audit for FY 2016	2/01/16
HC/E/F	HCS/TxHmL Enrollment Extension (Form 1045) Request Cut-Off Date for 2nd Quarter	2/15/16
SFTP	Monthly Encounter Data for January 2016	2/16/16 by 4 a.m.
CARE	Monthly IDD - Critical Incident Data for January 2016	2/29/16

March 2016

Type	Document	Due Date
HC	Corrective Action Plan for FY 2016 Financial and Compliance Audit or a “Letter of No Findings”	3/01/16
SFTP	Monthly Encounter Data for February 2016	3/16/16 by 4 a.m.
SFTP	FY 2016 Q2 IDD Financial Reporting	3/17/16
CARE	Monthly IDD - Critical Incident Data for February 2016	3/31/16

April 2016

Type	Document	Due Date
SFTP	Monthly Encounter Data for March 2016	4/15/16 by 4 a.m.
HC	FY 2016 Q2 Financial Statements and Certification Form G	4/15/16
CARE	Monthly IDD - Critical Incident Data for March 2016	4/29/16

May 2016

Type	Document	Due Date
HC/E/F	HCS/TxHmL Enrollment Extension (Form 1045) Request Cut-Off Date for 3rd Quarter	5/16/16
SFTP	Monthly Encounter Data for April 2016	5/16/16 by 4 a.m.
CARE	Monthly IDD - Critical Incident Data for April 2016	5/31/16

June 2016

Type	Document	Due Date
E	LIDDA Diversion Coordinator Job Description and Qualifications	6/10/16
E	PASRR Reporting Manual Q3 Report	6/10/16
E	Enhanced Community Coordination Invoice for May 2016 Expenditures	6/15/16
E	Transition Support Team Invoice for May 2016 Expenditures	6/15/16
E	Enhanced Community Coordination Q3 Report	6/15/16
E	Transition Support Team Q3 Report	6/15/16
SFTP	Monthly Encounter Data for May 2016	6/16/16 by 4 a.m.

SFTP	FY2016 Q3 Report III	6/16/16
CARE	Monthly IDD - Critical Incident Data for May 2016	6/30/16

July 2016

Type	Document	Due Date
E	Enhanced Community Coordination Invoice for June 2016 Expenditures	7/15/16
E	Transition Support Team Invoice for June 2016 Expenditures	7/15/16
HC	FY 2016 Q3 Financial Statements and Certification Form G	7/15/16
SFTP	Monthly Encounter Data for June 2016	7/18/16 by 4 a.m.
CARE	Monthly IDD - Critical Incident Data for June 2016	7/29/16

August 2016

Type	Document	Due Date
HC/E/F	HCS/TxHmL Enrollment Extension (Form 1045) Request Cut-Off Date for 4th Quarter	8/15/16
E	Enhanced Community Coordination Invoice for July 2016 Expenditures	8/15/16
E	Transition Support Team Invoice for July 2016 Expenditures	8/15/16
SFTP	Monthly Encounter Data for July 2016	8/16/16 by 4 a.m.
CARE	Monthly IDD - Critical Incident Data for July 2016	8/31/16
HC	Financial Auditor Engagement Letter for FY 2016	8/31/16

September 2016

Type	Document	Due Date
E	Annual Historically Underutilized Businesses (HUB) Sub-Contracting Report (Form F)	9/9/16
E	PASRR Service Coordination Caseload Annual Report	9/12/16
E	PASRR Reporting Manual Q4 Report	9/12/16
SFTP	FY 2016 Q4 IDD Financial Reporting	9/15/16
E	Crisis Services Q4 Report	9/15/16
E	Enhanced Community Coordination Invoice for August 2016 Expenditures	9/15/16
E	Transition Support Team Invoice for August 2016 Expenditures	9/15/16
E	Enhanced Community Coordination Q4 Report	9/15/16
E	Transition Support Team Q4 Report	9/15/16
SFTP	Monthly Encounter Data for August 2016	9/16/16 by 4 a.m.
CARE	Monthly IDD - Critical Incident Data for August 2016	9/30/16

October 2016

Type	Document	Due Date
E	Enhanced Community Coordination Invoice for September 2016 Expenditures	10/15/16
E	Transition Support Team Invoice for September 2016 Expenditures	10/15/16
SFTP	Monthly Encounter Data for September 2016	10/16/16 by 4 a.m.

HC/E	FY 2016 Q4 Financial Statements and Certification Form G	10/17/16
CARE	Monthly IDD - Critical Incident Data for September 2016	10/31/16

November 2016

Type	Document	Due Date
HC/E/F	HCS/TxHmL Enrollment Extension (Form 1045) Request Cut-Off Date for 1st Quarter	11/15/16
E	Enhanced Community Coordination Invoice for October 2016 Expenditures	11/15/16
E	Transition Support Team Invoice for October 2016 Expenditures	11/15/16
SFTP	Monthly Encounter Data for October 2016	11/16/16 by 4 a.m.
CARE	Monthly IDD - Critical Incident Data for October 2016	11/30/16

December 2016

Type	Document	Due Date
E	PASRR Reporting Manual Q1 Report	12/12/16
SFTP	FY 2016 Q1 Financial Reporting	12/15/16
E	Crisis Services Q1 Report	12/15/16
E	Enhanced Community Coordination Invoice for November 2016 Expenditures	12/15/16
E	Transition Support Team Invoice for November 2016 Expenditures	12/15/16
E	Enhanced Community Coordination Q1 Report	12/15/16
E	Transition Support Team Q1 Report	12/15/16
SFTP	Monthly Encounter Data for November 2016	12/16/16 by 4 a.m.
CARE	Monthly IDD - Critical Incident Data for November 2016	12/30/16
SFTP	FY 2016 Q4 IDD Financial Reporting (Final for FY 2016)	12/30/16 by 5 p.m.

January 2017

Type	Document	Due Date
E	LIDDA Diversion Coordinator Job Description and Qualifications	1/10/17
E	Enhanced Community Coordination Invoice for December 2016 Expenditures	1/15/17
E	Transition Support Team Invoice for December 2016 Expenditures	1/15/17
SFTP	Monthly Encounter Data for December 2016	1/16/17 by 4 a.m.
HC/E	FY 2016 Q1 Financial Statements and Certification Form G	1/17/17
CARE	Monthly IDD - Critical Incident Data for December 2016	1/31/17

February 2017

Type	Document	Due Date
HC	Financial and Compliance Audit for FY 2017	2/01/17
HC/E/F	HCS/TxHmL Enrollment Extension (Form 1045) Request Cut-Off Date for 2nd Quarter	2/15/17
E	Enhanced Community Coordination Invoice for January 2017	2/15/17

	Expenditures	
E	Transition Support Team Invoice for January 2017 Expenditures	2/15/17
SFTP	Monthly Encounter Data for January 2017	2/16/17 by 4 a.m.
CARE	Monthly IDD - Critical Incident Data for January 2017	2/28/17

March 2017

Type	Document	Due Date
HC/E	Corrective Action Plan for FY 2017 Financial and Compliance Audit or a "Letter of No Findings"	3/01/17
E	PASRR Reporting Manual Q2 Report	3/10/17
E	Crisis Services Q2 Report	3/15/17
E	Enhanced Community Coordination Invoice for February 2017 Expenditures	3/15/17
E	Transition Support Team Invoice for February 2017 Expenditures	3/15/17
E	Enhanced Community Coordination Q2 Report	3/15/17
E	Transition Support Team Q2 Report	3/15/17
SFTP	Monthly Encounter Data for February 2017	3/16/17 by 4 a.m.
SFTP	FY 2017 Q2 IDD Financial Reporting	3/16/17
CARE	Monthly IDD -Critical Incident Data for February 2017	3/31/17

April 2017

Type	Document	Due Date
E	Enhanced Community Coordination Invoice for March 2017 Expenditures	4/15/17
E	Transition Support Team Invoice for March 2017 Expenditures	4/15/17
SFTP	Monthly Encounter Data for March 2017	4/16/17 by 4 a.m.
HC/E	FY 2017 Q2 Financial Statements and Certification Form G	4/17/17
CARE	Monthly IDD -Critical Incident Data for March 2017	4/28/17

May 2017

Type	Document	Due Date
HC/E/F	HCS/TxHmL Enrollment Extension (Form 1045) Request Cut-Off Date for 3rd Quarter	5/15/17
E	Enhanced Community Coordination Invoice for April 2017 Expenditures	5/15/17
E	Transition Support Team Invoice for April 2017 Expenditures	5/15/17
SFTP	Monthly Encounter Data for April 2017	5/16/17 by 4 a.m.
CARE	Monthly IDD -Critical Incident Data for April 2017	5/31/17

June 2017

Type	Document	Due Date
E	LIDDA Diversion Coordinator Job Description and Qualifications	6/12/17
E	PASRR Reporting Manual Q3 Report	6/12/17
SFTP	FY 2017 Q3 IDD Financial Reporting	6/15/17
E	Crisis Services Q3 Report	6/15/17

E	Enhanced Community Coordination Invoice for May 2017 Expenditures	6/15/17
E	Transition Support Team Invoice for May 2017 Expenditures	6/15/17
E	Enhanced Community Coordination Quarterly Report	6/15/17
E	Transition Support Team Q3 Report	6/15/17
SFTP	Monthly Encounter Data for May 2017	6/16/17 by 4 a.m.
CARE	Monthly IDD - Critical Incident Data for May 2017	6/30/17

July 2017

Type	Document	Due Date
E	Enhanced Community Coordination Invoice for June 2017 Expenditures	7/15/17
E	Transition Support Team Invoice for June 2017 Expenditures	7/15/17
SFTP	Monthly Encounter Data for June 2017	7/16/17 by 4 a.m.
HC/E	FY 2017 Q3 Financial Statements and Certification Form G	7/17/17
CARE	Monthly IDD - Critical Incident Data for June 2017	7/31/17

August 2017

Type	Document	Due Date
HC/E/F	HCS/TxHmL Enrollment Extension (Form 1045) Request Cut-Off Date for 4th Quarter	8/15/17
E	Enhanced Community Coordination Invoice for July 2017 Expenditures	8/15/17
E	Transition Support Team Invoice for July 2017 Expenditures	8/15/17
SFTP	Monthly Encounter Data for July 2017	8/16/17 by 4 a.m.
CARE	Monthly IDD - Critical Incident Data for July 2017	8/31/17
HC/E	Financial Auditor Engagement Letter for FY 2017	8/31/17

September 2017

Type	Document	Due Date
E	Annual HUB Sub-Contracting Report (Form F)	9/11/17
E	PASRR Service Coordination Caseload Annual Report	9/11/17
E	PASRR Reporting Manual Q4 Report	9/11/17
E	Enhanced Community Coordination Q4 Report	9/15/17
E	Transition Support Team Q4 Report	9/15/17
E	Crisis Services Q4 Report	9/15/17
E	Enhanced Community Coordination Invoice for August 2017 Expenditures	9/15/17
E	Transition Support Team Invoice for August 2017 Expenditures	9/15/17
SFTP	Monthly Encounter Data for August 2017	9/16/17 by 4 a.m.
SFTP	FY 2017 Q4 IDD Financial Reporting	9/21/17
CARE	Monthly IDD - Critical Incident Data for August 2017	9/29/17

October 2017

Type	Document	Due Date
HC/E	FY 2017 Q4 Financial Statements and Certification Form G	10/17/17

November 2017

Type	Document	Due Date
	No submissions	

December 2017

Type	Document	Due Date
SFTP	FY 2017 Q4 IDD Financial Reporting (Final for FY 2017)	12/29/17 by 5 p.m.

Type	Documents with No Specific Due Date
CANRS	Client Abuse & Neglect Form CANRS AN-1-A form within one business day of completion of form.
HC	Contract Amendment Request (Form C), when necessary
HC/E	Supporting reports, data, work papers, and information, upon request.
HC/E	Within five business days after request, Corrective Action Plan (CAP) that addresses the correction of any critical health, safety, rights, abuse, and neglect issues identified by DADS and a description of local oversight activities to monitor and maintain the correction of the identified problem.
HC/E	Within 30 days after request, Corrective Action Plan (CAP) that addresses the correction of an LA problem, other than one listed above, identified by DADS and a description of local oversight activities to monitor and maintain the correction of the identified problem.
HC/E	Within ten business days after request, affidavits of the LIDDA's governing body (Form A) and Executive Director (Form B).
HC/E	Within 30 days after the occurrence of any event that materially affects the accuracy of the information contained in any declaration, certification, or disclosure previously filed (Form D)
E	Update to Form S within five business days after changes become effective. All changes must be clearly identified.
E	In the event of a change in the designated Diversion Coordinator, the LIDDA must submit to DADS an updated Form S within five business days and the name of the designated interim/permanent Diversion Coordinator, along with their qualifications (resume).

ATTACHMENT Q
Community First Choice (CFC):
Assessments, Service Planning, and Service Coordination

The LIDDA must have an executed Memorandum of Understanding (MOU) with the Medicaid management care organizations (MCOs) serving STAR+PLUS and STAR Health members in the LIDDA's local service area.

I. Initial Eligibility Determination Activities

A. For members referred to the LIDDA for assessments for eligibility for CFC services on the basis of IDD, the LIDDA must complete all assessment activities required by DADS to determine whether the member meets an ICF/IID level-of-care (LOC), including the Intellectual Disability/Related Condition (ID/RC) Assessment for CFC (Form 8578-CFC) and Form 8662 (Related Conditions Eligibility Screening Instrument or (RCESI), if the member's primary diagnosis is a related condition. The LIDDA may have to conduct a Determination of Intellectual Disability (DID) or endorse an existing DID. (See *DID: Best Practice Guidelines* for additional information about conducting DIDs.) The LIDDA shall submit the assessment information to DADS using the CARE system for an LOC determination. If a member's primary diagnosis is a related condition, the LIDDA must:
   1. retain a physician's attestation that the member has a condition listed on the DADS-approved list of related conditions; and
   2. confirm on CARE screen K23 that the LIDDA has a physician's attestation.

B. For all members under the age of 21 years and those members 21 years of age or older for whom DADS has determined does not meet the criteria for an ICF/IID LOC, the LIDDA must compile a packet with the following documentation and submit it to the MCO via the secure FTP site:
   1. completed Contact Information Sheet and CFC Packet Checklist (Form 1040);
   2. completed ID/RC Assessment for CFC (Form 8578-CFC); and
   3. copy of the DID report.

II. Initial service planning and assignment of service coordinator for members 21 years of age or older with an ICF/IID LOC

A. For members 21 years of age and older with an ICF/IID LOC, the LIDDA must conduct the activities described in Section II.B-C of this Attachment Q no later than 30 days after DADS authorizes the member's ICF/IID LOC.

B. The LIDDA conducts person-centered service planning with the member and the LAR. The LIDDA contacts the member or LAR to schedule a time to meet and complete the CFC assessment (Form H6516). The meeting is conducted face-to-face with the member and the LAR. The LAR may attend by telephone if the LAR is unable to attend in person. The time and location of the meeting must be

convenient to the member and the LAR. At the scheduled meeting, the LIDDA shall:

1. complete the CFC Assessment (Form H6516);
2. complete the Needs Assessment Addendum (Form 2060-B);
3. complete the Consumer Directed Services Option Overview (Form 1581);
4. identify with the member and the LAR, a date, time, and location for the joint meeting with the MCO service coordinator, that is approximately three weeks after the completion of Form H6516;
5. provides a copy of the brochure titled "Community First Choice: Choosing a Provider" available at https://www.dads.state.tx.us/providers/cfc/ on the navigation tab on left side of the screen;
6. tells the member/LAR to expect a list of CFC providers from the MCO within the next two weeks;
7. encourages the member/LAR to be prepared to identify the selected CFC provider at the joint meeting; and
8. tells the member/LAR to contact the MCO with questions about providers.

C. The LIDDA must compile a packet with the following documentation and submit it to the MCO via the secure FTP site:
   1. a completed DADS Form 1040 (Contact Information Sheet and CFC Packet Checklist) that includes the date, time, and location of the scheduled joint meeting, and where the MCO sends a list of CFC providers;
   2. a copy of the DID report;
   3. the completed ID/RC Assessment for CFC (Form 8578-CFC);
   4. the completed CFC Assessment (Form H6516);
   5. the completed Needs Assessment Addendum (Form 2060-B);
   6. completed Consumer Directed Services Option Overview (Form 1581); and
   7. any other related documentation that may need to be submitted.

D. When the MCO receives the packet from the LIDDA, the MCO determines if the member has a need for CFC services.
   1. If no services are on the recommended service plan (i.e., Form H6516 completed by the LIDDA), the MCO denies the request for services and sends the member an adverse determination letter, which includes an offer for a fair hearing. In accordance with Section V of this Attachment, the LIDDA must participate in a fair hearing, if requested by the member or LAR, to explain why no services were recommended.
   2. If there are services on the recommended service plan, but the MCO does not agree with the services being recommended, the MCO service coordinator contacts the LIDDA to discuss the service plan and to reach an agreement about changes to the service plan that will be presented to the member. Following an agreement, the MCO service coordinator, the member, the LAR, and LIDDA meet to jointly review the services for which the member will be authorized. The MCO then authorizes services and notifies the member. The MCO also notifies the LIDDA of the selected provider.

3. If there are services on the recommended service plan and the MCO service coordinator agrees with the services being recommended, the MCO service coordinator, the member, the LAR, and LIDDA meet to jointly review the services for which the member will be authorized. The MCO then authorizes services and notifies the member. The MCO also notifies the LIDDA of the selected provider.

E. The LIDDA must ensure an assigned service coordinator provides service coordination to the member while the member is receiving CFC services through an MCO in the LIDDA's local service area.

III. Annual Reassessment

A. No later than 60 calendar days prior to the expiration of the ICF/IID LOC for a member, the LIDDA must communicate with the appropriate MCO to determine whether the member is receiving CFC services. For members who are receiving CFC services, the LIDDA must conduct the reassessment activities described in this section and communicate with the MCOs as directed by DADS. For members who are not receiving CFC services, the LIDDA has no reassessment responsibilities.

B. The LIDDA completes the ID/RC Assessment for CFC (Form 8578-CFC) for DADS to determine if the member continues to meet the ICF/IID LOC criteria. The LIDDA may have to complete a new Determination of Intellectual Disability (DID), if warranted or if the member's current DID was completed when the member was under the age of 22 years and the testing was done more than five years ago. (See *DID: Best Practice Guidelines* for additional information about conducting DIDs.) The LIDDA submits the assessment information to DADS using the CARE system for a level of care determination.

C. For all members under the age of 21 years and those members 21 years of age or older for whom DADS has determined does not continue meet the criteria for an ICF/IID LOC, the LIDDA must compile a packet with the following documentation and submit it to the MCO via the secure FTP site:
   1. completed Contact Information Sheet and CFC Packet Checklist (Form 1040);
   2. completed ID/RC Assessment for CFC (Form 8578-CFC); and
   3. DID report, if a new DID was completed.

IV. Annual service planning and continuation of service coordinator for members 21 years of age or older who continue to have an ICF/IID LOC

A. For a member 21 years of age or older who continues to have an ICF/IID LOC, the LIDDA conducts person centered service planning to determine what services the member needs. The LIDDA contacts the member or LAR to schedule a time to meet and complete the CFC assessment (Form H6516). The meeting is conducted face-to-face with the member and LAR and occurs at a

time and location convenient to the member and LAR. At the scheduled meeting, the LIDDA:

1. completes the CFC Assessment (Form H6516);
2. completes the Needs Assessment Addendum (Form 2060-B);
3. completes the Consumer Directed Services Option Overview (Form 1581);
4. identifies with the member and the LAR, a date, time, and location for the joint meeting with the MCO service coordinator, that is approximately three weeks after the completion of Form H6516; and
5. determines if the member or LAR wants to change providers, and if so, requests that the MCO send the member a list of providers using Form 1040.

B. No later than 45 calendar days prior to the expiration of a member's ICF/IID LOC, the LIDDA must compile a packet with the following documentation and submit it to the MCO via the secure FTP site:
   1. completed Contact Information Sheet and CFC Packet Checklist (Form 1040) that includes the date, time, and location of the joint meeting, and where to send provider information, if applicable;
   2. completed ID/RC Assessment for CFC (Form 8578-CFC);
   3. copy of the DID report, if a new DID was completed;
   4. completed CFC Assessment (Form H6516);
   5. completed Needs Assessment Addendum (Form 2060-B); and
   6. completed Consumer Directed Services Option Overview (Form 1581).

C. When the MCO receives the packet from the LIDDA, the MCO determines if the member continues to have a need for CFC services.
   1. If no services are on the recommended service plan (i.e., completed H6516), the MCO denies the request for services and sends the member an adverse determination letter, which includes an offer for a fair hearing. In accordance with Section V of this Attachment Q, the LIDDA must participate in a fair hearing, if requested by the member or the LAR, to explain why no services were recommended.
   2. If there are services on the recommended service plan, but the MCO does not agree with the services being recommended, the MCO service coordinator contacts the LIDDA to discuss the service plan and to reach an agreement about changes to the service plan that will be presented to the member. Following agreement, the MCO service coordinator, the member, the LAR, and LIDDA meet to jointly review the services for which the member will be authorized. The MCO then authorizes services and notifies the member.
   3. If there are services on the recommended service plan and the MCO service coordinator agrees with the services being recommended, the MCO service coordinator, the member, the LAR, and LIDDA meet to jointly review the services for which the member will be authorized. The MCO then authorizes services and notifies the member.
   4. If the member selected a different provider, the MCO notifies the LIDDA of the name of the selected provider.

D. The LIDDA continues to provide service coordination to the member while the member is receiving CFC services through an MCO in the LIDDA's local service area.

V. LIDDA Responsibilities When a Member Appeals an MCO's Denial of Services

If an MCO denies a member's request for service because there were no services on the member's recommended service plan (i.e., Form H6516 completed by the LIDDA) and the member requests a fair hearing to appeal the denial, the LIDDA must participate in the fair hearing to explain why no services were recommended.

ATTACHMENT T
Relevant Rules Grid for Providers of LIDDAs

"Provider" means any person or entity that contracts with the LIDDA to provide intellectual and developmental disabilities community services to consumers or the part of the LIDDA directly providing the community services to consumers.

Base Rules The LIDDA must require its providers to comply with the following base rules. The LIDDA must describe the procedures for each provider to follow to ensure the provider's compliance.
1. Protected Health Information (40 TAC, 4-A)
2. Rights of Individuals with an Intellectual Disability (40 TAC, 4-C)
3. Charges for Community Services (40 TAC, 2-C)
4. Criminal History and Registry Clearances (40 TAC, 4-K)
5. Abuse, Neglect, and Exploitation rules: ▪ Abuse, Neglect, and Exploitation in Local IDD Authorities and Community Centers (40 TAC, 4-L) ▪ Investigations in DADS and DSHS Facilities and Related Programs (40 TAC, Chapter 711)
6. Local Authority Notification and Appeal (40 TAC, 2-A)

The following charts identify the services (left column) described in the Performance Contract next to the relevant rules (right column) for which the provider must comply. All rules are in Title 40 of the Texas Administrative Code (TAC) unless otherwise noted. Rules are identified with their chapter and subchapter designation. For example, 40 TAC, Chapter 2, Subchapter A, is identified as "(2-A)."

IDD Service	Relevant Rules for Provider
Screening	The LIDDA must describe the procedures for each provider to follow in order for the LIDDA to comply with Role and Responsibilities of an LIDDA (2-G) - §2.305(b)(4). Section 2.307(b) governs screening.
Eligibility Determination	Diagnostic Eligibility – IDD Priority Population (5-D)
Service Coordination:	
A. Basic Service Coordination	*This service may not be contracted out.* Service Coordination (2-L)
B. Continuity of Services – State Facilities	*This service may not be contracted out to a non-LIDDA entity.* Continuity of Services – State Facilities (2-F)

IDD Service	Relevant Rules for Provider
C. Service Authorization and Monitoring	*This service may not be contracted out.* Service Coordination (2-L)
D. Service Coordination – HCS or TxHmL Program	*This service may not be contracted out.* Service Coordination (2-L)
IDD Community Services:	
A. Community Support	The LIDDA must describe the procedures for each provider to follow in order for the LIDDA to comply with Role and Responsibilities of an LIDDA (2-G) - §2.305(b)(4).
B. Respite	The LIDDA must describe the procedures for each provider to follow in order for the LIDDA to comply with Role and Responsibilities of an LIDDA (2-G) - §2.305(b)(4).
C. Employment Assistance	The LIDDA must describe the procedures for each provider to follow in order for the LIDDA to comply with Role and Responsibilities of an LIDDA (2-G) - §2.305(b)(4).
D. Supported Employment	The LIDDA must describe the procedures for each provider to follow in order for the LIDDA to comply with Role and Responsibilities of an LIDDA (2-G) - §2.305(b)(4).
E. Nursing	The LIDDA must describe the procedures for each provider to follow in order for the LIDDA to comply with Role and Responsibilities of an LIDDA (2-G) - §2.305(b)(4).
F. Behavioral Support	The LIDDA must describe the procedures for each provider to follow in order for the LIDDA to comply with Role and Responsibilities of an LIDDA (2-G) - §2.305(b)(4). Section 2.313(e) governs behavioral support.
G. Specialized Therapies	The LIDDA must describe the procedures for each provider to follow in order for the LIDDA to comply with Role and Responsibilities of an LIDDA (2-G) - §2.305(b)(4).
H. Vocational Training	The LIDDA must describe the procedures for each provider to follow in order for the LIDDA to comply with Role and Responsibilities of an LIDDA (2-G) - §2.305(b)(4).

IDD Service	Relevant Rules for Provider
I. Day Habilitation	The LIDDA must describe the procedures for each provider to follow in order for the LIDDA to comply with Role and Responsibilities of an LIDDA (2-G) - §2.305(b)(4).
Residential Services:	
A. Family Living	
B. Residential Living	
C. Contracted Specialized Residences	

If the following activity is included in any of the services listed above …	**Then the provider must also comply with the following relevant rules …**
Medication Practices	The LIDDA must describe the procedures for each provider to follow in order for the LIDDA to comply with §2.313(c) of rules governing the Role and Responsibilities of an LIDDA (2-G).
Use of Restraint	The LIDDA must describe the procedures for each provider to follow in order for the LIDDA to comply with §2.313(f) of rules governing the Role and Responsibilities of an LIDDA (2-G).
Consent for Psychoactive Medication	The LIDDA must describe the procedures for each provider to follow in order for the LIDDA to comply with §2.313(d) of rules governing the Role and Responsibilities of an LIDDA (2-G).

Additional Relevant Licensure Requirements and Rules

Additional licensure requirements and rules of other state agencies which may be applicable include but are not limited to:

For Providers That Serve Food	Texas Department of State Health Services (DSHS) rules governing food service (25 TAC, Part 1, Chapter 229)
For Institutions Providing Basic Child Care including institutions serving children with intellectual disability, residential treatment centers, halfway houses, and therapeutic camps	Texas Department of Family and Protective Services rules governing general residential operations (40 TAC, Part 19, Chapter 748)
For Assisted Living Facilities	Rules governing assisted living facilities (40 TAC, Ch. 92)

ATTACHMENT Y
Crisis Respite

The Local Intellectual and Developmental Disability Authority (LIDDA) shall ensure the provision of crisis respite in the LIDDA's local service area accordance with the requirements stated in this Attachment Y.

A. Definitions

1. "Crisis" means a situation in which:
   a) the individual presents an immediate danger to self or others; or
   b) the individual's mental or physical health is at risk of serious deterioration; or
   c) an individual believes he or she presents an immediate danger to self or others or that his or her mental or physical health is at risk of serious deterioration.

2. "Crisis respite" means short-term (up to 14 calendar days) respite for individuals with intellectual or developmental disabilities (IDD) as follows:
   a) Out-of-home crisis respite provides therapeutic support in a safe environment with staff on-site providing 24-hour supervision to an individual who is demonstrating a crisis that cannot be stabilized in a less intensive setting. Out-of-home crisis respite is provided in a setting for which the state provides oversight (for example, an ICF, a HCS group home, a Department of State Health Services-authorized crisis respite facility, or crisis residential facility); and
   b) In-home crisis respite provides therapeutic support to an individual, who is demonstrating a crisis, in the individual's residence when it is deemed clinically appropriate for the individual to remain in his or her natural environment, and it is anticipated the crisis can be stabilized within a 72-hour period.

3. "Therapeutic support" means a flexible array of services, including behavioral support provided to individuals with IDD who require varying therapeutic and habilitative levels of intervention to holistically address the stressors that result in challenging behaviors. Support may include training in:
   a) Activities to strengthen appropriate developmental functioning in areas of socialization, self-advocacy and rights;
   b) Developing coping skills; and
   c) Reducing or avoiding stressors to prevent crisis events.

B. Crisis Respite Plan

This Section B applies only if the LIDDA does not have an approved crisis respite plan by August 31, 2016.

1. The LIDDA must develop a crisis respite plan (the "plan") that ensures the provision of crisis respite to individuals with IDD in the LIDDA's local service area. The plan must:
   a) How the LIDDA will ensure the continuous availability of crisis respite for individuals with IDD, including whether the LIDDA:
      i. intends to ensure the provision of out-of-home crisis respite, in-home crisis respite, or both; and
      ii. will be responsible for operating crisis respite directly or through subcontract(s);
   b) State if the LIDDA will be responsible for operating or contracting for an out-of-home crisis respite location, which must be a setting for which the state provides oversight, and describe:
      i. the intended location(s), identified by county;
      ii. how the LIDDA will ensure the provision of therapeutic support;
      iii. how the LIDDA will staff the location; and
      iv. staff qualifications, which at a minimum must be consistent with 40 TAC, §2.315(h)(4), and required training for staff;
   d) State if the LIDDA will be responsible for ensuring in-home crisis respite, and describe:
      i. how the LIDDA will ensure the provision of therapeutic support;
      ii. how the LIDDA will staff in-home respite; and
      iii. staff qualifications, which at a minimum must be consistent with 40 TAC, §2.315(h)(4), and required training for staff;
   e) Include a timeline for plan implementation after approval by DADS;
   f) Describe how the LIDDA will address adverse trends, including recidivism; and
   g) Describe how fiscal year 2016 funds will be used to arrange and ensure the provision of crisis respite.

2. The LIDDA must submit a crisis respite plan to DADS using a DADS-approved format.

3. DADS will notify the LIDDA if the crisis respite plan is approved or if there is a need to modify or clarify the plan. The LIDDAs are required to make modifications as needed.

C. Revision to Approved Crisis Respite Plan

1. The LIDDA must revise its approved crisis plan to include a description of:
   a) how fiscal year 2017 funding for crisis respite will be used to arrange and ensure the provision of crisis respite in fiscal year 2017;
   b) the estimated service targets for fiscal year 2017;
   c) the timeline for implementing the revised crisis plan after approval; and
   d) any other necessary revisions to the approved crisis plan, including plans for expanding crisis respite services.

2. The LIDDA must submit the revised crisis plan to DADS using a format approved by DADS by September 15, 2016.

3. DADS will notify the LIDDA if the crisis respite plan is approved or if there is a need to modify or clarify the plan. The LIDDAs are required to make modifications as needed.

D. Notice of Plan Approval and Plan Implementation

DADS will notify the LIDDA of approval of the crisis plan and will instruct the LIDDA to proceed with implementing the approved plan.

E. Communicating to Stakeholders

The LIDDA is responsible for communicating to stakeholders, including IDD providers, advocacy organizations, law enforcement, and schools, about the provision of crisis respite within its funded allocation.

F. Reporting

The LIDDA will maintain documentation and report to DADS, by the 15th day of the month following each fiscal quarter, information related to crisis respite, including but not limited to individuals who received crisis services, individuals diverted from law enforcement involvement and individuals diverted from institutional settings, using a template provided by DADS.

G. Payment

DADS will pay an amount not to exceed the allocation as noted on Attachment C (Allocation Schedule) to the LIDDA. For fiscal year 2016 the LIDDA may use the allocation for startup costs prior to DADS approval of the LIDDA's crisis respite plan submitted in accordance with Section B of this attachment. The LIDDA must comply with Attachment V (Uniform Grant Management Standards and Uniform Administrative Requirements, Cost Principles, & Audit Requirements for Federal Awards Allowable Costs) of this contract related to allowable cost per the Uniform Grant Management Standards published by the Governor's Office and Planning, June 2004. DADS will pay an amount not to exceed the allocation to the LIDDA to implement the LIDDA's approved revised crisis respite plan in fiscal year 2017.

ATTACHMENT Z
Crisis Intervention Specialist

I. Background

The 84th Session of the Texas Legislature provided LIDDAs with funds to support individuals with intellectual and developmental disabilities (IDD) with significant behavioral and psychiatric challenges. These individuals often exhibit significant needs requiring additional support beyond the array of services typically provided within community programs. The funds will expand resources to address crisis situations with individuals who have IDD.

II. Definitions

A. "Crisis" means a situation in which:
   1. the individual presents an immediate danger to self or others; or
   2. the individual's mental or physical health is at risk of serious deterioration; or
   3. an individual believes he or she presents an immediate danger to self or others or that his or her mental or physical health is at risk of serious deterioration.

B. "Crisis respite" means short-term (up to 14 calendar days) respite for individuals with intellectual or developmental disabilities (IDD) as follows.
   1. Out-of-home crisis respite provides therapeutic support in a safe environment with staff on-site providing 24-hour supervision to an individual who is demonstrating a crisis that cannot be stabilized in a less intensive setting. Out-of-home crisis respite is provided in a setting for which the state provides oversight (for example, an ICF, a HCS group home, a Department of State Health Services (DSHS)-authorized crisis respite facility, or crisis residential facility); and
   2. In-home crisis respite provides therapeutic support to an individual who is demonstrating a crisis in the individual's home when it is deemed clinically appropriate for the individual to remain in his or her natural environment and it is anticipated the crisis can be stabilized within a 72-hour period.

C. "MCOT" means mobile crisis outreach team funded by the Department of State Health Services pursuant to its contracts with local mental health authorities, specifically Information Item V, available at https://wwwstage.dshs.state.tx.us/mhcontracts/FY-2016-Performance-Contract.aspx.

D. "Therapeutic support" means a flexible array of services, including behavioral support provided for individuals with IDD who require varying therapeutic and habilitative levels of intervention to holistically address the stressors that result in challenging behaviors. Support may include training in:

1. Activities to strengthen appropriate developmental functioning in areas of socialization, self-advocacy and rights;
2. Developing coping skills; and
3. Reducing or avoiding stressors to prevent crisis events.

E. “Transition Support Team” (formerly referred to as the "Medical, Behavioral, and Psychiatric Support Team") means a team of professionals, regionally constituted, to provide educational activities, technical assistance, and de-identified case-specific peer review support to LIDDAs and IDD providers within a region.

III. Responsibilities of the LIDDA

A. One staff assigned as a lead crisis intervention specialist

The LIDDA shall assign one full-time employee or contract employee as a lead crisis intervention specialist to oversee all activities required by this Attachment Z. The funding for one full-time equivalent crisis intervention specialist for fiscal year 2017 is the amount identified on Attachment C (Allocation Schedule). The LIDDA must ensure the lead crisis intervention specialist is not assigned responsibilities, duties, or tasks other than those described in section III.E. of this Attachment Z.

B. Additional staff

1. Except as allowed by Section III.B.2 of this Attachment Z, if the LIDDA is allocated funding in excess of one full-time equivalent as identified on Attachment C (Allocation Schedule) , the LIDDA must use the excess funds to assign additional staff to support the lead crisis intervention specialist within 60 calendar days after execution of the Amendment. Any additional staff assigned in accordance with this Attachment Z are prohibited from providing service coordination.
2. With written approval from DADS, the LIDDA may use allocated funding in excess of one full-time equivalent as identified on Attachment C (Allocation Schedule) to fund the provision of crisis respite in accordance with Attachment Y (Crisis Respite).

C. Qualifications of a crisis intervention specialist and additional staff

1. The LIDDA must ensure a crisis intervention specialist:
   a) Meets the preferred qualifications of one of the following:
      i. a provider of behavioral support contained in DADS rules governing the role and responsibilities of a local intellectual and developmental disability authority in 40 TAC, Chapter 2, Subchapter G, §2.313(e)(1)(B);
      ii. a Licensed Marriage and Family Therapist;
      iii. a Psychiatrist;
      iv. a Licensed Master Social Worker who is clinically supervised by a Licensed Professional Counselor, Licensed Psychologist, Licensed

Marriage and Family Therapist, Licensed Clinical Social Worker, or Psychiatrist in accordance with the definition of "supervision" in 22 Texas Administrative Code (TAC), Chapter 781, Subchapter A, §781.102(57)(B) (Definitions); or

iii. a licensure applicant with a temporary social work license as long as the applicant is fully licensed within six month after hire, in accordance with 22 TAC, Chapter 781, Subchapter D, §781.441 (Temporary License) and is clinically supervised as described in ii. above; or

b) Meets the minimum qualifications of:
   i. A qualified intellectual disability professional as defined in 42 Code of Federal Regulations (CFR), §483.430(a); and
   ii. At least two years of experience working with individuals with IDD who have mental health and behavior support needs or linking people with IDD to mental health supports, in addition to the one year of required experience of a qualified intellectual disability professional described in 42 CFR , §483.430(a)(1).

2. When a crisis intervention specialist meets minimum qualifications, but does not meet preferred qualifications, the LIDDA must ensure a person with preferred qualifications is available for consultation when deemed necessary by the crisis intervention specialist or if requested by an individual or family member.

3. The LIDDA must ensure additional staff meets the qualifications for:
   a) A qualified intellectual disability professional as defined in 42 Code of Federal Regulations, §483.430(a); or
   b) A Board Certified Assistant Behavior Analyst (BCaBA).

4. The LIDDA must ensure a crisis intervention specialist and additional staff be knowledgeable about IDD programs and services in the local service area.

D. Required training for a crisis intervention specialist and additional staff

The LIDDA must ensure that a crisis intervention specialist completes the training modules available at https://tango.uthscsa.edu/mhwidd within 30 calendar days after being assigned as a crisis intervention specialist. The LIDDA must ensure a crisis intervention specialist completes additional training modules within 45 days of the posting of new modules on this site.

E. Duties of a Crisis Intervention Specialist

1. The LIDDA must ensure a crisis intervention specialist:
   a) Provides information about IDD programs and services to:
      i. individuals with IDD and their families; and
      ii. IDD providers in the local service area;
   b) Collaborates with appropriate LIDDA staff and Transition Support Team members to identify individuals with IDD in the LIDDA's local service area who are at risk of requiring crisis services, such as individuals who exhibit

repeated and severe behavior disturbances that jeopardize the individual's safety or current living arrangement; and

c) For an individual identified in Section E. b. above:
   i. collaborates with the service coordinator, other members of the service planning team, and paid provider, if any, to identify:
      I) prevention strategies to avoid potential crisis events and to promote the individual's coping skills; and
      II) training and supports needs that provide the greatest chance of success of living in the community, such as scheduled respite services or planned crisis respite to avoid a potential crisis event; and
   ii. supports the service coordinator's provision of on-going follow-up and monitoring activities, including assisting the service coordinator, other members of the service planning team, and paid provider, if any, in addressing concerns and issues identified during follow-up and monitoring visits, such as involvement with law enforcement or emergency room visits.

2. The LIDDA must ensure a crisis intervention specialist:
   a) Provides education about the manner in which to engage individuals with IDD and their unique needs to:
      i. members of an MCOT to increase the competency of the members;
      ii. law enforcement; and
      iii. others as appropriate;
   b) is available to provide consultation to an MCOT as needed or as clinically indicated regarding a crisis event involving an individual with IDD;
   c) collaborates with an MCOT to develop criteria for referring an individual with IDD in crisis to crisis respite;
   d) for an individual referred to crisis respite, develops a crisis respite service plan describing the therapeutic support needed by the individual;
   e) collaborates with the service coordinator, other members of the service planning team, paid provider, if any, and natural supports regarding crisis follow-up and relapse prevention activities, including:
      i. assisting with an individual's transition from crisis respite back to his or her home or other appropriate setting; and
      ii. addressing concerns and issues identified during follow-up and monitoring visits, such as involvement with law enforcement or emergency room visits; and
   f) documents all activities, collaboration, and consultation provided in accordance with this attachment.

F. Communicating to Stakeholders

The LIDDA is responsible for communicating to stakeholders, including IDD providers, advocacy organizations, law enforcement, and schools, about the creation of the crisis intervention specialist position and the general duties of the position.

G. Reporting

The LIDDA will maintain documentation and submit a quarterly report, in a format prescribed by DADS, by the 15th day of the month following each fiscal quarter, to include the following information:

1. Number of calls from an MCOT related to individuals with IDD and type of response provided (e.g., phone, in-person);
2. Number of calls related to individuals with IDD in crisis who were not referred by an MCOT;
3. Number of calls from MCOT related to individuals with IDD for which a crisis intervention specialist was not available and the reasons for not being available;
4. Number and type of referral(s) made on behalf of an individual with IDD in crisis or following a crisis event;
5. Number of individuals with IDD in crisis in which law enforcements was not notified;
6. Number of individuals with IDD in crisis in which law enforcement was notified;
7. Number of individuals with IDD in crisis who were transported to a hospital or jail;
8. Number of individuals with IDD reunified to their home and community settings following a crisis event;
9. Number of caregivers and paid providers to whom a crisis intervention specialist provided training and consultation;
10. Number of individuals at risk of requiring crisis services identified in accordance with Section III.E.1.b.of this Attachment Z; and
11. Number of individuals with IDD referred to crisis respite who did not transition back to their home from crisis respite within 14 calendar days.